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

before

ASSEMBLY INSTITUTIONS, HEALTH AND WELFARE COMMITTEE

on

STATE PERINATAL PLAN DESIGNATIONS

Held:
February 10, 1981
Assembly Majority Conference Room
State House
Trenton, New Jersey

MEMBERS OF COMMITTEE PRESENT:

Assemblyman George J. Otlowski, Chairman
Assemblyman Raymond Lesniak, Vice-Chairman
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

* * *

I N D E X

ASSEMBLYMAN GEORGE J. OTLOWSKI (CHAIRMAN): Good morning. The meeting will please come to order. Before we begin the testimony this morning, I just have a brief statement to make just to bring this into focus and I want to point out that this hearing is being conducted by the Assembly Institutions, Health and Welfare Committee. On my left is Assemblyman John Markert and on my right is the staff person, John Kohler.

Some people have asked what the interest of this legislative committee was in convening these hearings. I guess I can only put it as simply as I did to those who asked and that was that it is the Legislature who has the ultimate responsibility to the residents of this state. With regard to the State Perinatal Designation Plan, we share this responsibility with others in the health planning process such as the Department of Health and the Statewide Health Coordinating Council. Today, we would first like to hear from Mr. Bernard Rabinowitz, the Chairman of the Statewide Health Coordinating Council and Mr. Gerald Reilly, the Chairman of the Perinatal Sub-Committee. So, with that, will you two gentlemen come up here so we can have you on the machine here? Mr. Reilly, do you or Mr. Rabinowitz have a preliminary statement to make before we go on?

MR. REILLY: Yes, sir.

B E R N A R D R A B I N O W I T Z: I am Bernard Rabinowitz, Chairman of the Statewide Health Coordinating Council. We welcome this opportunity to come before your Committee, Assemblyman, because we feel that we are presently achieving a solution to a very sticky, complicated perinatal plan designation process for New Jersey and the SHCC has been working on this process for a matter of several years. We've had the Statewide Health Coordinating Council Perinatal Sub-Committee operating in addition to the Department of Health plan and in the course of developing this Statewide Perinatal Plan, we have been guided by a variety of principles. The primary one was to improve health care in the State of New Jersey. In the course of these deliberations, we have called upon expertise from the hospitals, from the professional area, from consumers and, indeed, from the many published sources. It was no surprise that we attracted such enormous public interest insofar as the perinatal designations are concerned and at each level in our deliberations in this planning process, we solicited at every level an input from those people who were directly affected and indirectly affected at the consumer level, at the professional level and at the hospital level. At our last session dealing with the perinatal designation, we came down, essentially, to several areas where we could not reach total agreement and, as a consequence, requested a 90 day extension for action by the SHCC in this connection and directed Commissioner Reilly and his sub-committee to deal fairly with the issues that were raised. Gerry, would you like to address that?

G E R A L D R E I L L Y: I think, as we all understand, the purpose of regionalization of any health care service is to assure the best quality that we can by assuring that the resources necessary to deliver a certain service are available at the site that purports to deliver that service, number one; and, number two, to do it in the most cost effective way we can. We're all terribly concerned with the seemingly uncontrolable escalation of health care costs and one part of the response to that escalation in cost is to try to have a rational planning process that assures that very, very high cost technologies and very, very high cost staffs are distributed in a way that makes sense for the people of New Jersey and at a cost that we can afford.

As we attempted to develop a plan for the regionalization of perinatal services in the State, certain criteria were developed, quantitative criteria, the number of births, the kinds of staffs, the number of bassinets and so forth, and when we attempted to apply those criteria against the real world of what I call the natural regionalization that has been occurring in New Jersey, we found that the fit was pretty good, but not perfect. Therein was the rub and the problem. Where the fit was not perfect with the present system of natural regionalization and had we moved ahead adopted designations consistent with the plan and regulation, there were a lot of people who felt that they would be unfairly out in the cold and I think, therein, lies the root of a lot of the feedback that you've been getting as members of the Legislature.

As Mr. Rabinowitz said, the State Health Planning Council, in November, asked us to go back and take a look at this fit of the planning regulation against the real world situation and see whether we could come up with some sensible recommendations. We've met, I think, four times since then; we've heard expert testimony from the medical community; we've heard expert testimony from the hospital community; we've heard testimony from the nursing community and at our meeting last week, the Sub-Committee on Perinatal agreed on a set of recommendations that we want to present to the State Health Planning Council on February 27. Let me outline those for you.

As a context, the Committee agreed and agreed strongly that the process of regionalization has to go forward because there are many important things to be done in improving perinatal care and this preoccupation with the designation process has diverted people from the real work of establishing the proper referal protocols between institutions, having institutions get on with the proper educational work, get on with attacking the root cause of many perinatal difficulties, which is lack of preparation and education of the mother and improper nutrition, low birth weight of infants and so on. So, the Committee felt it was very important for us to try to fashion a sensible compromise that would let us go forward.

The principles of the compromise are, number one, that we should approve level 3 designations for any facilities that clearly meet the current plan and regulation. One facility that falls into that category is St. Peter's in New Brunswick. Number two, and this is one of the roots of the compromise, that we should conduct a demonstration project involving all the hospitals in New Jersey, through which we would be able to approve, on a demonstration basis, several joint level 3 perinatal centers and several level 3 free standing perinatal centers that, while possessing all of the attributes of a fine quality perinatal level 3 center, do not meet the 2,000 birth requirement. The hospitals that, at this point, would appear to come in under this proposed demonstration would be Cooper-Lords in Camden, as a joint level 3 center; Monmouth-Jersey Shore in Eastern Monmouth County, as a joint level 3 center; St. Joseph's in Paterson and Newark Beth Isreal as level 3 centers who have slightly below 2,000 births.

The third principle, and this was another critical issue concerning a lot of people, was that we should permit low birth maternity units, generally under 500 per year, to continue operating, but require them to participate in the demonstration project that would entail special monitoring of both the cost and the outcomes of their activities. While it may be true that nationally there can be some problems demonstrated with hospitals with a low birth, that is not necessarily true in all situations and from the information that is available to me, it appears that all New Jersey hospitals providing maternity care are providing it an acceptable level. This principle would allow those facilities to continue to operate. The one stipulation

is that, to the extent that they are high cost, that is a cost that should be borne by the institution and not passed on to other third party payers. If an institution feels, because of its tradition and its committment to its community and the expectations of its community, that it does want to continue operating, even though it may be uneconomical in a strict cost accounting point of view--and we don't know that yet--they should be free to do that, but, on the other hand, they shouldn't expect other payers in the health care system to pay for that committment that they want to make.

The fourth principle is to move ahead with level one and two designations in accord, generally, with the plan and regulation for all other hospitals in the system and to investigate whether we should eventually be moving toward a two tiered system of perinatal services. There is a debate. In testimony we heard from the medical community, there seems to be some belief that we really should have a two tiered system rather than a three tiered system to avoid the excessive number of transports of infants between the three levels and also to assure certain levels of quality and to assure that certain procedures and support services are available at all situations where people would be having babies in New Jersey. The other side of that argument is that you need a three tiered system because it becomes very costly to concentrate that technology across a wide base of many level two's. We don't have a conclusive answer to that. It seems that throughout the nation the planners tend to be in favor of the three tiered system and the medical community seem to be in favor of the two tiered system. But, what we said is that for the present time we would go with the three tiered system, but have an honest, open mind and look at whether we should be moving toward a two tiered system.

The fifth principle is that this entire demonstration project should be conducted in an honest and dispassionate and objective way and we had testimony at our last meeting from Mr. Joel May from the Hospital Research Educational Trust as to how he and his organization would conduct such a research project. I think all members of the committee were impressed by both the lucidity of his explanation and his sense of integrity as a researcher. The Hospital Research Educational Trust is associated with the New Jersey Hospital Association and some would argue that that might cast suspicion on its objectivity. I think because of the character and reputation of that organization and its executive director, Mr. May, that both planners who are outside of the hospital system and people within the hospital system both have confidence in his organization and in the integrity of the research that would come from that organization. We are hopeful that when we go back to the SHCC on February 27 that we can get concensus from the full State Health Planning Council that this a viable direction, that we should move in. It allows us to give endorsement to a natural regionalization that has occured in New Jersey, but it does not give a final sign-off on that process. It requires us to move ahead and take a good hard look over a two year period as to the real outcomes and costs of that process and then we have to be honest enough, at the end of that period, to say if we've made any mistakes or if some of our assumptions were wrong, we have to be willing to re-examine them and I think it is important that that's understood at the very outset because you have people on two poles of this situation. You have people who would prefer to see the present system simply go forward with no scrutiny and be accepted and, on the other hand, you have people who would rather that we design a theoretically ideal system and impose it. Neither of those alternatives is going to work, in my opinion. I think what we have to do is have a compromise of those two views and I think we're moving in that direction.

ASSEMBLYMAN OTLOWSKI: Thank you for your testimony. Am I correct in deducing that you're in a period, now, of adjustment and you are still in this period of flexibility? However, you are staying in the three tier system, but with more flexibility and, as a matter of fact, you are still working on adjustment, is that what you're saying?

MR. REILLY: Yes. We would start out with a three tiered system and we would examine the question, the research project would examine the question of whether it might make more sense to have a two tiered system.

ASSEMBLYMAN OTLOWSKI: Assemblyman Snedeker?

ASSEMBLYMAN SNEDEKER: What's the cost of all these? We're just going into DRG and I know hospitals are having problems with this and now we're going to put another burden on top of them and say, "All right, now, start monitoring your births and reports and records," and somebody winds up paying for this in the State of New Jersey and it usually ends up being the person who goes to the hospital. So, what are we talking about with the cost of all this?

MR. REILLY: Well, the cost of the research project is estimated to be $150,000 to $200,000, over an 18 month, 2 year cycle. But, the very point of the regionalization, one of its objectives, is to minimize cost or reduce the rate of increase and I would suggest that it would be far in excess of the $150,000 or $200,000 that we would spend to validate that we have a rational system. If we would merely have no planning and let water seek its own level, in my opinion, you would have many, many hospitals naturally gravitating, for good reasons, to the highest level of technology, attempting to amass the most expert staff they could and a competition that is really not healthy in the health industry develops and I think you would have costs far in excess of any of the costs associated with trying to do it in a meaningful way.

ASSEMBLYMAN SNEDEKER: Jerry, I've never seen anything that we've done here in the State of New Jersey, since you and I have both been here, that we've saved money on.

MR. REILLY: Well, that's not true. Let me say something about that. I just say in a federal journal a comparison of states who are doing aggressive hospital cost containment against the national average and the New Jersey is about 4 percentage points better in the rate of controlling hospital costs than other states. These figures are off the top of my head, but if the national is moving at 13%, New Jersey was moving at 9%. If you put that 4% over a billion dollar hospital industry, that's $40 million per year that rate setting activities and the voluntary efforts of the hospital associations have generated in New Jersey and if we didn't have that effort we would have spent money. The proof of the pudding is that other states are spending it. So, I would disagree with that. We don't see it as a reduction in cost, but what you do see is a slowing in the rate of increase that you would otherwise have. I'll send you that statement.

ASSEMBLYMAN SNEDEKER: The problem that I have with this is that you generate so much paper through the state, flowing back and forth. It looks like another Thorough and Efficient Education problem that we're going to go through with just shuffling papers back and forth and really, you're not accomplishing anything. Can't you pilot this on just a few hospitals instead of trying to do this all through the State of New Jersey? It could be one or two with the State picking up the cost of the survey. Why make everyone go through this?

MR. REILLY: Well, most of the information required to do the research is readily available from materials already prepared and submitted by hospitals through the share system and the DRG system and so forth. I'm not the expert in research and I'm really not competent to explain it. But, when these kinds of questions were asked of Mr. May from the Hospital Research Education Trust, he had satisfactory answers that most of it was from sources readily available.

ASSEMBLYMAN SNEDEKER: They don't have to send you anything. You are going to be able to pump it out, what you have in your records now or what?

MR. REILLY: I think, by and large--and he also indicated that his conversations with hospitals--and you may ask Mr. Slavin who is going to testify later from the hospital association--they seem willing to cooperate in this effort in providing information.

ASSEMBLYMAN SNEDEKER: We don't give them much choice when we come up with a law that says you have to do it. That's not much of a choice that we give them when we say that they have to do this or we're going to do it anyway. That's all I have, Mr. Chairman. I'm not happy with it, but we're part of it, I guess.

ASSEMBLYMAN OTLOWSKI: Assemblyman Markert?

ASSEMBLYMAN MARKERT: Jerry, originally, we had a four tiered system or, at least, it was considered a four tiered system, I thought, which was the 1, the 2, the 2A and the 3. Basically, what has happened to the 2A level?

MR. REILLY: I think the contemplation is that the 2A would continue because it has certain unique requirements of geographical areas in the state that, while not warranting a 3 or require a 3, do require some special designation and I think the contemplation is that that will continue. At least that is my understanding of it.

ASSEMBLYMAN MARKERT: So, in those areas, rather than upgrade 2 to 3--which I completely agree with, by the way; I don't think we need level 3's every 250 miles in the state, but I do believe we need that area of the 2 and the 2A. Also, let's take area 1, the first level. Your studies are going to address the cost factors within those particular areas of the level 1's, as well as the others, correct?

MR. RABINOWITZ: Well, the study will cover the entire delivery of maternal perinatal care.

ASSEMBLYMAN MARKERT: Well, specifically, answer the question in regard to level 1.

MR. RABINOWITZ: 1's are included, absolutely.

ASSEMBLYMAN MARKERT: Fine. Therefore, there is the possibility that we still may be, at this point in time, eliminating the basic maternity care on the level 1 of those hospitals that are providing just that level?

MR. REILLY: No. There were five potential level 1 hospitals that could have been closed under the original plan and recommendation or recommended for closing. These were at or near 500 or below 500 births. There are 25 or 30, many level 1's in the state that the original plan contemplated operating from here on out. So, make that distinction. Among level 1's there is--

ASSEMBLYMAN MARKERT: I think the number was exactly five.

MR. REILLY: Then, there are level 1's that are not low birth. They have 1,000 to 1,500 births and then there were some that were below 1,000, but because of geographic isolation were going to be recommended to continue. The notion is that those would continue on into the future and meet basic needs. Then, there is another debate that says, perhaps, what we should be moving toward is a two tiered

system where a level 1 should either be becoming a 2 or should be deciding not to be in the maternity business. But, that's an open question. The present plan is that we have a three tiered system and there are level 1's that are continuing. I think the tendency would be, if you move in any direction, for those level 1's to become 2's over time and upgrade their capacity.

ASSEMBLYMAN MARKERT: Depending upon the birth record and so forth in the state, which happens to be decreasing at this point in time.

MR. REILLY: There is one other important point which is that to be a 1 is, in no way, a term of approbation. A level 1 facility has to be a first rate facility, capable of providing first rate services. The only question is, as conditions get esoteric and extremely complex, they may not have the technology to deal with that and have to have a proper way to refer those infants out or high risk mothers that can be identified beforehand to refer them out. But, a level 1 facility is a first rate facility. I think that that has to be understood.

ASSEMBLYMAN MARKERT: Jerry, if I might, in addressing that national level of cost that you said, just off the the top of your head, that New Jersey was four percentage points or close to it below the rest of the nation and as you said also, and you did address it, this has been a voluntary savings, I think. It was not through the legislation and through the department itself. I think it is because the industry has been policing itself and the industry has been working toward the containment of cost and the lowering of cost. This is probably why, in the State of New Jersey, we can reflect such a fine rate level in comparison to the rest of the country.

MR. REILLY: I don't know whether the hospital association would agree with you or not about whether how voluntary it has been. I think it has been both. I think they've made a good faith effort and they've been concerned about cost. But, really, I think the state regulatory oversight has had a large part to play in it as well. Because, other states have tried voluntary alone and it hasn't been as successful as we have.

ASSEMBLYMAN MARKERT: With relationship to that 90 day extension that you did approve, how is that 90 days now going to be effectuated with this new proposal that you are addressing to us today?

MR. REILLY: Well, that was a limitation imposed upon ourselves by the State Health Planning Council and the way we view it is that if the State Health Planning Council agrees with this plan and says, "Yes, we agree," then the Perinatal Subcommittee will meet again in March and start the process of designations once again.

ASSEMBLYMAN MARKERT: For my own thought now, just to get myself into this time frame, this new proposal is going to be suggested at what point in time? When is this 90 day extension or holdover going to end and at what point are you to be addressing the proposed new plan and by what time are they going to be possibly accepting or denying it?

MR. REILLY: Well, hopefully, February 27, this month, that will be 90 days since November. Hopefully, the State Health Planning Council will accept our proposal as a way to proceed with that. Then, in early March, I believe it is March 11, we're scheduled to meet again as a subcommittee to get on with the 1 and 2 designations. For the joint level 3's, there will have to be some additional work for the Health Department and those hospitals who want to participate in a joint level 3.

ASSEMBLYMAN MARKERT: All right, let's not go that far. February 27 is the deadline on the 90 days?

MR. RABINOWITZ: That is when the SHCC meets to receive Commissioner Reilly's report.

ASSEMBLYMAN MARKERT: The 90 days end on the 27th?

MR. RABINOWITZ: Right, roughly.

ASSEMBLYMAN MARKERT: And the 27th day you're going to meet, or before?

MR. RABINOWITZ: No, on the 27th.

ASSEMBLYMAN MARKERT: So, the outcome of that meeting, then, will give us the knowledge of what you intend to do.

MR. REILLY: Except for St. Peter's, there would be no action taken on designations on the 27th. What the SHCC would be doing is accepting our proposals to proceed except in these four principles. St. Peter's, we are recommending that they be designated right now, because there is need for current plan and regulation and there is no point in holding up that designation.

ASSEMBLYMAN MARKERT: I agree with you there.

MR. RABINOWITZ: I think it is important, also, just for the record, to understand that the designation process carries with it all of the safeguards that the regular certificate of need process carries in terms of appeal, in terms of providing data, providing background and anybody in the designation process has all of these levels to have an adequate review of his request to be so designated at all levels, including administrative review.

ASSEMBLYMAN SNEDEKER: Do you intend to publish these rules and regulations in the New Jersey Registrar, once you're ready with them?

MR. RABINOWITZ: Well, our meetings are, of course, public meetings.

ASSEMBLYMAN SNEDEKER: But, do you intend to publish the rules, as to how this is going to work, in the Registrar, as we usually do?

MR. REILLY: This plan and these regulations have already been through the publication process and the demonstration aspect of it would operate under a rule that's already been through the process. So, there would be no going back through the New Jersey Registrar or the Health Care Administration Board to put into operation these concepts.

ASSEMBLYMAN SNEDEKER: But, you're changing the plan, aren't you?

MR. REILLY: No. That's one of the things that we specifically decided not to do in the deliberations. We decided not to change the plan because nobody was able to say what numbers we could develop around which there would be complete concensus. Everybody felt that if we changed the number 2,000 to 1,800 or 500 to 250 we would run into the exact same problems that we had before. So, our recommendation is that we approach it on a demonstration basis and try to capitalize on the natural regionalization that has already occured in the state and say, "Okay, this is the way that it has been working. This is what the hospitals have been telling us makes sense. Let's look at it and test it out and give them the benefit of the doubt that it does make sense."

ASSEMBLYMAN SNEDEKER: Well, that demonstration, isn't that a change from what was published in the Registrar some time ago, in other words?

MR. REILLY: No. The plan would stand. If, after the demonstration, based upon better and more information, we decided that the plan should change formally, then we would go through that process and I think the Health Care Administration Board has to approve regulation changes and then it goes into the New Jersey Registrar.

ASSEMBLYMAN SNEDEKER: After the demonstration?

MR. RABINOWITZ: That would be after the demonstration. Our intention is to use the data developed by the demonstration process and by the study prepared by the HRET as a basis for modifying the regulations if it becomes necessary.

ASSEMBLYMAN SNEDEKER: You understand, as of yesterday, that the Legislature overrode the Governor and we have another crack at you as to whether or not you can adopt these rules and regulations, since we now have the right to go over the rules and regulations that department heads publish in the Registrar, as of yesterday.

MR. REILLY: I heard that.

ASSEMBLYMAN SNEDEKER: I think you will hear a lot more about it. There's going to be a question as to whether we do or don't, but we're going to go over it again, I'm sure.

ASSEMBLYMAN OTLOWSKI: In that connection, I asked one question. I asked that question because I thought we were on a road that changed course from where we were at the last hearing and when Assemblyman Snedeker now asks the question if there would be changes in the Registrar, you said no. How can you make changes or adjustments and not have them recorded as a part of the plan?

MR. REILLY: Well, the course that we were on, as I tried to outline in my introductory remarks, followed the plan and the regulations and I think that a lot of people felt that the plan and the regulations might have been too rigid and that it did not take into account the real world developments in New Jersey and the real patterns of care, patterns of referral and activities of many New Jersey institutions. But, the difficulty we faced was to decide to come up with a new set of numbers by which we would measure our institutions and our belief was that there was no set of numbers that would do the job. A more sensible approach would be to carefully look at the present, natural system of regionalization that we've had and see whether it makes sense and then decide whether we could come with new numbers and then whether we had to change the plan.

ASSEMBLYMAN OTLOWSKI: But, again, the basic question is: How can you have change if the change is not a part of the record?

MR. REILLY: Well, it is part of the record in the sense that this is a legal process in which people have legal rights and the minutes of the Subcommittee on Designation, our public record, all of our meetings were open, well-attended, well-covered by the media. When the Commissioner of Health actually has to make designations pursuant to our recommendations, all the parties involved have their appeal rights. If she's not going to be able to issue a designation until she gets a review from the Attorney General as to the appropriateness of the action taken, if we were to say, "Let's change the plan and let's change the regulation," our concern would be that that would be a one year process, by the time we did that, and that we would lose again the benefits of perinatal regionalization for that long period of time. What we're really concerned about is that we have to let the hospitals get on with fulfilling their responsibilities, in community education, in professional education and in the provision of care and the proper protocols for transfer. Infant mortality continues to be a serious problem in New Jersey. Although it has declined significantly, there is still a lot of work to be done and if we wait around for the perfect plan for another year, I think that we will be further behind in addressing those problems and the Committee feels that way. That's why we thought that the best way to proceed was on the demonstration basis.

MR. RABINOWITZ: For example, Assemblyman, if I may address the subject as well, the problem that Jerry alludes to was the fact that the SHCC had adopted

as non-waiverable certain criteria. What Commissioner Reilly is now saying is that he intends to suggest to the SHCC that the word non-waiverable, essentially, be eliminated. In that case, we can proceed without any major changes.

MR. REILLY: As an example of that, we were proceeding under the notion that you can't split intensive care beds and if you can't split intensive care beds, that means you can't have a joint perinatal center. Well, a lot of good arguments were made in a presentation to us that in some cases a joint perinatal center makes very good sense, can be more cost effective than a single perinatal center in a certain region. For example, in eastern Monmouth County, the argument is made that because of the number of people that they have there, if you're going to have a level 3 center, it is going to require--

ASSEMBLYMAN OTLOWSKI: Excuse me. We're getting caught in semantics here. It was a simple question put to you. The simple question that was put to you was the fact that there was an understanding that there were changes that were going to be made that were workable, practicable, acceptable to all of the people involved. Now, if you're going to make those changes, it seems to me that those changes would have to be put in the kind of simple language, that change can be spelled out and it seems to me that we're getting caught here. We're getting caught in the merry-go-round of semantics. Yes, we have change, but, no, the change isn't complete because we're not making changes. This is the kind of conversation that I'm getting here.

MR. RABINOWITZ: It's not quite that, Assemblyman, and I'm sorry that that's the impression that is coming across. The fact is that the regulations do permit demonstration projects to develop the data which can be used to alter regulations. So, this is not a departure and the only departure, as I say, is from using the word "non-waiverable" in terms of, for example, the number of births or the location of all of the bassinets in one spot.

ASSEMBLYMAN OTLOWSKI: But, it seems to me that if you're going to have something that is going to be, as I said, workable and be acceptable and practicable and, as a matter of fact, fit into the kind of a system that would allow for flexibility, allow for adjustment, allow for people to come in or for people to be put out after a reasonable amount of time, you're going to have to change your position from the position that you are in originally. Now, if you make that change, it seems to me that the question that Assemblyman Snedeker is asking is a very pertinant one. How is that going to reflect in the record or are we going to constantly be in the position that he then mentioned and I don't like to be placed in that position where we constantly have to have you under surveillance, constantly have to have legislative oversight. It seems to me that we ought to be able to work this out in a one shot thing and what we're doing now, we're right back where we started originally, it seems to me.

MR. REILLY: I understand what you're saying, but I don't think we're right back where we were. Originally, we had a plan and a regulation that made a lot of people unhappy because people said that it was too rigid, that it was inflexible, that it did not take into account legitimate factors in the real world. The choice we had was to try to rewrite that plan and that regulation in a way that would accomodate it and, as we tried to do that, I think we understood that we really didn't have enough information. We had maybe ten views of what that ideal plan should look like and my view was different from somebody else's view and a third person had a different view than my view and to come to a consensus on that, it would probably take a year and would delay the real progress that we think could be made in regionalization.

ASSEMBLYMAN OTLOWSKI: Why would it delay it, if you changed your course? Why delay it?

MR. REILLY: Because, the point of the demonstration is that the more we got into it, the more we found that we didn't have the kind of solid information that we had confidence in to make a determination five or ten years out and the demonstration would develop that.

ASSEMBLYMAN OTLOWSKI: Excuse me. You're making a decision, it seems to me, that may put a number of hospitals out of business.

MR. REILLY: No. That's the point.

MR. RABINOWITZ: That's exactly the point. We're not.

ASSEMBLYMAN OTLOWSKI: You're not making a decision that is going to affect other hospitals and their approach to this whole subject? It seems to me that what this Committee got from the hospitals was the fact that that very thing was happening, that they were frightened and afraid that a number of hospitals were going to be hurt.

MR. REILLY: They were exactly frightened of that and what this would do, particularly with those low birth hospitals, is to say that it is the policy of the State Health Planning Process not to say that they should go out of business because they fail to meet some criteria in a plan, but what they should do is they should honestly look at themselves over a period of time as to the outcomes of those units and the cost. Nobody is saying that they should close.

ASSEMBLYMAN OTLOWSKI: Let me ask you this question. In the course of a normal birth, what is the average cost to the hospital, the average cost?

MR. REILLY: I don't know that answer. I'm not competent to answer that.

ASSEMBLYMAN OTLOWSKI: You're not in a position to answer that question?

MR. REILLY: No, sir.

ASSEMBLYMAN OTLOWSKI: Then, how are we going to measure the differences in the cost of first, second and third level facilities if we don't have the basic cost?

MR. REILLY: Because, Mr. May from the Hospital Research Educational Trust is competent to answer that question and that data is available. I don't happen to have it in my mind. Other people have that information. I don't.

ASSEMBLYMAN MARKERT: Jerry, you know, what the Chairman is saying about going around and going anyplace but where we started from is the impression that I still have, after all of these questions and after all of the answers. On February 27, the 90 day hold on the proposed plan and regulations is finished, right?

MR. REILLY: Yes.

ASSEMBLYMAN MARKERT: I mean, the 90 day hold is over? We have reached the end of the 90 day period on the hold of the implementation of the plan and regulations.

MR. REILLY: But, nothing drastic happens at the end of the 90 days.

ASSEMBLYMAN MARKERT: Just answer the question. It ends as of the end of February 27.

MR. REILLY: Right.

ASSEMBLYMAN MARKERT: Therefore, without any type of action, formal action, on your behalf, that plan and regulation is effective.

MR. REILLY: No way.

ASSEMBLYMAN MARKERT: It's been printed in the Registrar. Why isn't it effective after that?

MR. REILLY: The plan and regulation is the roadmap which we travel when we make designations. The key decision is to make the designation. If we were, on the 27th, to recommend to the Commissioner that five low birth hospitals be recommended for closing, that is the key decision. That's not going to happen.

ASSEMBLYMAN MARKERT: Then, let me try to understand it. I think I have a little better concept now. The plan and the regulation is basically just a roadmap and the designations on that roadmap, if we were going to address it in that sense, that is going to be something that you are now going to make the proposal on? This is not, under the plan and regulation as it sits, going to become a reality until such time that you've been able to address these demonstration projects, which you anticipate is going to take, I don't know how long. You said what, about a year?

MR. REILLY: The demonstration projects for the joint level 3's, Mr. May estimates it will take about 18 months to conduct once the research design is in place. To take the analogy further, what our plan does is to look at the roadmap and say to the State Health Planning Council, "Give us a break. Give us a little flexibility in how we navigate that roadmap." We think the plan, basically, makes sense.

ASSEMBLYMAN MARKERT: You're going to ask for that flexibility on the 27th?

MR. REILLY: Correct.

ASSEMBLYMAN MARKERT: Will that be added to and become a part of the regulation and the plan?

MR. REILLY: We would ask for that regulation under the demonstration regulation that already exists. They just have to tell us that it is all right for us to use that.

ASSEMBLYMAN MARKERT: Well, if it already exists, the demonstration level already exists, how come you can't use it?

MR. REILLY: No. The authority to do a demonstration exists in theory. What we want to ask the State Health Planning Council is whether they will concur with our recommendations to let us apply it in this situation.

ASSEMBLYMAN MARKERT: What if that doesn't happen?

MR. REILLY: Then, we're back to ground zero. Then, we're right back in the soup.

ASSEMBLYMAN MARKERT: I would like to know, the minute after you have that meeting on the 27th, just what that decision is going to be. I'm sure the Chairman would want to know also.

ASSEMBLYMAN SNEDEKER: Jerry, they published the recommended courses of action and in here it says, 4.3c, in accordance with the perinatal regulation, all services with "fewer than 500 deliveries per year" shall be phased out or consolidated at the completion of the plan implementation process. Now, that is part of your published rules. So, if you have less than 500 deliveries per year, they must either be consolidated with someone else or be phased out. Now, that says nothing about a demonstration. It says we are or you will consolidate.

MR. REILLY: What we're asking is that under the demonstration regulation that we be permitted to not put into effect that provision of the plan, of the regulation, that we be permitted to have the low birth hospitals participate with the other hospitals in the state in the study of the perinatal system and that they not be asked to close.

ASSEMBLYMAN SNEDEKER: Why don't you withdraw these rules and regulations and change them altogether and say that in one set?

MR. RABINOWITZ: Because that would require another 18 months to 2 years to develop. I thought I had indicated--

ASSEMBLYMAN OTLOWSKI: Making that kind of a change would require that long a period of time?

MR. REILLY: It's not only that change. It's a whole variety of changes.

MR. RABINOWITZ: You see, Assemblyman, we're talking about the whole constellation of health care, maternal health care. It isn't just a regulation or a hospital that we're dealing with. So, in order to go back over this, in all fairness, as the Commissioner has indicated, we don't really have enough hard data to be able to say that 500 is the right number or 499 is the right number and if we adopt 499, someone will say that 489 is the right number. So, the intent of the essential process that the Commissioner will recommend to the SHCC is to give us an opportunity to implement the generalized perinatal process so that, for example, the hospitals that are designated can begin to collect what they are entitled to in terms of providing service.

ASSEMBLYMAN OTLOWSKI: It seems to me that you're going to have a problem with the Committee and even with the Legislature, particularly insofar as regulations are concerned, if the regulations do not reflect some of the things that we talked about and some of the things that we expected to happen as a result of this hearing. I think that that's going to be a mistake and I think you're walking right into trouble.

MR. REILLY: Assemblyman, what you're really asking a committee--I happen to work for the State. Maybe one other person on that committee does. These are volunteers, they are consumers, they are providers, they are affiliated with hospitals, they are lawyers, they are citizens of New Jersey. What you are asking me to tell that committee is that rather than develop an intelligent and reasonable--

ASSEMBLYMAN OTLOWSKI: Wait a minute. Maybe you're opening the door now. Are you saying that this committee, SHCC, that the function that they have is such that it is so rigid that it can't be changed and maybe what we ought to do is march them to the guillotine?

MR. REILLY: No, no. What I'm saying is that, obviously, the Legislature created the Act of the State that authorizes the SHCC. Obviously, the Legislature has the ultimate authority in a situation such as this. But, what I'm hearing you say to me is that I should tell those people that they should not work for a compromise, they should move to an extreme position, which is that they should not have anything in their plan that makes any hospital in the state nervous. Maybe I'm hearing that wrong.

ASSEMBLYMAN OTLOWSKI: The fact is that, now, you've opened another door because it may be that where the problem actually rests is with this SHCC. It may be there and it may be that we ought to take a look at that to see if that committee, of course, is going beyond any authority that any committee should have.

MR. REILLY: No, no, I don't think they are.

ASSEMBLYMAN SNEDEKER: Did they recommend all these things, Jerry, that we have in here? Did that committee recommend all these things?

MR. REILLY: That committee, after a process that involved many, many people, professional people, hospital people, not always agreeing, that State Health Clinic Council adopted that recommendation--well, they can't adopt. They don't have authority to do that. They recommended to the Commissioner of Health that that be adopted. The Commissioner of Health then recommends to the Health Care Administration Board that that be adopted. When it is proposed, it goes into the state registrar

and is published and then there is a comment period and then there is final adoption. So, the SHCC does not adopt regulations. It recommends. The SHCC, however, does adopt a state health plan.

ASSEMBLYMAN SNEDEKER: It is my understanding that you took the American Academy of Pediatricians and you had them as part of a group that recommended some things into this plan, right? I don't know whether you would call them part of the SHCC or part of the group that makes the recommendations or whatever.

MR. RABINOWITZ: No. We operate as a series of committees, just as you are a subcommittee. The subcommittees of the SHCC can draw on any resources that they have available and, as you can no doubt imagine, there are many people who are more than willing to come forward to participate in this process: those who have a vested interest and those who have an interest in one sort or another. So, we can honestly say that it probably has had as wide a broadcast and input as any process going at the state level. However, there isn't going to be universal agreement on any issue because this is an extraordinarily complex one. It was after the two years of study and planning that we, when coming down to the wire and coming down to the designation process which is separate from the creation of the plan, when we came down to the designation process, it was obvious that there were many localized factors, conditions that have grown up in New Jersey in regional areas in one place or another, that needed to be taken into account, and because we wanted this process to be a success in terms of medical care, quality of care and cost containment, we felt that it was the best course of action to take the 90 day delay in the designation process, refer the issue back to Commissioner Reilly's subcommittee to rehear some of the real questions that were being raised at various levels, and what Commissioner Reilly has given you here today is a summary of what he proposes to bring to the SHCC on its February 27 meeting.

ASSEMBLYMAN MARKERT: I'd like to, Mr. Chairman, suggest some other proposals that you bring to that meeting and I can start on page 34, under Recommended Courses of Action, and that is that you delete from the regulation 4.2a, 4.2b, 4.3, 4.3c, 4.3d, and, in place of those, suggest that the decision upon the services that will be allowed to continue for the general public of the State of New Jersey shall be based on the future findings of this new type of demonstration project that you intend to initiate and reach a conclusion at certain level 3's within 18 months and if you want to go to 2A within two years and so forth down the line and tell them that's exactly what we're looking for. Because, as long as these regulations stay in effect, you can suggest all you want and your demonstration projects can be great and just what we're looking for, as far as the Committee is concerned, as far as what we think the state should be involved in, but these regulations are still in effect and regardless of what you suggest, they're there and I would like to see this proposal come before the extension, the end of the extension on February 27.

MR. REILLY: Are you reading from the plan or from the regulation?

ASSEMBLYMAN MARKERT: I'm reading from the plan and I'm sure, since these are the recommended courses of action, they are part of the regulations. I would like to see that those areas are addressed within the regulation and considered for removal of the regulations, until such time as we propose the future direction of the perinatal units. This, then, will not affect the other part of the proposed plan, which we do not seem to have too much trouble with.

ASSEMBLYMAN OTLOWSKI: As a matter of fact, I would just like to leave this part of the hearing and, if you don't mine, just so we get a little fresh look at,just so we know where we're at at this moment, would you mind standing by. I would like to call Dr. Sisson?

Dr. Sisson, did you submit some kind of additional testimony today to Mr. Kohler? Would you just outline that to us please?

D O C T O R T. R. S I S S O N: Good morning, Mr. Chairman and members of the Committee.

ASSEMBLYMAN MARKERT: Mr. Chairman, may I just make one more proposal for the record. In those suggested changes that I put in the plan, I would just like to put five words in there. Also on page 34, 4.3b, at the end of the sentence I would like to have it continued and so read with, "consideration of human factors."

ASSEMBLYMAN OTLOWSKI: Dr. Sisson?

D O C T O R A N T H O N Y P. D E S P I R I T O: Mr. Chairman, my name is Anthony DeSpirito and I represent the Medical Society. I might be better if Dr. Sisson and I sat there at the same time, if you don't mind?

ASSEMBLYMAN OTLOWSKI: All right. Doctor, would you identify yourself for the record and the group that you are representing?

DR. DESPIRITO: Yes, sir. I appreciate the opportunity to appear here before you gentlemen. I am Dr. DeSprito and I am on the Board of Trustees for the State Medical Society and received a call to appear before your committee representing the medical society. Incidental to that, I am Chairman of the Academy of Pediatrics for the State of New Jersey and Dr. Sisson is the Chairman of our Perinatal Committee. I want you also to be aware of the fact that I'm from Jersey Shore Medical Center, which is involved in the tertiary care controversy, though I intend to represent the Academy and the Board of Trustees of the Medical Society.

ASSEMBLYMAN OTLOWSKI: Now, Dr. Sisson, you submitted a suplementary statement, isn't that true?

DR. SISSON: Yes, it is.

ASSEMBLYMAN OTLOWSKI: Of your own recollection, since you don't have the statement with you--Oh, you do have it. In that case, what does the statement say, the supplementary statement?

DR. SISSON: The supplementary statement elaborated on the Academy's previous position that the--

ASSEMBLYMAN OTLOWSKI: Now, Doctor, you heard what was said here this morning. Now, would this statement help us any, the supplementary statement?

DR. SISSON: I would hope it might offer some assistance. The regional position that you were kind enough to ask me to give at the last meeting has been expanded to emphasize the feeling of the Academy that there is and has been, for the past ten years, an ongoing, evolution of regional care that has been undertaken voluntarily by the hospitals and physicians in the state in response to the needs that were obvious. In response to greater technological improvements in perinatal care, the Academy feels that, in no sense, is the downgrading of services already offered, as they have evolved so far, useful and neither will the quality of care be improved by such a measure nor will cost savings be achieved. Claims for the state plan's cost effectiveness are not supported by experience or reliable data. In fact, the presumption that consolidation alone will yield large savings without reducing the quality of care has recently been refuted in a report in the New England Journal of Medicine and an addendum to that presentation.

We feel as we did before Commissioner Reilly's committee and, as he cogently observed, the state plan and regulations are, in our view, rather too ridid

and that, in general, the formulation of plans would be disadvantageously affected if the current regulations and plan were put into effect.

We wish to stress that the Academy feels it important for any plan to acknowledge that each region in the state differs from others, both geographically and socio-economically and in some instances ethnically and, thus, differs in its actual needs. Therefore, it is our contention that no one inflexible plan can truly be universally suitable and that each region, under any proposed state plan, can be given authority to fulfill its own requirements to accomodate regionalization to the natural concerns of its own communities and the people involved who, after all, are the ones being managed and told what to do.

The Academy's principle concern is that regionalization will promote, if it can't absolutely assure it, the delivery of a high quality of care to both mother and infant. We feel that this aim is the principle aim of regionalization and that no other consideration should be put ahead of that. There is no way that cost containment was ever designed as a principle pillar to support regionalization. Higher intent, nationwide, beginning as far back as my 12 years of association with regional planning, has been to reduce the maternal and infant mortality and morbidity rate. The entire evolution of the technology of neo-natal and perinatal care has been to this end. No one has pretended that the technology is less rather than more expensive. No one has pretended that transport is cheap rather than expensive. But, if they're worthwhile, they're worthwhile only to salvage otherwise mortally ill infants and, in some instances, mothers.

Therefore, I think that the Adademy's position is that, first, we should look to the effect of any plan on the quality of care and, then, accomodate costs to it. Obviously, this must be a consideration. It can't be 70% of it or even 50% of it if the quality of care is in any way jeopardized by such an attitude. I'm sure that I am not stating an attitude that anyone truly feels, least of all the people who have spent so many, many months attempting to come up with a workable plan. Please do not misunderstand me.

ASSEMBLYMAN OTLOWSKI: Excuse me, Doctor. First of all, I think I'm correct in indicating that there has been no testimony to this Committee about costs. No one has testified about the kind of costs that this would impose upon the patient, the kind of cost that this would impose upon the hospital, the kinds of cost that this plan would mean to the entire hospital industry. In any event, there has been no testimony about that and one of the fears that is being expressed by the Committee here is that we may be waltzing ourselves into a tremendous cost factor here that hasn't been developed and this is one of the reasons, it seems to me, that the Committee members want to get some kind of handle on cost. The other thing that is bothering the Committee, it seems to me--and this is where we're looking for enlightenment--the other thing that seems to be bothering this Committee is the fact that you are proposing a whole new approach to child delivery and perinatal care and the other infant care and, in that proposal, you are eliminating many of the present hospitals. You are eliminating many of the present hospitals from dealing with that particular kind of care. I was under the impression, and maybe I'm wrong, that since no cost factors have been developed, since we're talking about putting many hospitals out of business, what we were asking is, is there a better approach, is there a surer approach? Is there a better way of going about this than the Health Department people are proposing? This is what we had expected to hear and we expected to hear some clarification in very simple, Anglo-Saxon English.

DR. DESPIRITO: Could I address that, Mr. Chairman? We are not anxious to close any of the institutions currently delivering care. In the State of New Jersey, we are already regionalized. We do not have too many beds and the birth rate, Mr. Markert, is on the way up. It is anticipated that the birth rate in New Jersey will increase considerably. In that increase will be more adolescent pregnancies and more elderly, 30-40 year old, high risk mothers. This is not my figure, but the anticipated figure. The current infant mortality rate in the State of New Jersey has dropped precipitously over the last six to seven to ten years. It has all over the country, but in New Jersey, it has dropped to very reasonable levels, not to perfect levels. We're at about a 12% mortality figure and about 13%, in the latest figures that I have here from the 1979 Review of Annual Statistics of the United States. New Jersey is at a good spot at this point in time. In the last six years, we have dropped from a 20% infant mortality to about 12%. I don't have the '79 figures. What appears to be the irreducable minimum figure, that is about 8%. So, we're striving, again, to get down to the lower level. Where our increased infant mortality figures are are obviously in the cities. The death rate for the black is higher than it should be. It does not approach the non-black. So, we are getting to the figures.

We are proposing that we have a two level care system, by and large. We are interested, of course, as physicians,primarily,in quality care. In recent years, we have obviously been concerned with the cost of care and we were also concerned with the accessability of care. I want you to realize that within the first 8 minutes of life, if a baby does not have adequate oxygenation, he is going to be a chronically disabled, brain damaged child. That is within eight minutes and, probably, within five to eight minutes, if he has not been receiving adequate oxygen, he will be brain damaged. That's the figure. What we're saying is that every hospital that delivers in the State of New Jersey should have adequate preparations for supplying oxygen to that little infant until he can be cared for at that facility or at another facility. We are not over-bedded in tertiary care beds at the present time. We feel, by and large, except for accessability and quality of care and cost containment, that all institutions in the State of New Jersey should be up-dated to level 2. Now, if it proves that those institutions that are under 500 beds are delivering a quality care, cost effectively, and are in such areas that they are not accessible for the population, obviously, they should continue to be open. We would like to up-date almost all of the facilities to level 2. I think we will have different grades of level 2, yes, but we want to up-date those to level 2. So, we are proposing, primarily, a two level care, with occasional level 1 institutions. The Academy of Pediatrics, made up of nationally known figures, has said that in a metropolitan area there should be no level 1 care. New Jersey is generally metropolitan, recognizing that we do have some rural areas where we have to have level 1 care. I'm inspired by your questions before that you asked and we would be glad to answer any questions. Does that explain it, Mr. Chairman?

ASSEMBLYMAN OTLOWSKI: Mr. Snedeker, do you have any questions?

ASSEMBLYMAN SNEDEKER: I don't have any questions at this point, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: Mr. Markert?

ASSEMBLYMAN MARKERT: If I may, Dr. DeSpirito, what is New Jersey's rate with reference to the rest of the country, just to get a handle on it? I know you said that, right now, we were 20% and now it is down to about 12 or 13%. How are we now faring with the rest of the country and the other metropolitan areas?

DR. DESPIRITO: The vital statistics for the United States, infant mortality rate in 1979, was 13.0%. In New Jersey, in '78, we were down to 12.3%. I also have the figures for what appears to be '78 because the '79 and '80 figures I do not have. I do not know when they will be available. Now, this is printed in the Journal of Pediatrics. So, I'm quoting vital statistics that were reviewed at the University of Michigan. We were 12.8% at that point in time, in 1978. So, if I can give you the list here of all the states and we are certainly among the lower states among all the states. New York was 13.2%, Pennsylvania, 12.9%, Delaware, 14.9%, District of Columbia, 14.0% and I can go down to the other states.

ASSEMBLYMAN MARKERT: Okay, that gives me an idea, anyway, of where we're running.

DR. DESPIRITO: Now, this has all been a voluntary effort.

ASSEMBLYMAN MARKERT: I realize that and that's what I think I tried to point out in making a statement earlier when the Commissioner was here. Another question, if I might, to be able to decrease this--of course, I would like to see it at a zero level, just like everyone else would, but I know that that's an impossibility, not realistic. As you stated, that first five to eight minutes is probably the most critical time of the infant's continuation for a healthy life. So, they must receive the proper amount of oxygen and it must be available for them. Plus, I'm sure that there are other criteria involved in that first few minutes of life. You also stated that it is in our black area, at least the mortality in the black area is the highest. What about under the proposed plan which is now regulation or would be on February 27, how does that affect the areas or hospitals that are in those primarily black and Hispanic areas?

DR. DESPIRITO: There are obviously many good ideas in the plan and one of those is to increase the coordination of the level 3 care and educational and practical aspect to improve the care totally by education and by outreach centers to reach all of these areas that have a higher mortality rate. This is certainly an added plus to the entire program, to coordinate with the other hospitals delivering the care and to have educational programs and try to reach the areas that are not getting what we would call adequate care. Generally, they are in the inner city.

ASSEMBLYMAN MARKERT: Do we have many level 1's, at this point, classified as level 1's, as far as we know through this information, in the cities that you know of?

DR. DESPIRITO: Well, I'm not sure. One of the problems with the plan is that there was really not adequate review of what was existing in the state prior to the written rules and regulations as accepted. The last testimony that I have heard was the intent of having approximately 50% level 1 institutions in the State of New Jersey and this is one of the reasons why the Academy of Pediatrics became active in many ways to attempt to stop this because we felt that 50% of the hospitals in New Jersey delivering level 1 care was not very appropriate at all.

ASSEMBLYMAN OTLOWSKI: Should it be lower or higher?

DR. DESPIRITO: The Academy nationally, the bigwigs in neo-natology throughout the country have said, in a metropolitan area there should be very few level 1 institutions, if any.

ASSEMBLYMAN OTLOWSKI: They should be eliminated?

DR. DESPIRITO: They should be eliminated except in rural areas.

DR. SISSON: That is not to say closed, but upgraded.

ASSEMBLYMAN OTLOWSKI: Assemblyman Snedeker?

ASSEMBLYMAN SNEDEKER: Doctor, were you a member of any of the groups that helped this plan together or were you in this group or was there a representative from the Academy on the group?

DR. DESPIRITO: I must go back. About six years ago, I testified before the sub-committee that was forming the rules and regulations. I have been invited to participate, over the past year or so, in the sub-committee, where we tried unsuccessfully to change the rules and regulations. I offered testimony opposing the rules and regulations. This was not accepted. We had tried to reach the Commissioner since April of last year asking for a meeting with her and it never was accepted that we would meet with her. She would not accept the fact that we had problems and would not meet with us. I'm not complaining. I'm just giving you the facts. I have here a letter that I was influential in concerning our statement here. The Board of Trustees of the Medical Society had written this,at my instigation, to the Commissioner in September and we received a nice reply, but we were not, at that time, invited to participate in any further discussions concerning our concerns. I was invited to SHCC and Dr. Sisson was invited to the SHCC committee meetings several weeks ago and we were appropriately received. We presented out problems with the rules and regulations and I believe what you heard earlier today is the fact that some of our concerns have been voiced to them and they are accepting our concerns and they are coming to you, apparently, with an offer to do a study and thereby pass the rules and regulations, to some degree, by having a study performed, at which time the institutions would be happy temporarily over a year and a half to two year period, while the study is in place. I believe that's what you heard and it has been the result of testimony by ourselves and other people. We were very well received there and very cordially received.

ASSEMBLYMAN SNEDEKER: In non-medical terms, was it the general idea of the pediatricians, SHCC and everyone else who was concerned about the health delivery care for infants to establish hospitals such as the Children's Hospital in Philadelphia, three or four hospitals such as that in New Jersey since we were transporting children out of New Jersey or was it the object of this committee, in your opinion, to review the entire infant care and get rid of, eliminate some hospitals that were now delivering children?

DR. DESPIRITO: No, I don't think it was the intent to get rid of the hospitals not delivering children. I think it was an honest attempt by very many fine people voluntarily. Millions of dollars have been spent in voluntary and medical man hours and hospital man hours over the last several years at meetings. I can't tell you how man meetings that I've been to and this takes time out of everyone's practice and everything else. I honestly don't think it was an attempt to close any institutions. I think, really, it was an attempt to improve the quality of medical care. The problem is that we've had a good system in place and we need to improve upon that. We need to think about cost effectiveness and we're willing to do this and we'll offer our expertise to you and to the Department of Health. I think, honestly, the intent was to upgrade the quality of care. Incidental to the beginning of this program, the quality of care, because of technology and because of the regionalization process that is already in place, we do have a good system, which needs improvement.

ASSEMBLYMAN OTLOWSKI: Doctor, excuse me. You said, a moment ago, that these meetings that you had with this committee, how cordially you were received and then you said that this plan or suggestion that was made would probably proceed

for a year or so and then after that, you don't know what will happen. Isn't that what you said a moment ago here?

DR. DESPIRITO: Well, they are proposing--and as you indicated, we might as well put our cards on the table.

ASSEMBLYMAN OTLOWSKI: Well, if we're going to get anywhere, we have to talk frankly here.

DR. DESPIRITO: Sure. There's a reluctance on their part, the Department of Health, to change the rules and regulations for whatever reasons they have. As a consequence of refusing to change the rules and regulations, as you have so wisely indicated, they're coming up with what is called the demonstration project. Now, good research is great and I think that anyone would cooperate in any demonstration project. But, the rules and regulations will not have been changed.

ASSEMBLYMAN OTLOWSKI: So, what you're saying, in effect, at this point, is that you still have grave misgivings about the direction and the approach to this whole problem. Isn't that what you're saying?

DR. DESPIRITO: Yes, sir.

ASSEMBLYMAN OTLOWSKI: All right. Let's take that position, that you have grave misgivings and you have many questions yet. At this point, you are still suggesting that your position about the plan and the changes that should be made to that plan should be, number one, that you are on the road to improved care. You were on the road to hold costs down. Now, what you would want to see done is that whole thing expanded and improved. Is that what you are saying?

DR. DESPIRITO: I think you put it very well, sir.

DR. SISSON: I would like to add one further comment to the statement by Dr. DeSpirito and that is that the Academy, in its suggestions, not just to sound like harping critics to the bitter end, has proposed that the committee, appropriate committee of the Academy, Maternal Child and Perinatal Health, offer to serve in whatever appropriate way it can and with other appropriate medical bodies as an expert technical group to assist the State in monitoring and evaluation of perinatal care. That would be in all hospitals throughout the state on a routine and ongoing basis for the foreseeable future. There must be some overview, of course, as to how perinatal care is delivered and this type of professional evaluation may be helpful. If it is, the Academy stands most eager to be of that assistance.

DR. DESPIRITO: I would like to add just one other point which I think you should note. The rules and regulations indicate that there can be out-of-hospital birthing centers. We feel that this is not appropriate. One of the reasons for the major declines over the years of the infant mortality rate is that we've had in-hospital deliveries ready to rescusitate children. Approximately 50% of all problem children that are delivered to the intensive care nursery are not predictable in advance. We think we would be doing a disservice in encouraging out-of-hospital deliveries.

ASSEMBLYMAN OTLOWSKI: What you're saying is that immediate hospital care is very, very important.

DR. DESPIRITO: Yes, sir.

ASSEMBLYMAN OTLOWSKI: And also what you're saying is that delay by transportation could be fatal.

DR. DESPIRITO: Sir, we have to have immediate facilities. Even if I have a level 3 care 25 or 35 miles away, that infant has to be stablized with oxygen, perhaps intravenous, etc., immediately or the tertiary care centers will get babies that are going to be retarded and die and so forth. They need that immediate care.

ASSEMBLYMAN OTLOWSKI: What you are saying is that the present plan doesn't provide for this, that the present plan, as a matter of fact, is creating a gap, is creating a wider gap and a bigger vacuum. Is that what you're saying?

DR. DESPIRITO: If we include in that plan birthing centers outside of hospitals, where there is no pediatrician in attendance, just a midwife--

ASSEMBLYMAN OTLOWSKI: And what you're saying, if you're going to cope with this problem and if you're going to cope with it effectively, is that the present hospitals that are in the business of delivery have to be improved. Is that right?

DR. DESPIRITO: Some of the institutions, we want to encourage them to be able to handle all of the difficulties and, hence, some of the institutions may need improvement.

ASSEMBLYMAN OTLOWSKI: Are you saying also that this can be done at reasonable costs?

DR. DESPIRITO: I would hope so, sir.

ASSEMBLYMAN OTLOWSKI: Mr. Kohler?

MR. KOHLER: I was going to ask, your recommendation about upgrading all hospitals to level 2 care, let me assume for a second, for example, you have a level 2 hospital that's been upgraded and it has 1600 deliveries per year and you have a level 2 hospital that has 900 deliveries per year. Is it reasonable to assume that the cost for the 900 deliveries per year, per baby, are going to be quite higher?

DR. DESPIRITO: You know, it probably would happen because of the level of care at that institution. If you look at the cost of care at your institutions in the State of New Jersey, you will find that the tertiary care hospitals, the medical school hospitals, what one would consider the better level of care, generally is higher than in the smaller community hospital. It is a matter of educational programs. It's a matter of full-time people, etc. So, one would have to look at the entire hospital, but it is conceivable that a 900 delivery care center would have a pediatrician in attendance taking care of the infant, whereas at a 1600 bed hospital that is also level 2, they may have a neonatologist available and this would increase the cost and so forth. We're not saying that we need a neonatologist at every hospital in the State of New Jersey. We can't even supply that number, but all the pediatricians are trained in the care of the newborn, can stabilize that infant and, when necessary, ship him out. Remember, if all the level 2's are very low and can't handle a baby on a machine for 24 hours, we're going to overburden the level 3's. We don't want that because sometimes we get a baby in difficulty for 24 hours, transient difficulty with breathing, and the next day, he's better. Many of the meningitises don't have to be transfered to a level 3. So, what we're saying to you is that there level 2 institutions that will make it more cost effective to deliver care at that institution rather than take every sick infant that appears sick when he is first born and for medical/legal reasons, etc., move him out because he should be at a level 3.

MR. KOHLER: I guess what I was moving towards was simply the disparity in annual deliveries, for example, with more and more hospitals coming on the DRG system. It would seem reasonable to assume that the ones with the lower number of births, providing the same amount of care, their cost per unit or cost per baby or cost per delivery would be substantially higher and they would not get reimbursed back what they had been spending. So, it would be reasonable to assume that any below, let's say, a statewide average of annual deliveries, that maternity unit in that particular hospital would be a money losing proposition.

DR. DESPIRITO: I really can't address that.

DR. SISSON: I think there is one way of looking at it. First, I think we must acknowledge that the number of deliveries is only one factor. It is not a sole governing factor in the cost of delivery of maternal and infant care. Recognizing that it does have some impact, what is more important is the character of the 900 babies delivered. If this is in an inner city hospital delivering 900 babies, 60% of which are at great risk, the number of infants requiring more sophisticated care will be higher than in 1600 delivery per year hospital in an affluent suburb with a risk factor of 20%. Therefore, the 900 delivery hospital would, indeed, be more costly simply because the type of infant cared for requires more extensive treatment. This does not answer your question, but I think it does say why it is a difficult one to answer.

ASSEMBLYMAN OTLOWSKI: But, if I understand the point that you're trying to make, it is the fact that you would better the level 2 care in all hospitals. Is that the point that you're making?

DR. DESPIRITO: Yes, sir, almost all hospitals.

ASSEMBLYMAN OTLOWSKI: Unless you have something else, Doctor, that you want to add, I think you've made your point.

ASSEMBLYMAN MARKERT: I would like one question, if I may, Mr. Chairman. We were talking about the situation with midwives, rather than actual hospital births.

ASSEMBLYMAN OTLOWSKI: How did we get into the midwife business?

ASSEMBLYMAN MARKERT: This is a recommendation or, at least, it's in this plan. I remember reading it and I can't find it now, but I know it's there. Then we talked about the percentages that might be for the child to be able to receive that instant care that first few minutes. Do you have any kind of records or statistics that might address the mortality rate to those children who have been born outside of the facilities, hospital facilities?

DR. DESPIRITO: Well, there is very little in this country simply because midwifery has not been practiced here for a good many generations. In England, however, they did, in the 1950's, take one week and follow all infants born in the British Isles during that week for 15 years and on a seven year and then a 15 year follow-up, the character of obstetrical care had changed and found that with the abolition of home and other non-hospital deliveries, this was the single greatest factor influencing the remarkable drop in infant mortality, like 50% over a 7 year period. On that, I can give you the reference.

ASSEMBLYMAN MARKERT: But, this plan does recommend that we still agree with that type of birth and this is a part that you feel you do not agree with or you feel it should be excluded from the proposed plan.

DR. SISSON: We would certainly prefer to see it in the hospital.

ASSEMBLYMAN MARKERT: I don't know how the regulations read. I don't have them. I know it was just in the proposed plan. Commissioner, can you help me? Is that in the regulations?

MR. REILLY: I will stress certain words for you. Although this plan is related chiefly to special in-patient services, it must be borne in mind that almost 90% of all births are uneventful in the medical sense. For this large group, alternatives to in-patient hospital delivery should be made available so that the delivery of infants is based on what is medically sound and what parents want through such alternatives including out-of-hospital facilities called a birthing center and home deliveries. Whenever the parents and the physician agree, it should be possible to provide for out-of-hospital deliveries. That is certainly different from you've heard.

ASSEMBLYMAN MARKERT: That does clear up some of the questions that I had on it. Thank you.

ASSEMBLYMAN OTLOWSKI: All right, Doctor. Thank you very much. Mr. Joseph Slavin?

J O S E P H S L A V I N: I am Jospeh Slavin and I am Vice-President of Planning for the New Jersey Hospital Association. I would like to make some brief remarks, I think, to clear up some issues.

I attended the last hearing and I think there were a lot of misconceptions given to the Committee regarding to what is going on in New Jersey and, the second part, there were some serious questions and statements made about the state plan, which I would like to bring up, if I may.

We keep hearing about 2000 deliveries as a minimum for level 3 centers and this goes back to a national study done quite a few years ago by the American College of Gynecologists and Pediatricians. 2000 is the number that is constantly being used and is in the regulations. If you don't have 2000, you can't be a level 3. That same study also said that there ought to be, and it's in the regulation, there ought to be 10,000 deliveries in an area to support a level 3 center. So, there are two numbers that we're talking about. If you go though the HSA areas in the state--I don't know if you're that familiar, but HSA 1 would be Bergen and Passaic, the second one would be Newark metropolitan are, HSA 3 is Hudson, 4 is central Jersey, and 5 is Southern New Jersey. If you just took the 10,000, saying that if there are 10,000 deliveries, that should be a critical mass to support a level 3 center. The column on the far right, you will notice that area 1 had a potential of one center.

Another misconception is that the state plan, as adopted, was a compilation of all public hearings and what the HSA's recommended. The Health Commissioner made note of this before. It is very important, I think, to realize that the HSA's went through a public hearing process and recommended to the SHCC, they made recommendations. I will just concentrate on one for time reasons. They recommended that St. Joseph's Hospital be designated as a level 3 center. When they came to the SHCC, the decision had to be made that the regulation that said that you had to have 2000 deliveries should apply. They happen to have 1700 and some. In HSA 2, I think it was Newark Beth Israel Hospital, which had over 1900 deliveries. But, the state regulation says that you must have 2000. Therefore, the SHCC could not give them designation and that's how they got into the dilemna that they're in.

It's interesting, if you just took the 10,000 as a critical mass with a very simplistic overview, you would find that you need somewhere between 7 and 9 level 3 centers. It so happens that that is what the HSA's originally recommended to the SHCC. The SHCC was the one that adopted a state plan which called for different designations.

Just a few others here, I think it is important to emphasize that we have a system in the state. There has been an impression created, I think, through the newspapers and through--

ASSEMBLYMAN OTLOWSKI: You have a system presently.

MR. SLAVIN: It's here and it's working and I would like to show you how it's working. Somehow people think that we're going to start a level 3 center at St. Joseph's and St. Peter's, etc. These are figures from 1979, which were in the application submitted to the state. Assuming that there are 90,000 deliveries in this state, and I think everyone would agree that 3% will require level 3 care. That's commonly accepted standard. If anything, it is conservative. It is much

higher in the urban areas and lower in surburban areas, etc. But, for a statewide average, we would say that there should be somewhere around 2700 infants who should have received level 3, tertiary care. You go down that column on the far left saying neo-natal transfers, again, getting to St. Joseph's Hospital, St. Joseph's Hospital has been functioning, I guess, for the last six or seven years that I know of giving tertiary care. In 1979, they received from other hospitals 287 transfers, infants requiring some type of tertiary care and we can supply the data on every hospital in North Jersey who did transfer in there. With the United Hospitals in Newark, they have a significant referral pattern also from the Newark Metropolitan area out into Morris County.

The point I'm making--also the maternal transfers is also a significant number and this is where physicians have recognized that there may be a high risk infant being born, that the mother is in a high risk category. So, they have transfered the mother, sometimes, possibly, as she enters the hospital to deliver or maybe prior to that, transfer her to St. Joseph's Hospital because they think the baby is going to be high risk. They let the baby be born there and, as the physicians point out, it is the best place to provide that care.

Just adding those two together, these numbers fall together and I'm not trying to play games with numbers. You come up with somewhere around 1500 or 1800 infants and mothers who are transported into one of these existing centers. It's also safe to assume, as the doctors alluded to, these are in highly urbanized areas. At St. Joseph's Hospital, for every baby that was transfered in, out of those 1700 deliveries, it is safe to assume that there was another high risk baby born there because they are located in Paterson. It's not accidental that all these high risk centers, the level 3 centers, have developed in urban areas. That's where the--

ASSEMBLYMAN OTLOWSKI: That's where the action is.

MR. SLAVIN: Right, that's where the action is. What I'm trying to say is that we have a system. If you count that up, there's about seven to nine centers that have been operating for a number of years. I go back to the HSA's and the HSA's have recommended somewhere between seven and nine centers. The problem is that it doesn't seem to fit the regulation. That seems to be the problem.

I wanted to bring this last thing up. At the last meeting, questions were asked of the Health Commissioner as to how New Jersey is doing, what is the neo-natology mortality rate and the maternal mortality rate. This is actually an enlargement of the Health Commissioner's annual report on public health statistics. If you look in the column entitled, "Neo-natal deaths," there is reference made and a lot of testimony that Colorado and Arizona have very fine systems and they've reduced by 50% because they have this system, which Commissioner alluded to and we want to put in New Jersey. If you go back to about 1970, on the neo-natal deaths, the death rate was 15.9. I say 1970 because--

ASSEMBLYMAN OTLOWSKI: Excuse me, they picked Colorado and Nevada?

MR. SLAVIN: I think it was Colorado and Arizona that were the two examples that were in the testimony before this Committee as successful operations. If you look at the neo-natal death rate in 1970, when neo-natology really started in New Jersey and it wasn't a matter that we were late. It was just starting all over the country at that time. Neo-natologists became a Board certified specialty about that time and the units started developing: St. Joseph's, Beth Israel, Monmouth Medical, Camden, etc., and the infant mortality rate was 15.9 and in 1979, it was 8.7. So, apparently, at least my interpretation is that the system seems to be working. The mortality rate is dropping significantly, approximately 50% if you take 1979 figures.

The other, I think, important item was the maternal death rate. Again, there were a lot of statements regarding that. If you look at the bottom line there, the actual bottom line, 1978, there were nine maternal deaths in the State of New Jersey and we had 90,000 deliveries. Now, there is another report which Dr. Finley has alluded to and I believe the number is somewhere around 25 or so. This is from the annual report from the State Health Department, registrar of vital statistics. There is another report which Dr. Finley has alluded to about the mortality rates which, I believe, was somewhere in the 20's, maternal deaths. I think it is important to realize that there is a distinction and may be why the difference is here. I don't know what the difference is, to be honest with you. These are the only figures that we could use. It is published by the Registrar, by the statistics. There is a distinction in maternal deaths between preventable and non-preventable. For example--and we could cite cases that actually came in during 1979--a mother in one case was having some kind of heart problem and was transfered from one hospital to the tertiary center because they knew she was in heart failure. This was written up in the paper, as a matter of fact. Unfortunately, she deceased as a result of heart surgery and complications following the delivery. The baby survived. That shows up in Dr. Finley's report as a maternal death. It certainly can't be classified as a preventable type situation. This was a very unfortunate thing, but it had nothing to do with the maternal care and the delivery. There are many other instances like that.

There are also some strange statistical anomolies in the report. If a smaller hospital transfers a high risk mother over to a tertiary center, it shows up there as a maternal death and affects their mortality statistics and not the smaller center. So, I think if we ever got all that information out, you would see that there is a significantly higher number of maternal deaths probably in the high centers. It just makes sense.

There was another question that was asked about how do we compare to other states. New Jersey ranks very high and I think we try to be as objective as possible and use industrialized states on this rather than Arizona or something which may make New Jersey look better. We stand very high in low birth weight. There can almost be comparison between low birth weight and prematurity and infants requiring level 3 care. It shows that we ran fairly high of all of the states in terms of the number of infants with low birth weight, how they are being taken care of and the final chart here shows the infant mortality rate in New Jersey compared to the other states. The point I'm trying to make is that while New Jersey has a significant higher rate of low birth infants, it has a lower infant mortality. So, it seems that the system is working again. If it were reversed, it would present us with some problems. Apparantly, the system seems to be working.

Regarding the closure issue--and I would hope, once and for all, we could put that to rest--we keep hearing about the problem of closures of those under 500. I think the facts were brought out that it is a regulation and it is going to stay there until somebody takes it out of the regulations.

ASSEMBLYMAN OTLOWSKI: What is the point that you are making about that?

MR. SLAVIN: Under 500.

ASSEMBLYMAN OTLOWSKI: What about the under 500?

MR. SLAVIN: Under 500 is in the regulation and the only way it is going to change is having the regulation changed, a point that the Assemblyman made earlier. My records indicate that there are three, North Hudson, Riverside, and

Warren Hospitals, and I believe Salem County was under 500, but they are over 500 deliveries now, three hospitals and I think the State Health Department has agreed to continue to look at Warren Hospital, which is a shade below 500, but because there is an unusual pattern of deliveries there, there are over 200 babies a year being born in Easton, Pennsylvania, from the Phillipsburg area and if they ever move back into Phillipsburg, that obstetrical number will increase. So, we're talking about, at the most, two or three hospitals out of the 78 who applied for designation.

The other part, which I don't think anyone has ever pointed out,since 1976 there have been 12 hospitals in the state who have voluntarily closed their obstetrical departments. Montclair Community was the last of the 12. It is a continuing pattern and it is something that does take time. We at the Association believe that that is something that is a voluntary thing that the hospital, board of trustees and local community has to work out. It should not be mandated.

If you want to ask questions on that or if I could address the state plan, I would be happy to proceed in either fashion.

ASSEMBLYMAN OTLOWSKI: Why don't you go on with the state plan.

MR. SLAVIN: I think there were a lot of statements made regarding the fact that the state plan was considered together with the regulation and has been adopted by the Health Care Board and published in the state regulations. The plan was never adopted, never presented to the Health Care Board and the plan was never adopted as regulation. There is a set of regulations over here. I've been around a few years in planning and, as a matter of fact, I think I was in the same room when the certificate of need law was passed in 1970. There was a set of regulations which I now understand the Legislature has oversight powers on. The department staffs adopted regulations which is their interpretations of the regulation. They can go one step further and they can adopt the plan, which is, again, their interpretation of the regulation. I subscribe to the fact that there are several instances where statements are in the plan--I can't be specific because I wasn't prepared to address this issue and I didn't bring the material--but I think in some of them, joint centers, bed minimums and things like that, they appear in the plan, but not in the regulation. There have been several times when the issue has been raised at the SHCC, is the plan a regulation or does it have to go through the administrative review and the Health Care Board, etc., and the question usually gets answered by the state staff, the Health Department staff and they say, since it is adopted by the SHCC, it has the force of regulation and that is an issue that I can't answer. I think that is something that may have to be addressed by your committee.

There were one or two other issues regarding the regulation. The problem of 2000 deliveries and under 500, whether the regulation should be changed is one of them. If you go back into the legislative history of the regulation, at one point, the regulation said that waivers can be granted by the Health Commissioner. There was an update of the regulation a year or so later and all reference to waivers were taken out. So, that is apparently why the Health Department is locked in and cannot grant waivers for under 2000 or maybe they do not want to grant waivers for under 2000 or under 500. That's something that can be verified.

The other point that I think Mr. Otlowski had made about out of state hospitals, I don't think there will ever be an intent that all babies should be treated in New Jersey hospitals. There are some very sophisticated hospitals in Philadelphia and New York which would continue to receive infants requiring very sophisticated care. However, I think if this perinatal system continues to develop in New Jersey,

there may be fewer that will have to be transfered out. Again, it is a decision, a very delicate decision that has to be made by the physician and the parents, obviously. Childrens' Hospital in Philadelphia, for example, 25% of their admissions are from New Jersey residents. I know a significant amount from the Trenton area go to Philadelphia, Childrens', St. Christopher's and other hospitals. I would suspect, over the years, if the concept of a level 2, with intermmediate care beds, residency programs, begins to develop maybe fewer would have to be transfered because the capabilities would be here. But, we're not saying that we're going to duplicate the sophisticated equipment and services that they have in those centers.

ASSEMBLYMAN OTLOWSKI: From what you've just said, are you indicating that, again, what the doctors have said, that if you improve the present system, you will be performing a great service for the State and, as a matter of fact, not only performing a great service, but you would be going about it economically and efficiently without shaking the whole structure apart?

MR. SLAVIN: I think a couple of the difficult areas are the level 1's and level 2's. I'm not sure what kind of investment, in terms of capital, has to be made by a so-called level 1 to get to a level 2. I suspect that the equipment is there. It's not major equipment that you're talking about. There may be additional staffing required; there may be additional staff training; and the possibility of some full-time directors of these services. The problem is going to be to try and put a wide range of hospitals into one mold. Hackensack Hospital located near New York has a lot of relationships in terms of residency programs and all. They have physicians on their staff--they have 1800 deliveries a year--they have physicians on their staff who can do pediatric surgery, etc. The other extreme, you may have Hackettstown, New Jersey, which has 700 or 800 deliveries a year, which I don't think would ever intend to have themselves put on the same level as one of these sophisticated level 2's. I don't know how the state plan is going to address that. It is going to be a tough thing to come up with a two-tiered system recognizing individual differences.

ASSEMBLYMAN OTLOWSKI: In your opinion, did the state plan sufficiently recognize the fact that New Jersey had unique experiences and unique situations, unique hospitals, unique population that that wasn't addressed sufficiently, that they went to Colorado where there are mountains and no people and where they went to Arizona where there is desert and no people? How did they pick Colorado and Arizona?

MR. SLAVIN: Well, that was just one set of testimony presented before you. In fairness to the state committee, I think they really addressed all the plans. They listened to a lot of testimony from the HSA's, from the community people coming up and recommending things and when they got ready to make their decision, they were locked into a set of regulations for which there were no waivers and that's the problem that they have now. They cannot designate some of these centers because--for example, Newark Beth Israel in Newark--

ASSEMBLYMAN OTLOWSKI: You mean to tell me, in the state plan they eliminated all waivers?

MR. SLAVIN: There are no waivers in the state plan because it is in the regulation. The regulation says that you must have 2000 deliveries.

ASSEMBLYMAN OTLOWSKI: Waivers are the necessary safety valves for human stupidity and human weakness.

MR. SLAVIN: The waivers that I guess I'm hearing from the back is through the demonstration project.

ASSEMBLYMAN MARKERT: Your statement, if I may, said that the upgraded or the current posting of these regulations eliminate the waivers for--

MR. SLAVIN: Level 3 and the under 500 group.

ASSEMBLYMAN MARKERT: Is that true?

MR. REILLY: Well, I wasn't involved in making that plan. I know nothing of the history of it. I don't know whether it has waivers or not, but the very point of the compromise suggested is to make up for that deficiency in the plan, that apparently doesn't allow for waiverability in certain areas. That's why the compromise was proposed.

ASSEMBLYMAN MARKERT: Well, not only that compromise, but that compromise is a part of this new demonstration project.

MR. REILLY: Exactly.

ASSEMBLYMAN MARKERT: But, it is there right now, as far as you know?

MR. REILLY: Under the guise of a demonstration, but I'm not familiar with what they can waive and what they can't waive.

ASSEMBLYMAN MARKERT: Well, maybe we can ask--

ASSEMBLYMAN OTLOWSKI: Wait a minute. There's enough confusion here now without screwing up the hearing. Let's stay on the track here. Let me ask you this. You're concerned about the waivers, from a hospital point of view?

MR. SLAVIN: Yes. I'm concerned that there has not been a recognition that the level 3 centers do exist and are, in fact, delivering this care and have been delivering the care and cannot be given a designation because they don't meet this number, 2000, which could have been 2500 or 1500.

ASSEMBLYMAN OTLOWSKI: Now, just to bring your testimony into focus, you are saying, as I understand it, that based upon the experience in New Jersey, based upon our facilities, based upon the technical manpower that we have, doctors broken down into the different categories of pediatricians and so on, that the system has been working here and the system has been working well and, if anything, it needs updating, it needs improvement, but you wouldn't destroy the whole structure by putting a plan on top of this that would do that very thing. Is that what you're saying?

MR. SLAVIN: That is our concern, yes.

ASSEMBLYMAN OTLOWSKI: Assemblyman Snedeker?

ASSEMBLYMAN SNEDEKER: Has the Association come to any understanding with the Department that they are in agreement with the demonstration program?

MR. SLAVIN: Yes. Basically, we would support the demonstration program.

ASSEMBLYMAN SNEDEKER: Why do you think the demonstration program is any different than what the plan is?

MR. SLAVIN: I'm trying to explain the--

ASSEMBLYMAN SNEDEKER: What is your understanding of the demonstration program, then?

MR. SLAVIN: My understanding of the demonstration program--and we're supportive of it--is that it is a way around the regulations. I wanted to make it very clear in the beginning that the plan was never adopted as regulation. It is being used as regulation. There are certain pieces in the regulation, namely, the non-waivers of 2000 and under 500, which are causing the problems. It appears that this might be a compromise, a way around to say, "Is St. Joe's Hospital, in effect, in fact, delivering tertiary care and, if they are, they would be so designated." The 2000 would have to be waivered at some point in time. Whether that goes back to regulation or not, I don't know, quite frankly.

ASSEMBLYMAN OTLOWSKI: Excuse me. What the Assemblyman is asking you, are you willing to endorse the demonstration project because you view that as something separate and apart from the plan itself?

MR. SLAVIN: Yes. I see it as a compromise between the Department and the Association to work toward a solution.

ASSEMBLYMAN OTLOWSKI: Wait a minute. I think we're talking about two different things. If I understand you correctly, you're saying that you are willing to take the risk with the demonstration plan because the demonstration plan is precisely that and it's not a part of the real plan, it's not a part of something that you want to be bound to, it's not something that you want to buy, it's not something that you want to endorse, but you are willing to take a chance on the temporary thing, which is the demonstration plan. Is that what you are saying?

MR. SLAVIN: Yes. I think one of the concerns is, on the reimbursement side, I don't know what the state's plans are in terms of reimbursing some of these centers. They may decide not to.

ASSEMBLYMAN SNEDEKER: You mean, for the demonstration?

MR. SLAVIN: Without a demonstration, they may decide not to reimburse them for the level of care they're giving because there are no designations. It is a very serious concern of many hospitals.

ASSEMBLYMAN SNEDEKER: In your opinion, there is no plan?

MR. SLAVIN: My opinion is that there is a plan that's been adopted by the SHCC.

ASSEMBLYMAN SNEDEKER: In your opinion, there are no rules and regulations.

MR. SLAVIN: There are regulations that have been adopted through the Administrative Procedure Act. There is a state plan which was brought out in previous testimony, which has not been adopted through the Administrative Procedure Act, but is being used as regulation.

ASSEMBLYMAN SNEDEKER: In what sense is that being used in the hospitals and regulations if it hasn't been adopted? I don't follow your testimony in that sense.

MR. SLAVIN: I can cite specific cases. I believe one of the joint centers, and I'm not sure whether joint centers were ever addressed in the regulations. They're addressed in the plan. I don't know what the statutory authority is for some of the things appearing in the state plan.

ASSEMBLYMAN SNEDEKER: Then, the demonstration program which you seem to favor, at least on a trial to see how it works, have you seen the demonstration program in writing?

MR. SLAVIN: No. First of all, the SHCC, at their next meeting, has to agree to the demonstration program. This is all speculation that they will endorse it. They may not.

ASSEMBLYMAN SNEDEKER: The demonstration program, do you have a copy of it?

MR. SLAVIN: No. It's only at the discussion stage now.

ASSEMBLYMAN SNEDEKER: Who discussed it with the Hospital Association?

MR. SLAVIN: No. It is the Hospital Research Trust and the SHCC committee. They have met and gone over the whole thing. We have been attending the meetings and we have listened and it appears to be the direction to go.

ASSEMBLYMAN SNEDEKER: And this is what you think the SHCC may adopt then and you would be in favor of that demonstration program?

MR. SLAVIN: Yes, we would.

ASSEMBLYMAN OTLOWSKI: Excuse me. Are you saying--let's make this testimony clear because it may be that the Committee will make a recommendation to have this particular part refered to an oversight committee. Let's bring this into focus. Are you saying that this planning committee, this SHCC committee, that they have adopted a plan contrary to the regulations?

MR. SLAVIN: Not contrary to the regulations, but in addition to the regulations.

ASSEMBLYMAN OTLOWSKI: Okay, let me put the question this way. They have adopted a plan which they assume that they had the authority to adopt without following the regulations? Can you answer that question?

MR. SLAVIN: Yes, sir. Without following the Administrative Procedures Act by putting it in the registrar and into the Health Care Board, yes, I believe they were told they did not have to follow that procedure.

ASSEMBLYMAN OTLOWSKI: Now, just for the purpose of the record, if that is so, then at the present time, they would be in violation of the law, as it now stands.

MR. SLAVIN: I'm not an attorney; I couldn't interpret that for you.

ASSEMBLYMAN OTLOWSKI: All right, let me put the next question. In any event, it would be something that this committee would have the obligation to refer to the Oversight Committee to determine if the legislation and if the regulations were followed according to law.

MR. SLAVIN: I assume that is your responsibility.

ASSEMBLYMAN SNEDEKER: Mr. Chairman, can you find out from someone in the Department which one is the demonstration program and which one is the plan?

MR. KOHLER: What we have here, we have something that says, "Standards and General Criteria to the Planning and Certification and Designation of Perinatal Services, adopted with revisions by the HCAB.

MR. WAGNER: That is a regulation that has gone through the full Administrative Procedures Act. That is a regulation in every sense of the word. The plan is not a regulation and contrary to what Mr. Slavin said, we never considered it a regulation. What the Attorney General says is that in the process of a hearing or whatever a plan which is developed by the SHCC is something which is of importance in terms of making decisions in that kind of a setting. No one in the Health Department has ever said that that is a regulation.

ASSEMBLYMAN SNEDEKER: The regulations have been adopted?

MR. WAGNER: The regulations have been adopted and the two things that are bugging everyone is that the regulation says if you are under 500 deliveries, you close down, and if you don't do 2,000, you don't become a level 3. They are the two things and they were followed up in the plan. Now, the fact of life is, gentlemen, that the legislation says that if a hospital is effective and efficient and properly utilized, you must get fully reimbursed. So, all the numbers that you hear about and all the problems you are going through result in dollars being spent. I can assure you that if you run a unit under 500 units, you are going to lose money and if you have the Vice-President from the Hospital Association here, I am sure that he will join me in saying that that is true. When you are doing a level 3 hospital, you are spending a lot of money for staff and equipment. The more you have, the more money you spend. Therefore, what everyone has been trying to do is to try to strike a balance so that we have enough level 3's in the State of New Jersey, which

will meet our needs, won't cost us the State bank and, on the other hand, so we don't have small units on the other side, although they may do a nice job for the mothers and babies and are not costing a great deal of money. That's why you have all of this controversy. It is not just a question of doctors versus the Health Department versus the SHCC or the Association versus someone else. There are a lot of issues in here and they cost money. We're trying to do the best job we can to provide those kinds of services within a reasonable amount of dollars. Despite what Dr. Sisson says, the Association which he represents says very clearly--

ASSEMBLYMAN OTLOWSKI: Wait a minute. We're going way far afield. We're getting off the track here. Can we just stay with this testimony here for a minute, please?

MR. WAGNER: Cost is a factor.

ASSEMBLYMAN SNEDEKER: Mr. Chairman, this confuses me. This is the regulation and--

ASSEMBLYMAN OTLOWSKI: Well, we're going to have Mr. Wagner testify later.

ASSEMBLYMAN SNEDEKER: What is the New Jersey State plan? Is this a plan?

MR. WAGNER: That's a plan, yes, sir.

ASSEMBLYMAN SNEDEKER: This is the demonstration plan?

MR. WAGNER: No. The demonstration plan, there is a proposal that has been made by HRET to do that demonstration, which I believe you have available. That proposal has been endorsed by the Hospital Association. I believe Mr. Slavin is saying that very clearly. I think all of us would like to proceed with that demonstration with an investigator. And, as a result of that demonstration, I think that all parties would also have to agree, at the end of it, that whatever the results are, we're going to live by them, which may mean that some people close down, that some regulations change or not change and so on and so forth.

ASSEMBLYMAN OTLOWSKI: Well, let me just say this. I think the purpose of this committee hearing, as all legislative hearings, is to determine if there is a need for a better legislative approach. Now, that's the purpose of any committee hearing and that's the purpose of this hearing.

MR. SLAVIN: Mr. Snedeker, you asked before--the plan that you had there is the one that I'm refering to. It was never put through any administrative procedures.

ASSEMBLYMAN SNEDEKER: But, the regulations were.

MR. SLAVIN: The regulations were.

ASSEMBLYMAN SNEDEKER: Are you saying that they're going under any section of this plan that is not in those regulations?

MR. SLAVIN: I'm saying that there may be instances in there-- I'm not prepared to give you all of them right now--which are an extension and may be an overextension of interpretation of the regulations.

ASSEMBLYMAN SNEDEKER: In the plan?

MR. SLAVIN: In the plan.

ASSEMBLYMAN SNEDEKER: But, you don't have to abide by the plan because it's not in the regulations.

MR. SLAVIN: Well, contrary to some of the testimony, I have attended many of the SHCC meetings--and it is possibly is in the minutes--where they have been told that the plan has the force of regulation. Now, if that's not true, I think that should be corrected.

MR. WAGNER: Well, I have stated for the record that the plan is not a regulation. The Attorney General says that in viewing issues of the dispute that a plan is important to the case, but they do not view it as a regulation. I have tried to make that distinction at many meetings that I have attended, including those which Mr. Slavin has attended.

ASSEMBLYMAN OTLOWSKI: Excuse me. If that's the case, I don't see why we're concerned about the plan at all since the plan has no effect, since the plan doesn't have the force of law. We should have no concern at all with the plan. As the word indicates, it is merely a plan.

ASSEMBLYMAN MARKERT: Mr. Chairman, we addressed a few moments ago the fact that in the upgraded version or in the latest rules and regulations that the elimination of the waiver procedure--

MR. SLAVIN: That's correct.

ASSEMBLYMAN MARKERT: Yet, I have these regulations and it is dated September 13, 1979. Does anyone know if there is a later version? Because, in this version, we do have the structure for waivers for the minimum number of deliveries, which would then identify the level 1 or 2 perinatal care units. We do have that and that is in Section C. Now, unless that has been changed or eliminated, I don't know.

MR. WAGNER: That is correct. There are waivers and there wasn't any change in the regulation.

ASSEMBLYMAN MARKERT: Then they are here.

MR. WAGENR: They went through a full hearing, all day, and there are two things that are not waivered and Mr. Slavin is quite correct, under 500 and the 2000 requirement. But, in between, there are lots of waivers.

ASSEMBLYMAN MARKERT: I have that in that section. My next question was, if this is the only waiver section, then you are right, it does not address the below 500 or over 2000 requirement.

MR. WAGNER: That is correct.

MR. SLAVIN: But, in the previous regulations, there were waivers allowed for those two.

MR. WAGNER: That is incorrect.

ASSEMBLYMAN MARKERT: Maybe what you mean, in the plan, there were waivers.

MR. SLAVIN: I'm talking about the regulations that were adopted two or three years prior to that.

MR. WAGNER: I do not agree with that.

MR. SLAVIN: Well, that's something that we'll have to develop.

ASSEMBLYMAN MARKERT: All we'll have to do is get the regulations.

ASSEMBLYMAN OTLOWSKI: Excuse me. I'm not going to get into a debate here.

MR. KOHLER: I'd like to ask one question with regard to the regulations and the plan, this demonstration project. If the Hospital Association agrees with the demonstration project--and I guess my question will be addressed to Dave-- these regulations go into effect when?

MR. WAGNER: February 27.

MR. REILLY: They're in effect now.

MR. KOHLER: Okay, are we going to close any hospitals down under 500 until the demonstration project is up?

MR. REILLY: No.

ASSEMBLYMAN MARKERT: Mr. Chairman, one question. I thought there was a 90 day waiver of these rules and regulations.

MR. REILLY: No. We attempted to come back to the State Health Planning Council, the SHCC, with recommendations for designation under the regulation and under that plan. They said to us, "We're not willing to hear your recommendations right now. We want you to go back and see if you can develop a better approach." So, the regulations were not suspended. They just said, "We're not going to act on your recommendations." If they accept the proposed compromise which we and the Hospital Association agree upon, then we will go back and start designating again.

ASSEMBLYMAN MARKERT: I think I've got it clear now.

ASSEMBLYMAN OTLOWSKI: Assemblyman Bassano?

ASSEMBLYMAN BASSANO: No questions.

ASSEMBLYMAN OTLOWSKI: Thank you for your time, Mr. Slavin. The representative from Small Miracles? We need that right now. Would you please identify yourself and the organization that you represent?

N O R E E N D U N N: My name is Noreen Dunn and I am speaking as a parent. We are Small Miracles Auxiliary and we are associated with Jersey Shore Medical Center.

The State Commissioner of Health mandated that a hospital must deliver 2,000 babies to meet the criteria for operation of a level 3 perinatal unit. While Jersey Shore Medical Center falls short of that arbitrary quota, it more than compensates in doctors, personnel and equipment.

The Small Miracles Auxiliary is a group of parents united to support the perinatal unit at Jersey Shore Medical Center. In a three month period we have obtained approximately 11,000 signatures of people who believe as we do. It is the concern of the Auxiliary that the health and well-being of other infants and mothers not be compromised by being transported to hospitals even further away than Jersey Shore Medical Center. It is also distressing that in Ocean County, the most rapidly growing county in the area, we are threatened with the elimination of an excellent, existing facility in nearby Monmouth County. The threat of losing this truly vital facility deeply troubles us and we will continue to fight to maintain the existing level of care available at Jersey Shore Medical Center.

Jersey Shore Medical Center is on a major highway and adjacent to several other major highways. Some of the parents whose children have been patients in the hospital's regional neonatal ICU come from as far south as Toms River, Point Pleasant and even more distant communities. They found it very difficult to have to travel even this far every day. This problem would be made even worse if the facility at Jersey Shore Medical Center is not permitted to function as a regional perinatal center. The bond between mother and child would also be threatened if they would be forced to transport babies even greater distances to other hospitals.

Time is of vital importance in these situations. Being able to obtain immediate care can mean the difference between life and death. We must keep this unit open. We need the skills of these physicians and nurses who have been specially trained to care for high risk mothers and infants.

The hospital is also a teaching institution where medical students, residents and fellows can study and gain experience in medicine, obstetrics-gynecology, pediatrics, surgery and dentistry, and in the specialties of perinatology, neonatology and pulmonology. High-level training of this type is usually found only at large

university hospitals and we feel fortunate to have a center of this caliber in our midst. In order to attract and keep the best possible professionals, we must have facilities in which they can use their skills.

We feel, for the benefit of the parents and babies of Monmouth and Ocean Counties, the perinatal unit at Jersey Shore Medical Center must be receive a level 3 designation. Thank you.

ASSEMBLYMAN OTLOWSKI: Assemblyman Snedeker?

ASSEMBLYMAN SNEDEKER: Yes. What facility are you talking about that might be eliminated in Monmouth County? Which one are they talking about eliminating? In your statement, you said there was something in Monmouth that was going to be eliminated.

MS. DUNN: Well, the fact that they would downgrade the present service at Jersey Shore Medical Center.

ASSEMBLYMAN SNEDEKER: But, they're not going to eliminate any hospital or any perinatal care area?

MS. DUNN: No.

ASSEMBLYMAN SNEDEKER: It seems as though there is a tremendous drop in the Jersey Shore live births compared to the Monmouth County Medical Center. Your's have gone down in '71 from 2064 to 1278 in '79. Is there a reason for that? I'm just questioning as to why there is a drop. Monmouth Medical Center, how far is that from Neptune? Is that a long distance?

MS. DUNN: I would say that it's a half hour and it's off the highway.

ASSEMBLYMAN SNEDEKER: So, that would be the one that would get the designation of a higher level than your's would.

MS. DUNN: But, it would be harder to get to.

ASSEMBLYMAN SNEDEKER: Your's have decreased by approximately 50% and Monmouth Medical Center has increased by approximately the same number. Do you know of any reason for that?

MS. DUNN: I'm only speaking as a parent.

DR. DESPIRITO: I would be glad to address that, sir.

ASSEMBLYMAN OTLOWSKI: Do you want some help from the doctor, Assemblyman?

ASSEMBLYMAN SNEDEKER: Yes, I would just like to know the reasoning why.

ASSEMBLYMAN OTLOWSKI: Doctor, would you give the Assemblyman the answer.

DR. DESPIRITO: I am Dr. DeSpirito, who previously testified. I am also, as I indicated earlier, the attending pediatrician and Chief of Medical Education at Jersey Shore Medical Center. The primary drop in the newborn delivery, which is climbing slowly up now is due to the opening of Freehold Hospital. You will find, with the opening of the Freehold Hospital--

ASSEMBLYMAN OTLOWSKI: That caused the drop?

DR. DESPIRITO: Yes, because most the babies and parents from the Freehold area were coming into Jersey Shore Medical Center prior to the opening of Freehold Hospital. At the time that Freehold Hospital opened, we lost about one third of our deliveries.

ASSEMBLYMAN OTLOWSKI: Assemblyman, does that answer your question?

ASSEMBLYMAN SNEDEKER: That answers my question, yes. The other question is, there has been no designation between the Jersey Shore and Monmouth Hospital, that's been defered, as I understand it and has not been decided at this point, and you think it should stay as a level 3 in both of those areas.

MS. DUNN: Yes.

ASSEMBLYMAN SNEDEKER: That's all I have, Mr. Chairman.

ASSEMBLYMAN OTLOWSKI: As a matter of fact, you wouldn't be upset if it remained a level 2, would you? Would you be upset about that?

MS. DUNN: Yes, if it would mean that we would lose perinatologists, who take care of the high risk mothers. If we received a level 2, I don't think the perinatologists would be available.

ASSEMBLYMAN OTLOWSKI: And, you are saying that it should stay a level 3, regardless of the numbers?

MS. DUNN: Yes.

ASSEMBLYMAN OTLOWSKI: Thank you very much.

MS. DUNN: Thank you.

ASSEMBLYMAN OTLOWSKI: Mr. Edward Peloquin? Mr. Peloquin, would you give us your name, your title and your association, for the record?

E D W A R D P E L O Q U I N: Thank you Assemblyman, members of the Committee. My name is Edward Peloquin. I am the Executive Director of the Central Jersey Health Planning Council and my Board of Directors has directed me to address this committee and attempt to do a couple of things. One is to bring you the facts of the actual implementation of a state regulation and a state plan on how it affects an area. I can do that in very simple terms. I'm not going to go into detail because a lot of the points have been covered.

ASSEMBLYMAN OTLOWSKI: What area are you talking about?

MR. PELOQUIN: The area that I'm talking about is the six counties of Central Jersey, Monmouth, Hunterdon, Somerset, Middlesex, Ocean and Mercer Counties, a little over 2 million people in that health systems area 4, as alluded to on the charts here earlier. The organization that I represent is a volunteer, private group. It contracts with the federal and state government to perform a number of services. One of those services is fact finding and within that fact finding, we also have the responsibility to take the regulations that exist and apply those regulations to the reality of day to day life in our area and this gives us a way to look at the facts.

Some of the points that I want to address initially depart from my preparation and confirm two or three facts that are very germaine to the discussion. First of all, there is a set of regulations, as was testified to earlier. In those regulations, based on attorneys' advice and based on other review, there are only three factors that are not waiverable at the present time. That is the 2,000 delivery minimum, the 500 delivery minimum, and that an obstetrical service must have ten obstetrical beds. Everything else in the regulation is waiverable. The reason that it is waiverable is because there are a lot of unknowns in the actual process and the actual outcomes in applying that regulation. In order to try and make some sense of the regulations in real life, a state plan had to be developed. We view the plan as a guideline, not as an impenetrable wall, not as something that we would have to live with. It gave us a starting point of how those regulations apply to our 2 million people and how it might sort out the various health care services.

In that sense, we then had the obligation to take the testimony of people,the volunteers, physicians, consumers and the like and develop a plan of our own, which we have, the Areawide Perinatal Designation Plan, which gets into every detail that you discussed this morning and analyzed it in depth. And, there are some

ready answers based on this plan. This plan went through over 180 people, volunteers. It was studied and restudied and, interestingly enough, two things have come clear, and I sympathize with your job. This morning you heard statements from medical societies, you heard statements from hospital associations, from the state process and we heard all of these statements and with each of them, there is a certain fact and a certain fiction. It is not fiction by intent, buy by point of view and what they bring to what they perceive to be the case. We have to sort all of this out and the plan that was done for our 2 million people sorted that out.

Some interesting things evolved from that. First of all, there is a lack of a really, truly preventive health care system in the whole area to prevent the onset of injury, illness, and disease and unnecessary complications to births. At the same time, there are hospitals, namely Jersey Shore Medical Center, namely Monmouth Medical Center, namely St. Peter's Medical Center, which are already providing a high level 3 type care.

Between those two points, there had to be some improvements in the system. There was a natural evolution in the system. Certain regionalization was achieved through natural evolution. But, we reached a point where it was going to become extremely costly if the evolution took place by itself without any real access or benefit to the people, without any real quality benefit to the people. At the same time, there would not be the intrusion of preventive systems if we didn't have some kind of regulation, some kind of a plan to now fine-tune the system, to improve it. This is exactly where we are with this process.

For example, we asked about cost, estimated cost. I can give you an interesting figure. If we were to let the system naturally evolve in our area, the hospitals in the area would have put up, in round figures, about $956,000 to make improvements they wanted to make to their particular services. Most of these were in the level 3 area, St. Peter's Medical Center and Monmouth Medical Center. But, in so doing, if Monmouth Medical Center did make those improvements, they would worsen the situation at Jersey Shore Medical Center and some of the ills and some of the problems that you heard just a moment ago would have been worsened. There would have been not enough patients to handle the load and the quality of care at Jersey Shore Medical Center and that was a problem to us.

Another thing, in another part of the area, a hospital would want to build to a level 2 capacity. It was not time to build to a level 2 capacity. It was not time to add that equipment. They were going to do it anyway.

If you figure that $956,000 in capital costs, without the regulations, that $956,000 would have gone into the system under natural evolution. With the regulations and with the compromises in the plan that we evolved, about 32% of that cost would be eliminated without any adverse harm to the people, without reducing quality and overall, we would have a cost savings of approximately $325,000. That's where we are with this system. It is fine tuning, to get the excess cost out, but still bring in the excess in quality.

I things like this throughout the entire process of the plan in the documents to be submitted to the State. When we got to the State Health Coordinating Council, the SHCC did, indeed, adopt a very stringent addition to the state health plan and they adopted a very strong attitude. We were one of those people who said, "It is a plan, not a regulation." The State Health Council has the ability to amend that plan. I would respect their right not to want to amend it until there were good facts, until they had time to assess the actual impact. They put the 90 day

moratorium on to do that and now, as you hear, the demonstration project is being proposed. I will submit to you that the demonstration project is approved as submitted by the SHCC. The problem with Jersey Shore Medical Center will be accomodated. We already have in draft form and submitted for technical review now a joint center application that will come less costly than designating either one of the centers independently and it will save what they're looking for at Jersey Shore in Ocean County and what they're looking for in Monmouth County, but we have to have the demonstration program that they're talking about.

A lot of things come into play here. One of the things that struck us constantly is that the medical experts could not agree on the level and quality of care in terms of the number of beds, the number of nurses, the number and size of space of the facility to give the level 3 care. If you look at the level 3 centers proposed in the State of New Jersey, they are all different and each of them cost this much or this much or this much. But, somewhere in there, there is a proper cost given the given situation. The demonstration program, as we understand it, is to do two things. One is to demonstrate whether the number 2,000 is a proper number. That was set in order to be cost efficient. There is no question about that. It was also set to assure that there would be enough deliveries so that the quality of patient care given by the nurses and staff, there would be enough patients for them to exercise their skills and maintain their skills. The demonstration project, as I understand it, is to say, "Okay, there are some centers that show less than 2,000 and there are some over 2,000. Which of those centers will actually give us, in the next two years, the quality at the reasonable cost and the access involved?"

The other part with the 500 and under is very simple. Is there a will and ability for the public to support a very costly operation under 500 or will they have to go to the government for more subsidy or increased medicaid payment or something like that? We really don't know that and the demonstration project, which is pointed up by the HSA's and the hospital associations and the doctors, says, "All right, let's test that also." In any event, it does, in our opinion and in an analysis of our attorney's opinion, no violation to the regulation if you demonstrate on those points. If you want a regulatory change, you can change the regulations over a period of time, but our point is that you should go with the demonstration now, get the level 3's into place like St. Peter's, get the joint centers into the demonstration, test it out and, at that point in time, you will have accomplished in two years with real substantive fact what everybody is conjecturing about now. This is extremely important from the perspective of, I think, the people that I represent and it is important for them to understand that there are some other problems which will be addressed in the process.

I'll give you one other example of a problem. It was a statement made earlier about rescusitation and the problem of not being able to have oxygen available. If you look at the regulations, you will see that the level 1 centers are required to have the oxygen available. I think there were some things mixed up in the testimony that took it outside of a level one into some other operation such as a midwife or a birthing center. You heard the response to that. Only if the doctor and patient agrees will there be such an operation. It is a medical decision. But, level 1 is not devoid of the oxygen supply situation. It is there to take care of that emergency and level 2's and level 3's all have the same capacity.

What I'm saying is that in sorting out this fact and fiction, the result of all that sorting, all that analysis came out in the HSA plans. All the HSA's

produced these plans. We went into the SHCC and the SHCC appropriately supported the process, they restudied it and they are now compromising on a factual basis and it will be coming out in the next month or two with a remedy for the situation that's been created by a very stringent adherence to the plan. That's why people are supporting the demonstration.

I also have to say in closing, unlike some other legislation that we're currently involved with, I would like to say to the committee that an oversight hearing, to me, is the way to go. We are dealing in other legislation in this Assembly and in the Senate where a particular institution was supposedly hurt and they fought their individual case through the Assembly. This is not the case here. I understand what you are doing and why you got this testimony and I would like to hope that we would have further opportunity to deal with the oversight. The closing remark that I have is not by me, is not by anyone on the Health Department staff or the Hospital Association staff, but it is a composite statement of the experts of the country in perinatal care and obstetrical services upon which these regulations were built and refered to several times. It is a committee on perinatal health which writes the report on improving the outcome of pregnancy. It was a national report which everyone based their assumptions on.

In my haste to get this testimony to you, because I think there are questions that you are going to want to ask, I've glossed over several points and I've spoken very fast and I apologize for that. I know it's late. But, I wanted to get to this last point. The purpose of the regulation, the purpose of the plan, the purpose as such is to accomplish the following objective: Quality care to all pregnant women and newborns, maximum utilization of trained perinatal personnel and intensive care facilities, and at reasonable cost effectiveness. Now, all of the experts, contrary to the testimony that you heard today, understands that there is a reasonable cost effectiveness involved and cost is a factor. Quality is a factor and access is a factor and it is the job of the HSA's and the planning process to balance those three. I think, when this is all said and done, when you look at it two years from now, I think you will find that the State of New Jersey is going to be praised for having done that with no adverse effect to the population involved. Thank you.

ASSEMBLYMAN OTLOWSKI: Mr. Peloquin, just to help us bring your point of view into focus so that we can be in a better position to evaluate your testimony, you're the Executive Director of HSA? Would you just tell us what that is, please?

MR. PELOQUIN: The words that go with the HSA are Health Systems Agency.

ASSEMBLYMAN OTLOWSKI: And who are they?

MR. PELOQUIN: They are a voluntary board of directors selected by public election in each of the six counties and each of those six counties have thirty people who are providers and consumers of health services, people like yourself and other people in this room.

ASSEMBLYMAN OTLOWSKI: That is generated by what, by federal legislation?

MR. PELOQUIN: That's generated by federal legislation and adopted by reference in state legislation under the state Certificate of Need law, the DRG law.

ASSEMBLYMAN OTLOWSKI: Under that law and under that structure, your role is what?

MR. PELOQUIN: Our role is to do as I said earlier, find out the facts, apply the regulations and standards to the reality of what goes on every day and

to assess whether or not the way proposed by the state or the way proposed by the individual hospitals is the best way to meet the ends. Usually, it is a compromise between the two and how we do that, we develop a plan, a document that says, this is the point of view of the hospitals and the providers, this is the point of view of the state and the regulators, and this is the point of view of the people who use these services and it is usually in between. We develop a plan, sometimes called a special plan like this one here. Sometimes, it is called "The Annual Health Systems Plan" or "The Annual Implementation Plan." But, it is made up for that purpose and that is exactly what we produce on an annual basis.

ASSEMBLYMAN OTLOWSKI: This plan for this particular approach to this particular problem has been going on countrywide now for how long?

MR. PELOQUIN: This particular problem has been going on, probably, for the last year and a half from my knowledge of it from other areas around the country.

ASSEMBLYMAN OTLOWSKI: And it has been implemented, as I understand it, in Colorado and Arizona?

MR. PELOQUIN: In Colorado, which I am familiar with, the regionalization of Colorado was implemented because there was simply a lack of people and there were the mountains, and in order to get enough of the quality care there, you had to concentrate your resources in Denver and you had to have a way reach out to the people far away to bring them in. So, that problem in Colorado is very different from a very densely populated state problem, which could evolve its own system. The two differences, however, if you look at the cost in Colorado and the cost in New Jersey, you see that in New Jersey there are certain potentials to become over-costly in the sense that you pay more than what you really need in New Jersey. That's why the regulations came about and this is the kind of thing you have to deal with.

ASSEMBLYMAN OTLOWSKI: So, in the birth of that organization, of that bureaucratic offspring, you have only had the experience of Colorado and Arizona?

MR. PELOQUIN: No, Assemblyman. As a matter of fact, there is experience in dealing with Georgia, Florida, I can't name the other number of states we have have looked at in terms of some activity, all of which, by the way, have predominantly proceeded because of the legislation that enabled this kind of planning to begin.

ASSEMBLYMAN OTLOWSKI: But, no place is the system working or has been working that would be comparable to the kind of population, the kind of experiences you would have in New Jersey, is there?

MR. PELOQUIN: There are systems working and there are reasons why they can be applied in general terms in New Jersey. As far as being comparable to New Jersey, I think New Jersey is unique. There is a unique set of circumstances here and you have to devise one that is tailored to your unique set of circumstances. But, there are general principles, levels of care, certain quality at that level, certain cost ratios among the services and they're applied in other places, yes.

ASSEMBLYMAN OTLOWSKI: But, in no place is the whole plan, the whole package being put into operation other than in Colorado and Arizona?

MR. PELOQUIN: No, sir. There are other places where it is in operation, most recently, when the committee was hearing, a couple of weeks ago, testimony from the SHCC committee that Commissioner Reilly heads. There was testimony of an actual operation in Georgia, the Atlanta, Georgia area. There was testimony from Cleveland, Chicago--

ASSEMBLYMAN OTLOWSKI: It's already working in Atlanta?

MR. PELOQUIN: Yes.

ASSEMBLYMAN OTLOWSKI: Do you have any knowledge of the program in Atlanta?

MR. PELOQUIN: Only what I have read and what I've heard in testimony. I have no first-hand knowledge.

ASSEMBLYMAN OTLOWSKI: Assemblyman Snedeker?

ASSEMBLYMAN SNEDEKER: Yes. You read the regionalization introduction of the plan and it states in there about quality care--I won't read it over again--but the one thing that bothers me, it doesn't state in there about the availability of the mileage you have to travel or the distance away. Nowhere in that regionalization is that considered. It's not worded in there. It's the trained personnel, the assurance of reasonable and cost effectiveness, but I think you also have to consider the reasonableness of getting to the facility. I note that in your recommendations, all of the Mercer County facilities, over which Region 4, the HSA, has the designation, all of those have been defered. Why?

MR. PELOQUIN: Because, in that area--there will be a meeting tomorrow, as a matter of fact, at noon--for a year and a half, the HSA, with the support of the Health Department, the Hospital Association and the five hospitals have been putting together a much bigger package, which includes obstetrical services. They are putting together a package which will result in the closure and conversion, voluntarily of some obstetrical services, but, in addition, the reshifting of services among three to five hospitals and the reorganization of service for the entire Mercer County area will occur. It is a much bigger change of which obstetrical is just a part. Because it is a much bigger change, there was reason for the delay in order to get all the pieces in at one time and this is exactly why it has been delayed and will be coming to closure on that within the next few months.

ASSEMBLYMAN SNEDEKER: We have four hospitals in Mercer County that have maternity services. Are you telling me that they're going to consolidate those into a plan of some kind within the next week or so?

MR. PELOQUIN: That is correct, Assemblyman.

ASSEMBLYMAN SNEDEKER: And, you're going to make a recommendation on what level each one will have?

MR. PELOQUIN: That's correct.

ASSEMBLYMAN SNEDEKER: Does your Association agree with the utilization of standards as far as the level in numbers? For example, level 1 is 1,000 and level 2 is 1,500. Do you agree that those regulations that are going into effect are correct?

MR. PELOQUIN: Those are not regulations, Assemblyman. The only regulation--

ASSEMBLYMAN SNEDEKER: They are regulations.

MR. PELOQUIN: They're waiverable.

ASSEMBLYMAN SNEDEKER: But, they're still regulations.

MR. PELOQUIN: They're waiverable, the 1,000 or the 1,500. As an absolute number, no, we don't agree with any absolute number. The absolute number gives us a guideline to which we can then apply the actual circumstances, the actual cost of the facility, the actual quality. Also, something you might be interested in--we deal with time--we have a time standard, a travel time standard, and the entire plan that we drew for our area places a person no further than 20 to 30 minutes away from any obstetrical service and that is by design. That's not by happenstance. Time is a major consideration in deciding where the level 3's should go, where the level 2's should go and where the level 1's should go.

ASSEMBLYMAN SNEDEKER: Now, when the regulations were established, what input did HSA 4, what input did you have in this?

MR. PELOQUIN: We had the opportunity to review the draft regulations, to provide comments from a technical point of view on the draft regulations. I would say that, possibly, us with all the other HSA's and with other people commenting, we're one of the forces that established a basis for waiver in a lot of areas. We saw a lot of areas that we had certain types of problems. We were not successful in achieving waiver for the 2,000 or the 500, which are the two standards fixed in the regulations. However, as I see now, if the demonstration goes through, then you have the ability to check that standard before you determine whether it should be taken out or it should be added or modified. But, by and large, the rest of it we had adequate input to. We had an opportunity to discuss the points of view and to consider what the effects would be.

ASSEMBLYMAN SNEDEKER: Of the facilities that the HSA designated, how many did the SHCC agree to? In other words, if you said it should be a level 1, did they agree to level 1 or if you said it should be a level 2, did they agree to the level 2?

MR. PELOQUIN: I don't have the precise numbers in front of me, but I can give it to you by designation level. At level 3, St. Peter's Medical Center was recommended for level 3. That was concurred with. The Jersey Shore-Monmouth Medical Center, we defered and they defered that also because they knew we were working toward this joint center which would be less costly than a single designation in Monmouth and Ocean. It was also a problem with the State Health Coordinating Council plan and whether or not we could get that second level 3. We, of course, argued that we should have a waiver, we should have an amendment to the plan to do that. With level 2's, we have a different kind of problem. With level 2's, the problem that we're facing is that we did not get from the SHCC preliminary recommendations the same number of level 2's that we asked for and I can get the number for you, but it is probably available through another source. The issue of level 2's is that we have many level 2's that have six or seven or eight intensive care bassinets, very specialized bassinets in their units and the way the State plan is drawn, you eliminate--using an example of, let's say, eight hospitals, let's say all eight hospitals had 5, 6, or 7 intensive care bassinets. Under the State plan, you may eliminate four of those hospitals and you would have to consolidate bassinets from four into the other four hospitals, so to speak. So, what happens is you have to find space for 56 bassinets or you have to say that the medical practice in that area is putting too many patients improperly diagnosed into those bassinets. We were not in a position at that point to say that the medical practice in that areas was flawed. We're not in a position to say that the number of babies was an improper number. What we did find out is that if you had to consolidate all of the bassinets into four facilities from eight facilities, you would have to spend more capital. You're going to have to build space to accomodate these other hospitals. So, consequently, we came back to the SHCC and our recommendations would have more level 2's than what the SHCC original plan would recommend for the very reason that it is contrary to the regulation. You wouldn't be proving access and you're only going to wind up raising costs and the quality would be, basically, the same. So, our plan, in essence, did recognize that point and that's why we asked for more level 2's than they recommended.

ASSEMBLYMAN SNEDEKER: Do you think, then, that the SHCC is reasonable, in the sense and the time when interest and building and construction is probably at its highest, and they're going to have to tell facilities and another hospital is going to be level 2 and they're going to have to expand. Where are they going to get the money?

MR. PELOQUIN: That is precisely our point and I don't believe the SHCC, in the process of that experience with the SHCC, is so unreasonable that they are going to drive institutions into spending more money unnecessarily without any kind of benefit. That will be a no benefit situation. I have to believe that. My experience with the SHCC believes that; my experience with the process up through the county communities, through our Board of Directors,through the Health Care Administration Board, through the SHCC, through the Commissioner. It is my opinion that has worked with these kinds of checks and balances. I think the oversight hearing is an opportunity to explain that it works. There has been a lot of information given and I can understand your dilemna. But, I think the process will work. I really believe that.

ASSEMBLYMAN SNEDEKER: Do you feel that changing a hospital from whatever--there are no levels at this point. But, if we designate a hospital that we would call a level 1 today under the regulations and what is required and you designated that a level 1, do you feel that that would take those in the pediatrician section to move to another hospital, to go to a level 2 hospital?

MR. PELOQUIN: I think the pediatricians who would be supporting a level 1 hospital will, by and large, still provide the support service to the level 1 or to a level 2 for a number of reasons. In order to do so, the pediatrician will have to actually, probably, dislocate. Who wants to just drop their office in this kind of situation. The pediatrician would also have to make other arrangements and referrals at a facility that they really, probably would prefer not or they would have practiced there before. Pediatricians, in my understanding of them, talking to several of them, basically have said, if it is a level 1, they will of course take care of their patients. That is their obligation and if that's where they are practicing, they will practice the medicine there that is required. At the same time, they will make sure that those patients who need additional care at the level 2's, they will get them that care because that is their obligation, again. I think the pediatricians and the physicians in the community, once they clearly know the system of 1, 2, and 3, will find that they'll have a system. They won't have to guess anymore either. They won't really have to know whether something is open. They can know. They get into the system and the system moves the people to where they can practice and where they can get the best care. A lot of people have been in favor of this, from the physicians that we've talked to and have basically said that it has a lot of advantages to the physician and security to the patient and the patient care that they can render, knowing that a competent, qualified staff is going to be there at those facilities.

ASSEMBLYMAN SNEDEKER: When I look at the listing that you refer to just in Mercer, you say that this is going to be discussed in the next week or so. I hope all ths hospitals in Mercer know this.

MR. PELOQUIN: They've been discussing it for two years.

ASSEMBLYMAN SNEDEKER: One of them is St. Francis Hospital, which had, in 1971--that's a Catholic hospital--it had in 1971, 1880 live births and in 1979, it had 700. Now, we're below a level 1.

MR. PELOQUIN: 700 at St. Francis Medical Center?

ASSEMBLYMAN SNEDEKER: That's what it says on the sheet that I have in front of me. It said 1,048 in 1978 and in 1979, 700. Now, if you're going to tell St. Francis that they're going to be below a level 1, I think you're going to have a civil war in this county.

MR. PELOQUIN: I think that you will find--those figures don't jive with mine as of the last two weeks. But, be that as it may, let's take the premise that they're dropping below that level 1. One of the things that you have in the Trenton area, and this is really important, is that you do not have enough births in that area of those three hospitals to sustain three level 2 facilities or else you're going to pay through the nose with no improved access and no improved quality and the reason the hospitals have been working with us to consolidate it, they know they must, like any business that fall into those kind of times, maximize their resources into two facilities. We're not talking about dropping into level 1. We're talking about one of those hospitals dropping out of obstetrics completely, voluntarily so that the other two and the community can survive with the level of births that is justified both with quality, the number of mix of patients that you need for the staff, and so that the access and the cost are at the least possible for that area. We're going more radical than that and they're doing it voluntarily with us.

ASSEMBLYMAN SNEDEKER: Then, you're certainly going to have to move some physicians out of the hospital that you drop out of that care and that physician is going to have to move out of that hospital.

MR. PELOQUIN: I think I will have to address that point very, very much in this way. We have a system in this country that is a system that compromises between the physician, the physician's practice preferences, the hospital and the consumer. The consumer, by and large, loses that compromise. Now, what happens is, the physician in that area may have to travel 5 or 6 or 7 minutes further to the other hospital, but in doing so, they will have advantages that they don't have under the system now. They have the potential of a residency program, additional training, the potential of having cases that are more economical, efficient and effective for quality environment and, by and large, the physicians that have opposed the process in that area are opposed to any change. But, the change isn't going to be adverse, maybe five or six minutes travel time difference.

ASSEMBLYMAN SNEDEKER: You're saying that there is change. I don't question that there is a need for change sometimes, but, also, there is the basic right that the individual has to go that hospital that he or she wants to go to where their physician now practices. You're telling me that you're going to eliminate some services from that hospital and you're going to say to me that I have to go to another hospital whether or not I want to go or not. I must go to that hospital.

MR. PELOQUIN: If the patient did not use third party payment and if the patient did not use medicaid or medicare and the patient was operating in a market where the patient had to take his checkbook out and pay for the services in that manner, I would be the first one to pull out of the planning process. Unfortunately, that is not the way it is. What I'm saying is that for the convenience or for the benefit of patients, we're penalizing a lot more people at a nickel and dime a day, going into billions of dollars. Every little case like Mercer is exactly that way. There is going to have to be something that says, "This hospital is no longer available to patients," but there is an alternative available to you and I'll bet my bottom dollar right now that the physicians and the people will use those alternatives because every place this has happened, they come out the better for it because the

cost goes down, they, basically, can get the better services and they end up, after they've learned the changeover after a little time, in a better and more productive relationship. I have to emphasize that in Mercer, this is a voluntary effort of the five hospitals, spurred by this plan and because of the spector of the regulation, they know they have to do something and they're willing to do this. For a year and a half, we've been meeting almost regularly, with the five hospitals, with the Hospital Association, with the Health Department, to do this kind of of thing and it is the way that people are going to have to bite the bullet if you're going to quit escalating health care costs and your medicaid budget out the window. I'm sorry, but that is a fact of life. I hate to be very blunt about it, Assemblyman, but that is exactly the way things shape up and I have the facts to prove it.

ASSEMBLYMAN SNEDEKER: If you go down to your same area, Monmouth County, where two have been defered, one has been made a level 1 and all those have been defered by the SHCC, at this point, in Monmouth County, and there have been two deferrals in there to decide whether or not you would have a level 3 and, if you can't waive that 2,000 amount in there, you're not going to have a level 3 in Monmouth County, then.

MR. PELOQUIN: We don't need a waiver of the 2,000 for a level 3. In the plan, it was recognized that the joint centers could exist and if joint centers could produce the same results as a single center of 2,000, you will find that what happened in Monmouth County--Jersey Shore Medical Center--

ASSEMBLYMAN SNEDEKER: What's a joint center?

MR. PELOQUIN: That's what I'm going to get into. Jersey Shore Medical Center and Freehold Area Hospital combined to a joint center. In order to combine with Monmouth Medical Center--at this point in time, Monmouth Medical Center, for very good reasons, was reluctant to combine in the early days. What our Board said was as follows. Because of the neonatologists, the physicians, the nursing, the training and because the equipment and the facility was already in place and had already been invested in several years ago, it makes sense for a joint center to be created between Monmouth and Jersey Shore Medical Center. Jersey Shore Medical Center, in turn, wanting to assure their assets and their situation were protected and to continue the service to the people that you heard from earlier today, also developed with Freehold Area Hospital a possible joint center application as an alternative. Now, what is a joint center? In essence, a joint center, in very simple terms, is a coordinator or manager of operations that manages the operations of transportation, data collection, the overall distribution of facilities and services using the two sites, the physicians and nurses at Jersey Shore, the physicians and nurses at Monmouth Medical Center, single phone number, single point of contact and that community would be able to call or a physician would be able to call one place, one number and express what they need, their problem, if they run into problems. Also, the management of these two centers would be much more efficient and effective. That's what a joint center basically is. It is a joint management of two sites.

ASSEMBLYMAN SNEDEKER: It's two hospitals combined together.

MR. PELOQUIN: Basically, that's right.

MR. REILLY: We're talking about this service.

ASSEMBLYMAN SNEDEKER: How about the DRG when you start with this here. When you get into a DRG and each hospital has to go into a DRG basis and has to figure out its own cost there, what are you doing to these hospitals then?

MR. PELOQUIN: In this case, if Monmouth Medical Center were allowed

to proceed on its own to build toward a single free-standing center, or if Jersey Shore were allowed to proceed on its own to build a free-standing, level 3 center, the total cost of that operation would be approximately $500,000. Under a joint center, all that cost disappears and and what you come in with is an administrative overhead cost. When the DRG system is applied, they're going to apply the DRG system in such a fashion that the true cases at Jersey Shore, which are level 3 cases although they may not be the 2,000 and some odd cases and the number of cases at Monmouth Medical Center would have to be reimbursed for the actual care given and the same at Jersey Shore. But, what's been taken out is unnecessary overhead that the DRG won't have to reimburse and that's exactly what would happen. The alternative is--and this is the interesting part--is that you have a need for 15 intensive care beds in that area. You have 10 at Monmouth and 5 at Jersey Shore. If you take the 5 at Jersey Shore out, Monmouth Medical can't expand any longer.

ASSEMBLYMAN SNEDEKER: I thought we were talking about Freehold a minute ago.

MR. PELOQUIN: Freehold is the other option. Jersey Shore had an alternative with Freehold and, in that case, the split there was such that Freehold and Jersey Shore would become a joint management just as I described earlier.

ASSEMBLYMAN SNEDEKER: Greater Freehold Hospital is in Freehold?

MR. PELOQUIN: That's correct.

ASSEMBLYMAN SNEDEKER: Jersey Shore Hospital is in Neptune.

MR. PELOQUIN: That's correct.

ASSEMBLYMAN SNEDEKER: What is the mileage between those two hospitals?

MR. PELOQUIN: Roughly, 15 to 18 minutes.

ASSEMBLYMAN SNEDEKER: What are you driving?

MR. PELOQUIN: I'm driving a normal Chevrolet and I get there in between 15 and 18 minutes.

ASSEMBLYMAN SNEDEKER: Between Neptune and Freehold?

MR. PELOQUIN: Yes.

ASSEMBLYMAN SNEDEKER: You do very well then and you better watch it because you're going to get a ticket going between Neptune and Freehold because that's a heck of a long distance. I don't think that you can do that.

MR. PELOQUIN: We rejected that as an HSA, Assemblyman. We basically did not support that proposal.

MR. KOHLER: If Freehold and Jersey Shore combined, you mean that you would have two level 3 centers?

MR. PELOQUIN: No. The Freehold-Jersey Shore project was an alternative that was put forth by Jersey Shore and Freehold when they felt that they would never get, because of the state plan rigidity or for other reasons, the combined Jersey Shore-Monmouth. Just last week, we had the meeting with Jersey Shore and Monmouth. The draft application of the combined center is already circulating for technical review between those two facilities. Freehold was an alternative possibility, not the one required.

ASSEMBLYMAN SNEDEKER: I have no more questions.

ASSEMBLYMAN OTLOWSKI: We're going to recess for lunch and we're going to return at 1:45. Will you please be back at 1:45?

(at which time a luncheon recess was had)

AFTER LUNCH:

ASSEMBLYMAN OTLOWSKI: Can we resume the hearing, please? Mr. Peloquin, you were talking about different hospitals in different areas. Have you concluded that phase of your testimony? What else did you want to add, at this point?

MR. PELOQUIN: I think what I wanted to add was a last minute consideration based on all I've heard this morning. Basically, the demonstration project, as it is talked about, as we heard it being proposed, is one that, in our opinion, would do two things. One, it would get us on with what most of the hospitals in our area want, assuming that our plan, the one that we have here, would be adopted by the SHCC. On the other hand, apparantly, the remedy to the problem may not be to remedy the process, in other words, the HSA or the SHCC review and all of that. The remedy may lie in some amendments to the regulations. I can understand that. My concern is that we don't delay too long on whatever the remedy is because what will happen in the process is that we will continue to see building on the inequities and on the problems in the system and the longer we go without a remedy, the longer we're going to have these inequities and problems and we can't get on with the improvements. I think everyone generally agrees that we need to improve the system. It's not changing, it's improving.

ASSEMBLYMAN OTLOWSKI: Excuse me. That's just the point. I don't think anybody is belaboring the point that the system cannot be improved. I think everybody agrees to that. But, what people disagree about is the fact that the radical surgery isn't necessary that some people want to apply to the patient, particularly the SHCC people. But, in any event, this is what's coming out this morning. It's obvious that the hospital people, and particularly the doctors that are representing the pediatricians, this is what they're pointing out. They're pointing out that there is no question that there is room for improvement, but it's a question of what kind of improvement you're talking about. They are obviously not talking about the kind of improvement that you're talking about. Yet, I suppose you're going to say that this is the only crap game available in town and you have to play in this game, because that's where we are with this program.

MR. PELOQUIN: I would not say that at all.

ASSEMBLYMAN OTLOWSKI: Well, what would you say? What other alternatives are available? Is there a better plan?

MR. PELOQUIN: Yes. The HSA plan is a better plan.

ASSEMBLYMAN OTLOWSKI: And, what would that entail?

MR. PELOQUIN: That plan would entail the SHCC amending their state plan to incorporate the HSA plans and, at this point in time, since the regulations still are on the books, adopting the regulations for those three parts of the regulations that are still a problem, the 2,000 and the 500 and one other little part that is of no concern to anyone. That would do the job. I think the fear is that the Department or someone higher than the SHCC will not abide by that plan. I think that's the fear that I've heard expressed by the people who fear the worst of the plan. I think there are two ways of finding that out. One, let the SHCC take its actions, let the SHCC make its recommendations as such and see what happens and remedy it through the regulations, or look at it right now in terms of the regulations. But, the planning process itself has worked within the context of the regulations. If the regulations are wrong, then they need to be reviewed and changed. That's all I'm saying.

ASSEMBLYMAN OTLOWSKI: Is there anything else you want to add to your testimony?

MR. PELOQUIN: No, not at this time. Thank you.

ASSEMBLYMAN OTLOWSKI: Thank you very much. Mr. Kornett? Would you give us your name and the organization that you represent?

M I C H A E L K O R N E T T: Yes, sir. My name is Michael Kornett, Deputy Executive Director of John F. Kennedy Medical Center. Just for the record, I would like it known that John F. Kennedy Medical Center is a 441 bed licensed acute and rehabilitation medical center located in Edison, New Jersey

Earlier testimony today, Mr. Chairman, has centered around the problem of 500 beds or less type hospitals or those hospitals seeking level 3 designation who probably, for some reason or another, have not qualified for the 2,000 births per year. There are other problems in the system. I am here to testify regarding John F. Kennedy Medical Center's request to be designated as a level 2 perinatal facility for the care of mothers and newborn. I would like to point one thing out before I get started with the prepared text. I am going to deviate from time to time from it and I just want to draw your attention to that fact.

First, let me say that Kennedy Medical Center certainly agrees with the concept of regionalization and supports the efforts of hospitals to share services. We have worked for such programs.

We have also agreed that in order to improve perinatal care and to provide quality services that are also efficient, expensive perinatal facilities should not be needlessly duplicated.

What we cannot agree with, however, is the manner in which the State Health Department began implementing its regionalizational plan--judging from our own case and and from other other hospitals' experiences.

The Health Department has apparently undertaken a course of forcible elimination or reduction of existing perinatal services wholesale and across the board, merely to make the numbers and levels of perinatal facilities in the state conform to its paper plan.

As our case indicates, this course of action represents government in a vacuum, implementation of government policies without any serious consideration of the needs and wishes of the governed--I think that was brought out this morning--the hospitals and the people they serve.

One goal of the perinatal regionalization plan is obviously to improve services statewide. But, it is no help for mothers who must travel great distances in surburban ares to give birth because local hospitals have been forced to close perinatal units or mothers whose infants are transferred to another hospital for the kind of care that the hospital has been forced to abandon to fit the plan.

It is a certainty that there will be many cases like these if the state health planners continue to operate in such a manner of "social engineering" which has already failed dismally in other nations.

I am here to urge you that the state planners not be allowed to plunge again into the disastrous course of closing or reducing perinatal facilities to make them conform to to a paper plan, regardless of the local needs or the hardships of the mothers and their babies or far-reaching effects on other hospital services.

I believe that earlier testimony offered this morning has offered simple solutions to complex problems. I urge this committee not to be lured into a false sense of equity. As Mr. Peloquin has pointed out, there are many local recommendations that are either ignored or rejected at the SHCC level. Kennedy Medical Center is a case in point.

We have been operating for several years as a facility which completely meets State Health Department criteria for level 2 perinatal facilities. This facility was carefully planned in accordance with government mandated planning procedures and our occupancy and birth rates indicate that its services are definately needed by the local residents.

As to the state's criteria, the number of deliveries at Kennedy Medical Center exceeds the level set by the Health Department, the number of board-certified obstetrics and gynecological specialists at Kennedy Medical Center is one of the highest in the state and nearly half of our newborn admissions come from outside our primary service area. This is a critical point because the state said we serve only our primary service area. This was used as an argument against our receiving a level 2 designation although we were never told that in fact.

We have already successfully completed every step in the HSA IV review process following our request for a level 2 designation. Even the site visits by the survey teams from the HSA and the Health Department were completed without any indication of major problems, which means we required no waiver from any part of the criteria and would experience no additional cost to continue our obviously level 2 operation.

Yet, just two days after the Health Department visit, we were told that although there are two level 2 designations still available in our region, a subcommittee of the State Health Coordinating Council would recommend on November 21 that we not be given one of them.

If that recommendation had been accepted, for what reason have we so carefully planned and operated our perinatal unit thus far? And, most importantly, how could it possibly become known that we would not get the designation we requested even before the report of the site evaluation committee--which we understood would be favorable--was completed, presented or reviewed?

I ask you on the committee to also consider the following: In our hospital and others the effects of such unfair decisions will be more far-reaching than just the impact on perinatal services and the patients.

At Kennedy Medical Center, for example, a reduction in services from the level 2 type we now have to a level 1 would damage other programs.

1. The prospect of reducing us to basic services will discourage application by young physicians to our currently successful Family Practice Residency Program now training 19 residents a year in this heavily demanded specialty.
2. Having fewer residents enrolled would also force us to cut back on family medical services the residency unit supplies to area residents who do not have a private family doctor.
3. If perinatal occupancy rates drop, many babies with abnormalities will be denied the chance for critically important early intervention pediatric rehabilitation programs. Through our Robert Wood Johnson Jr. Rehabilitation Institute, which is part of our medical center, we are able to screen newborn and immediately bring those in danger of less than normal development into our early corrective programs.
4. Less than a level 2 designation for Kennedy Medical Center also threatens our educational and patient service programs which depend or dovetail with its perinatal operations. This includes the pending residency program in obstetrics and gynecology with the School

of Medicine at Rutgers University.

5. A denial of a level 2 designation will seriously threaten our financial stability because we will be maintaining our facilities on a par with other level 2 hospitals and may only be reimbursed at a level 1 rate, should that come to pass. Kennedy Medical Center will find it more difficult to meet bond obligations--bonds which are issued by state agencies. A prospective drop in our occupancy rate in the perinatal section as physicians admit patients to other level 2 facilities will also cause financial loss. Now, these financial losses are a reduction in services and revenue and will represent a major deception to current bondholders and will threaten the forthcoming $9 million issue to finance other programs already approved for the Medical Center by the State Department of Health.

This is a brief summary of the effects that such an arbitrary and unfair decision will have on John F. Kennedy Medical Center. Other hospitals in the state face the same serious problems.

Before I close, I should like to make one more point about the review process. At recent meetings of the SHCC, subcommittees and committees, members of these review agencies criticized hospitals for attempting to rally so-called political pressure to win their case. Assemblyman Otlowski, you questioned Mr. Reilly this morning as to the review process of the SHCC. Those of you who are unfamiliar with this review system should be aware that hospitals are given no chance during these sessions to present their cases or to answer questions raised. It is far less than a democratic arrangement. We are never told what the findings of the HSA staff are in advance of the meetings and so, because of lack of knowledge and this gag rule, we cannot respond. Therefore, when we feel that our programs--and thus the people whom we serve--have been shortchanged or wrongly curtailed, we turn properly to our elected officials. You and other public officials are the ones who represent the public we serve. If this is using political pressure to seek such help from you, then I suppose we are guilty.

In this light, we urge this committee to look long and carefully at the entire planning process for this particular program and to make sure that local needs--in all communities you represent--are not subverted to a master plan--of which perinatal is only an element--that has no flexibility or ignores the human factors. In my opinion, there has not been enough factual information offered here today for this committee to make any other decision than to extend the present moratorium until such time that you are clear that all issues have been presented. Thank you.

ASSEMBLYMAN OTLOWSKI: Are you saying that you never had an opportunity to present, make such a presentation to that committee?

MR. KORNETT: When that committee meets in session, sir, those people whose applications are discussed, it is in an open forum. You can be present, but you cannot respond to questions. At the HSA levels and at the community advisory council levels, the local levels, where people could understand our needs, we do participate.

ASSEMBLYMAN OTLOWSKI: What political process do they want you to use?

MR. KORNETT: The political process that we use is naturally to turn to our elected officials.

ASSEMBLYMAN OTLOWSKI: Do they have a better suggestion?

MR. KORNETT: I don't know if they do or not, but we've been criticized not only this time but many times in the past.

ASSEMBLYMAN OTLOWSKI: Why were you criticized for using the political process? I can't understand that.

MR. KORNETT: I think many hospitals who probably would be present here today would not want to be singled out as one who comes forward and tells it like it is. This is only one of many issues that they will face in the future. We have to deal with the regulators on a daily basis and it is, I would think, an extremely unpopular thing to do.

ASSEMBLYMAN OTLOWSKI: I just can't believe that, that they don't want you to use the ordained, established political process, the constitutional process of the country. In any event, what you are saying in your statement is that you would be terribly hurt by the reduction of this level that they would put you into, is that right?

MR. KORNETT: What I am saying in summary, sir, is that we have met every area of the criteria without a waiver, no cost would be experienced to continue with our obvious level designation, and the recommendation came from the HSA IV to approve Kennedy Medical Center as a level 2 facility because they understand the local needs and when it reaches another level, the state level, it is either ignored or rejected. The process becomes dim as it rises through the state levels.

ASSEMBLYMAN OTLOWSKI: In hospital age, your hospital is regarded almost as a new hospital, isn't it?

MR. KORNETT: Our hospital is 13 years old. We have grown from a 205 bed institution to now 441 beds in 13 years. We have grown from a level of some 300 employees to 1710, today. We have 357 attending physicians. We have 25 board certified OB-GYN specialists. We have two salaried pediatricians in our hospital, as well as the 19 in the Family Practice Residency program. We have other paid house staff who are on duty full-time at our institution, coupled with the fact that we have, probably, the only pediatric rehabilitation program for newborns and infants, as well as a follow-up infant wellness clinic and a team that assesses those mothers and infants who are identified as those that are at risk when they come to our institution.

ASSEMBLYMAN OTLOWSKI: And you did all of that based upon the different developments and different services and activities that you took on in your period of development and in your period of construction? You took all of that on. You incurred debt to do everything that you have done now and you said in your testimony that by cutting this out, you would be jeopardizing the payment of your bond issue, you would be jeopardizing funding your interest rates on your bonds and, generally, affecting the entire hospital structure by being reduced to a level 1. Is that what you are saying in your testimony?

MR. KORNETT: I'm saying that serious consequences could emerge from that. Standard and Poors and, also, Moody's who are rating agencies of bonds have just reviewed our bond issue, our 1973 and 1977 indebtedness, which amounts to in excess of $14 million.

ASSEMBLYMAN OTLOWSKI: Your hospital is capitalized at what, $20 million, $30 million?

MR. KORNETT: Approximately $28 million.

ASSEMBLYMAN OTLOWSKI: Your total capitalization is approximately $28 million?

MR. KORNETT: Programs that were all approved by the state through the certificate of need process. Our Pediatric Rehabilitation Program is one that was also approved not too long ago by the certificate of need process, dovetailing into our perinatal unit and, of course, the acute facility. Getting back to the financial strains, that could possibly be experienced. There is a deception. The State of New Jersey does not have a very good reputation with respect to good security in the bond market. Because of the experience that is coming about through the uncertainty with the DRG program, there has been a certain lack of interest in the purchase of bonds. In the past, there are certain financial measurements that have to be made to meet debt service and--

ASSEMBLYMAN OTLOWSKI: This DRG, is that a uniform organization? What is this DRG?

MR. KORNETT: This is a new experience, the new reimbursement experience by the State. It is called Diagnostic Related Groups. 26 hospitals were in it last year and 40 more have been asked to participate this year. The problem is that when you go to the rating agencies for new issues, there is a great deal of difficulty outside of New Jersey for the sale of bonds, New York and New Jersey.

ASSEMBLYMAN OTLOWSKI: Well, how do you sell your bonds for a hospital if you have all of these problems?

MR. KORNETT: There has been a very careful marketing of the bonds by a few select underwriters. The New Jersey Health Care Facility's bonding authority has done a reasonably good job in trying to educate the rating agencies as to the guarantees that are supposed to be explicit in the DRG program. Most of the forecasting is done by way of a feasibility study from approved feasibility consultants. They take into account historic services that are available in an institution. A feasibility study that was just prepared for our institution would have very negative connotations should we lose part of our designation, lose some of our occupancy, lose some of our physicians and outstanding bondholders, who bought those bonds in good faith, would also have a problem understanding what is happening what is happening here in the State of New Jersey. I pointed out to you before that the perinatal issue is only the tip of the iceberg. There are a lot of issues that haven't been raised here today that are much more important than who gets what in the State of New Jersey. The natural evolution that was discussed here this morning has worked. There is a certain economy for services to rise and fall in the health care industry. It has been indicated that 12 hospitals have closed their OB services in recent years. It is the economic pressures that have caused those closings.

ASSEMBLYMAN OTLOWSKI: Let me ask you this question. In your pediatric area, when did you get a certificate of need? When was the last time that you applied for a certificate of need?

MR. KORNETT: For our Pediatric Rehabilitation Program, I believe that was in 1978.

ASSEMBLYMAN OTLOWSKI: At that time, wasn't there any question about the fact that your level of care could be reduced in that area?

MR. KORNETT: No, sir.

ASSEMBLYMAN OTLOWSKI: But, they, nevertheless, granted you a certificate of need?

MR. KORNETT: Yes, sir.

ASSEMBLYMAN OTLOWSKI: What kind of money did you spend at that time, do you remember?

MR. KORNETT: Specifically, for that program, no,because it was co-mingled with other rehabilitation programs.

ASSEMBLYMAN OTLOWSKI: I'm going to declare a five minute recess. I just want to brief Assemblyman Lesniak who missed the train this morning.

(At which time a five minute recess was had)

ASSEMBLYMAN LESNIAK: We will now come back into session. I am Assemblyman Raymond Lesniak and I am Vice-Chairman of the Committee. Chairman Otlowski has left and Assemblyman Markert had an emergency at home and he had to leave also. By the way, is Mr. Wagner here from the Department? You are Mr. Kornett from Kennedy Medical Center?

MR. KORNETT: That's correct.

ASSEMBLYMAN LESNIAK: I would like to review some of the matters that I just spoke to Assemblyman Otlowski about regarding the process of development of the plan and the input from individual hospitals. Is it a fact that your input not only was not sought, but not allowed to be made in the development of that plan?

MR. KORNETT: I was not present at the SHCC meeting. I have been present at other SHCC meetings where the matters are discussed in open forum, but those people who have issues before the SHCC are not asked to respond to questions nor can they respond to questions.

ASSEMBLYMAN LESNIAK: Can you request to be heard?

MR. KORNETT: I'm really not sure, sir.

MR. RABINOWITZ: I would like to address that because I think to accept that at face value, the comment you just heard, would be a travesty of the process.

ASSEMBLYMAN LESNIAK: Can you tell me what, in fact, the situation is?

MR. RABINOWITZ: Before any issue gets close to the SHCC level, it has been heard at great length, pro and con, with supporting data, both by the applicant on any particular health care issue, plus the data provided by the State Health Department staff.

ASSEMBLYMAN LESNIAK: Can you be a little more specific on that?

MR. RABINOWITZ: Yes. When a certificate of need request, for example, is originally anticipated--

ASSEMBLYMAN LESNIAK: We're not talking about a certificate of need. We're talking about the development of the state plan.

MR. RABINOWITZ: The question that was addressed--

ASSEMBLYMAN LESNIAK: The question that I am concerned with and the question that I addressed was the development of the state plan.

MR. RABINOWITZ: Let's talk about the development of the state plan. The state plan, as well, was a product of enormous input at each HSA level.

ASSEMBLYMAN LESNIAK: When you say enormous input, will you please be specific? I'm trying to find specifics in terms of opportunities for individual hospitals to express their viewpoints to the committee.

MR. RABINOWITZ: It is my impression and I believe it is the fact that hospitals, doctors, nurses, consumers, hospital administrators, all had enormous input at the base of the planning process.

ASSEMBLYMAN LESNIAK: I appreciate your impressions, but I don't think I'm getting an answer.

MR. REILLY: Assemblyman, they're talking about two separate things. The designation process is the process in which the gentleman indicated that he felt at the state level his hospital hadn't had an opportunity to be heard. Because the rules of the State Health Planning Council are that hospitals are represented through their Health Systems Agency spokesman, in the subcommittee that reviewed the designation from JFK, he wasn't heard and his hospital wasn't heard. No hospital was heard. What was heard was the recommendation from each HSA. If there was a question about a particular hospital, it was put through their HSA executive director and then to the hospital and back to the committee. The reason for that is that at the local level, at the HSA level, they are heard by their HSA boards, both their county boards, which I think is 30 people,and the regional board, which is 30 people from each county in region 4 and they do have an opportunity to be heard. It is no denial of due process of a lack of an open system. We're absolutely open. The meetings are completely open. People wrote me hundreds of letters, personally. We heard testimony from the association, the Hospital Association, pediatricians, obstetricians of the state, nurses. That's one issue.

The second issue raised--

ASSEMBLYMAN LESNIAK: Jerry, if I may, associations don't represent the viewpoint, the overall viewpoint of their members. Any one particular member may have a grievance, legitimate or not. Do they have an avenue to make that grievance known?

MR. REILLY: Absolutely. Written testimony is absolutely solicited. In fact, newspaper ads were put out to solicit written testimony. It is a logistical problem. We simply couldn't hear from 92 hospitals in the time frame that we had, particularly since they had all been heard very clearly at their lower level. That's the designation process.

The second issue, the question you asked, was there input in the planning, per se? They are measured against the plan, the designation. The plan, testimony was given earlier today, and I wasn't party to it so I'm just repeating what I heard, the plan has been evolving over a number of years and has had a lot of input from a lot of different people, often times not being able to agree, but many, many people were heard many, many times. Obviously, there is still not a consensus on the efficacy of that plan, but it has been an absolutely open process. There has been no attempt to deny people's rights to be heard and speak their piece. It is simply logistics. We have to rely on the HSA's. We can't hear from 92 hospitals on each issue.

ASSEMBLYMAN LESNIAK: Mr. Kornett, were you involved with the HSA in your area?

MR. KORNETT: We had a representative from our hospital, including our executive director, who have made presentations to the HSA. I personally was not involved.

ASSEMBLYMAN LESNIAK: Mr. Peloquin, how do you view your role in terms of the members that you cover, the hospitals that you cover, and your articulation of that view to either the Department or the SHCC?

MR. PELOQUIN: In terms of the plan, I had in my testimony, for illustration, an areawide perinatal designation plan dated August, 1980. This is the plan that is specific to our six county, central Jersey area. The process of developing this plan, including mailing this document to various people in our area, and just for reference, all hospitals, and everyone else generally affected, in the draft form, and they had opportunity both at the public meeting and in written form and in meetings

with staff or board members to comment on the development of this plan before it ever got approved by our board. This is what Jerry is alluding to and this plan is the one that comes up and becomes the basis upon which we made recommendation for JFK to be a level 2. So, it was done with that input with the state.

MR. KORNETT: In my testimony, I had pointed out that we had complied with all the criteria necessary for a level 2 designation. The site visits by both the HSA IV and the State Health Department revealed no deficiencies in meeting those criteria. The fact of the matter is that the testimony this morning centered around hospitals of less than 500 beds or 500 deliveries or those with less than 2,000 deliveries, whether those with less than 500 deliveries should be closed, or whether those with less than 2,000 deliveries can climb into a level 3 category and whether or not waivers could be granted. There have been many unsupported solutions offered this morning, without representation from hospitals, as to mechanisms which could possibly work to patch up some of those areas if the proper waivers were available. Our case was one where we clearly met all the criteria. One of the reasons we were led to believe is that we didn't service women and newborns outside of our primary service area. The fact of the matter is that only 50.4% of our newborns came from our primary service area. 27.5% of our newborns came from out of Middlesex County.

ASSEMBLYMAN LESNIAK: Can I ask you a question in terms of procedure? What is the appeal process in terms of designation?

MR. KORNETT: The appeal process, should this system be allowed to continue, should no moratorium be imposed, simply means that the SHCC would make its recommendations to the Commissioner and the Commissioner then would have her own discretion as to whether or not she would approve the plan. The planning process--

ASSEMBLYMAN LESNIAK: I'm not talking about the plan. Assuming that the plan were to go into effect on February 27--is that the deadline?

MR. REILLY: No. What we did, the State Health Planning Council said to our committee, "We don't like your recommendations. Go back and look at it again and come back to us on February 27." The plan is in effect today and it would be in effect beyond February 27. What they didn't like were the recommendations that we made to them. The plan is the roadmap and the designations are the signs.

ASSEMBLYMAN LESNIAK: But, there is a moratorium on the implementation of that plan.

MR. REILLY: Right, exactly.

ASSEMBLYMAN LESNIAK: Is that moratorium no longer in effect on February 27, unless action is taken before then?

MR. REILLY: No. It was a self-imposed moratorium. The Legislature passed a piece of legislation, which I think this Committee was not too happy with, without reference, that told the Health Department, I believe, that they couldn't do anything in this area of perinatal.

MR. KOHLER: Any health care service.

MR. REILLY: Any health care service, okay. But, before the Legislature took that action, the State Health Planning Council itself said, "We don't like these recommendations. They don't comport with our sense of what reality is. Go back and look at it again." That's what we've been doing, but the regulation still was in effect.

ASSEMBLYMAN LESNIAK: What I am concerned with is what happens on February 27.

MR. REILLY: If the State Health Planning Council, after hearing the report from the subcommittee, which I chair, agrees with that proposed compromise, then we would proceed to designate hospitals along the lines of our proposal.

ASSEMBLYMAN LESNIAK: Once a hospital is designated to whatever level, what appeal process do they have to that designation?

MR. REILLY: If we would make a recommendation with regard to this hospital, if we were to recommend that it be a level 1 and the Health Commissioner concurred in that and designated them a level 1, they can then appeal that designation process to the HCAB.

MR. CALABRIA: If the Commissioner were to deny a hospital, for instance, JFK, a level 2, the letter that says you are denied outlines the appeal process. You have twenty days. It goes to an administrative law judge who hears both sides of the issue. The administrative law judge issues a report which goes to the Health Care Administration Board. The Health Care Administration Board can either say, "We agree with the denial," or "We think it ought to go back to the process, we want to change it." If they uphold the denial, the applicant can then go to court.

MR. KORNETT: There was one minor technicality left out of that explanation. The applicant has a right to appeal to the administrative law division providing, of course, that the Commissioner of Health or the Department of Health allows the applicant to go to the administrative law division.

MR. RABINOWITZ: Oh, no. That's not correct.

MR. KORNETT: If that's not correct, I stand corrected, but that's my understanding or impression.

ASSEMBLYMAN LESNIAK: Just one other question. Again, I apologize for not hearing you at the beginning of your testimony. Are you saying that you meet the criteria and, nevertheless, you were denied the designation based on the criteria that you meet?

MR. KORNETT: Absolutely.

ASSEMBLYMAN LESNIAK: It would appear to me that you have a legal remedy. I'm not saying that you should have to resort to that.

MR. KORNETT: Well, I skipped some of my testimony. Before you came here, we offered the prepared text, but eliminated some of the prepared text and offered other comments. One of the areas which we found quite disturbing was the review teams, both review teams of the HSA IV and the Department of Health who indicated that we had no major deficiencies. We would require no waiver, no additional expense to comply and we were given every reason to believe that the level 2 designation would be forthcoming. Yet, just two days after the Department of Health visit, we were told that although there two level 2 designations still available in our region, a paper plan if you will, a subcommittee of the State Health Coordinating Council would recommend on November 21 that we not given one of them.

ASSEMBLYMAN LESNIAK: Were there reasons given for that recommendation?

MR. KORNETT: We have subsequently learned, because our Director of Pediatrics had gotten in touch with the reviewing physician, and he was also disturbed because he had not turned in his report yet to the State Health Coordinating Council.

ASSEMBLYMAN LESNIAK: Were those reasons as to why you were being denied put in writing or verbally?

MR. KORNETT: We were led to believe that the reason was that mothers and newborns, referred to as neonates--

ASSEMBLYMAN LESNIAK: When you say, "led to believe", what do you mean?

MR. KORNETT: I don't have anything to put my hands on at this point.

ASSEMBLYMAN LESNIAK: You were told in writing that you wouldn't get the designation?

MR. KORNETT: No, we were not told in writing. It never came to a vote.

MR. REILLY: I'm not sure it never came to a vote. I don't know how anybody could have told you before the committee met what the committee was going to do because, as the Chairman of that committee, I don't know what I'm going to do when I'm there. Nonetheless, and I don't have minutes of that meeting in front of me--there are minutes of that meeting--and the recommendation of the subcommittee to the SHCC, if his information is correct, was that JFK be a level 1 and not a 2. Now, I don't have it in front of me, but I assume there were reasons associated with that decision. Mr. Sherbert, the Executive Director, has written me several letters making his case that they have many more referrals into their hospital then they thought was our impression. It is by no means certain that they are not going to be a level 2 on the rebound round of this evaluation. We had a plan that a certain amount of level 2's in certain parts of the state and there were less 2's to go around than there were applicants. So, there had to be some judgements made and the committee was proceeding under those guidelines. If they accept our new proposal, we're going to have a new set of guidelines and their HSA, I'm sure, is still an advocate for them being a 2 and that's going to be objectively listened to.

ASSEMBLYMAN LESNIAK: Mr. Peloquin?

MR. PELOQUIN: I have the copy of the recommendations that were adopted by the state committee relevant to JFK Medical Center, if you need those for the record. Basically, they do support Mr. Kornett's information. However, the information was of the record and I would have to agree with Mr. Reilly that there are people on the review committee who tend to voice their opinion ahead of the meeting and the facts don't support it as we all know. In this case, the facts were that the state recommended a non-endorsement because, according to the state, it did not demonstrate a need for the service because the criteria of low birth weight was 5.5% at JFK where the state criteria was 6.5%. So, they did not have enough low birth weight deliveries at JFK to meet the state standards.

ASSEMBLYMAN LESNIAK: Do you want to explain that?

MR. PELOQUIN: At the risk of making a different point, the point being that the criteria is potentially technical and potentially in need of a lot of understanding that go into this review. In this particular case, low birth weight is a criteria to determine need for a center.

ASSEMBLYMAN LESNIAK: Excuse me. Can you just take two minutes or five minutes or twenty minutes to explain what low birth weight is?

MR. PELOQUIN: That is, generally--

MR. KOHLER: Can I ask you just one question? Isn't it a fact that it is figured in, one of many, to determine whether you get a level 2 or a level 3 or a level 1?

ASSEMBLYMAN LESNIAK: That's fine, but what is low birth weight?

MR. PELOQUIN: At the risk of going from memory--

ASSEMBLYMAN LESNIAK: Is that a certain percentage of infants born below a certain weight?

MR. PELOQUIN: That is correct, 2500 grams or under.

ASSEMBLYMAN LESNIAK: Jerry, am I hearing correctly that that--was that the sole criteria for the determination, the reasons given?

MR. PELOQUIN: I'm reading the statement. We do not agree with it and--

ASSEMBLYMAN LESNIAK: I understand that, but was that their--

MR. PELOQUIN: There was another criteria also. I will give you the numbers. A total of 87 of their births in one year, which was 1,585, a total of 87 of those births were births of under 2500 grams or less. Now, that's low birth weight. The state average was 6.5% and JFK's average was 5.5%. That was one reason that the state gave. The other one was a statement about the application being deficient in that it did not indicate referrals into JFK from an area beyond the immediate service area of JFK, which our analysis totally contradicts. The next statement was, since the regulation outlines virtually no difference between level 1 and level 2 obstetrically and since there is no need for additional intermediate care bassinets in the area, with bassinets being recommended at St. Peter's and Perth Amboy, there is no need for another level 2 service in Middlesex County. It is that last point, quite frankly, which I thought gave weight to the decision and it is that last point that I spoke to in my testimony--and I know you weren't able to be here--dealing with level 2's. If I may repeat it to make my point, the point is that we have a number of hospitals already in the system that has evolved that have these special care bassinets and they run in the unber of 6, 7, 5, 6, 7 at each hospital. Now, the state standard has said 10 of these bassinets. Well, what's happened at JFK Medical Center, they have 6 of the bassinets and at this point in time, Middlesex General Hospital has 7, Somerset Medical Center has 5, Perth Amboy has 7 and St. Peter's has 6. What happens is that all these bassinets are basically filled continuously. Now, somewhere along the line we are faced, as an HSA, with making a medical judgement. Either the medical judgement that said these patients belong in these bassinets was erroneous and we really didn't need all those bassinets or, if you needed all those bassinets and you were to close down a number of level 2 facilities and remove those bassinets, such as JFK and Somerset, which were recommended to be closed down, you still would need the bassinets because the patient load would be there. If that were the case, that means that the facilities that level 2's would have to expand. You would have to have capital expenditure, dollars and personnel there, a totally unnecessary expenditure. That was not clearly addressed in a lot of the planning done up until the time we got into the planning in August and that's the basis of our case that we'll be going into the SHCC on and I was asked the question whether the SHCC would be sensitive to these other cost ramifications. I happen to believe that they will, but I can understand people in the process who believe that the SHCC or the Commissioner will not and I think that's part of the issue, quite frankly.

ASSEMBLYMAN LESNIAK: That's one of the reasons why we're here, to ensure that both the SHCC and the Commissioner do view all the reasonable arguments both pro and con on the issue or else legislative remedy or legislative oversight will be forthcoming.

MR. PELOQUIN: Assemblyman, could I comment on that point because there was a statement made earlier and I got confused. The issue came up about the political process earlier and Chairman Otlowski looked a bit offended at a statement that seemed to say that the political process was somehow looked at with disdain the HSA's and the SHCC and the fact that somebody went through the political process was upsetting. It was not upsetting for most of us when this committee went to oversight. That is a different matter. Naturally, it is a fact that oversight is a basic remedy

for a statewide problem. What was also occurring about the same time, and I'm involved in the other piece of legislation that's involved now, the old Raritan Valley Hospital, was that when an applicant, an aggrieved applicant, who subscribes to this process for all purposes except when he loses a single party decides to the legislative process for a single remedy, that's when most of us get really upset about it. If the remedy, as such, or the process involved in that single remedy is so disastrous, it can be taken care of in oversight. I wanted to make that distinction between what people were saying and what they were reacting to. I don't think anybody wanted to offend the Chairman of the Committee about the rights of a committee or the right of anybody to go to the Legislature because we will go to the Legislature ourselves. But, I think it is the basis on which we go to it is what was missing in the conversation.

ASSEMBLYMAN LESNIAK: I happen to agree with you fully and, of course, both the SHCC and the Commissioner, or at least the Department of the Commissioner, are both creatures of the Legislature and the Legislature can change that makeup and mold as it and the Governor sees fit to do. Mr. Kornett, I would just like to ask you one other question. How do you view the so-called compromise plan which nobody is quite sure what it is yet?

MR. KORNETT: I'm sorry. I really don't understand what the compromise it myself. If we're talking about the demonstration project which was discussed this morning--is that what you are referring to?

ASSEMBLYMAN LESNIAK: Yes.

MR. KORNETT: I personally don't support the demonstration project and I'm sure I speak on behalf of our institution and probably several other hospitals who are caught in the same bind. The demonstration process, as I heard it explained this morning, and I could be wrong on that score, means that on February 27, when the 90 days of the moratorium runs out, that all things stay stases, all designations that are currently going to be recommended by the SHCC will be in place.

ASSEMBLYMAN LESNIAK: Okay, if that's a misunderstanding, I would like that clarified now.

MR. REILLY: There is a slight misunderstanding. He has no concept of what I said. What the subcommittee of the SHCC is going to recommend to the whole SHCC is that they lay aside the regulation and the plan and substitute for it, under a demonstration regulation, which is a separate regulation, this proposal. Number one, anybody who meets the requirements of the present plan for level 3 designation, such as St. Peter's in New Brunswick, be designated.

ASSEMBLYMAN LESNIAK: Regardless of any other such similar designations in that area?

MR. REILLY: Well, it all fits together. Number two, for certain facilities that have evolved into a natural regionalization that everybody can recognize, but it is hard to quantify, that we ask them to participate in the demonstration project as a demonstration perinatal level 3 center, such as St. Joseph's in Paterson and Newark Beth Israel, and that we ask Cooper and Lords in Camden to participate as a joint level 3 perinatal center and we ask Monmouth and Jersey Shore Medical Center to participate in a joint perinatal level 3 center in eastern Monmouth County and that we move ahead with the designations of the 1's and 2's and also examine the notion of whether we should be moving to a two tiered system down the road. Number five, that all of this be subject to an evaluation that the Hospital Research Educational Trust would conduct. This is an organization that is in, but not of the New Jersey Hospital Association. You have on the table the preliminary research design for the demonstration that they have presented to us.

Also, the recommendation will be to create a special advisory committee, similar to the cardiac advisory committee, to regularly visit all centers throughout the state and evaluate the progress. This is to bring in professional input beyond that which we who are not medical people on the committee could bring.

I think, also in that context, are going to take a fresh look at the absolute number of 2's designated for some parts of the state, particularly if there is some concept, in the long term, where we perhaps would need to move toward a two-tiered system--and there is debate on that. There may be more room for twos than the original conception indicated.

That's the proposed compromise. It doesn't make everybody happy, but its virtue is that it gets on with the business of perinatal regionalization. It doesn't give it 100% imprimatur, but an 80% imprimatur and says, "Let's study it for a couple years and then decide is it working for New Jersey and then either change it a little bit, change it a lot or go with it." The key issue in this birth weight question, birth weight, as medical people have testified, is one of the key predictors in infant mortality and morbidity and all this fuss over who gets 1, 2, and 3 is diverting people from getting on with the business of doing a professional education, and doing their patient indication and doing their proper referral protocols and it seems, at least in the committee's opinion, that it's time to move and give a partial ratification to the natural system of regionalization that is already there, but not 100% by off on it, until we have a chance to study it with the help of the Hospital Association. The Hospital Association said earlier and they have said earlier, on behalf of the Hospital Association, that they are in favor of this compromise.

ASSEMBLYMAN LESNIAK: It is your opinion, therefore, that the original plan was deficient?

MR. REILLY: My opinion is that the original plan was the honest effort of honest people, but that it was not flexible in the context of the real world and I have some objectivity. I had nothing to do with that plan.

ASSEMBLYMAN LESNIAK: Under the new plan, no hospitals would be closed?

MR. REILLY: That's very important. I forgot that point. The low birth hospitals, the original plan called for their closure within a year. What this proposal would say is that they may continue to operate, but they have to participate as part of the demonstration and have special monitoring of their costs and outcome and if they have costs that are excessive because they are very small, they should be expected to bear those costs and not the other third party payers. If, because of their tradition and committment, they want to provide the service and it is more costly, they should be willing to pay that from other funds, but not that they have to get out of the business, provided that they are operating at an acceptable level. In all the evidence that we have, or at least that I've seen, is that New Jersey hospitals are operating at an acceptable level of care and there is no reason from that point of view, at this point, to say that they should be closed.

ASSEMBLYMAN LESNIAK: That opinion is somewhat divergent from the Commissioner of Health.

MR. REILLY: Well, I'm not going to characterize other people's opinion. That is what the committee believes, based upon the testimony that we've heard.

ASSEMBLYMAN LESNIAK: You have one further comment, Mr. Kornett?

MR. KORNETT: I'd like to make just two comments. The system of how we're represented as an institution through the County Advisory Council, our own HSA, who make recommendations,as they see it on the local level, to the SHCC, has

been properly explained to you. The answer to your direct question, can we speak up on our own behalf to the SHCC, is no, and we could have avoided that process. As far as my understanding of the demonstration project, as I started to explain, in my view, nothing would change other than the few exceptions and the proposal to study the situation beyond February 27. With respect to the level 1 and 2 hospitals, nothing would change.

ASSEMBLYMAN LESNIAK: First of all, I think you ought to understand that just as we could not allow every single person who has any connection or is going to affected by these regulations or the plan to testify, they have to have a certain procedure. Our concern is that you had a full and fair opportunity to present your case, so to speak, in the process.

Secondly, I think you may have too negative of an approach. I think the process has been open, to date. The Commissioner and the SHCC, and Jerry in particular, have been open to comments and suggestions and criticisms and I think the fact that there is movement toward modification and adding more flexibility in the system demonstrates that and I think, maybe, your negative approach may not be totally justified.

MR. KORNETT: In a more positive strain, if I may, we have a case for a level 2 perinatal facility and a JFK document was supplied to the SHCC on November 17 wherein we supplied--

ASSEMBLYMAN LESNIAK: I've seen it.

MR. KORNETT: It has a checklist in here of every criteria to be a perinatal designation 2 and the rationale for it. Now, if you have criteria for certain levels, whether it be in the health care industry or whatever governed industry it is, and you meet the criteria, I think there is a problem when we're trying to just fit the local needs of people into a paper plan where specific numbers are designated and it doesn't take into account people and the patients we serve.

ASSEMBLYMAN LESNIAK: That may have occurred in the past. I don't know. I'm not going to pass judgement on it. Hopefully, that procedure will be worked out.

MR. REILLY: It is important to know, too, that the SHCC took no final action on the designation. It may have been that your information was one of the bits of persuasive testimony that caused them to pause. I don't know. It may be.

ASSEMBLYMAN LESNIAK: I think we have made progress. Thank you. First of all, I would like to announce that the committee will continue this public hearing process awaiting to see what happens on February 27. Our committee aide, John Kohler, has been asked to attend that meeting and to report to the committee his perspective of what occurred and we will continue to review this entire process. Is there anyone else on the witness list who would like to testify and has not had an opportunity? Is there anyone who is not on the list that would like an opportunity to testify?

MR. RABINOWITZ: I have just one brief comment, Assemblyman. I am Mr. Rabinowitz, Chairman of the Statewide Health Coordinating Council and I simply want to reiterate, because I'm afraid it got lost in the general discussion this morning, that the SHCC's position was was extraordinarily responsible in this connection. The work leading up to the preparation of both the plan and the designation document constituted years, literally years, and I hate to tell how many man years were involved in this process. In addition to which, the numbers that we came up with were numbers pulled out of the air, because I have a hunch that the general impression at this hearing was that these numbers bore no relation to the real world.

ASSEMBLYMAN LESNIAK: That's not my opinion, by the way. I just want to make that clear.

MR. RABINOWITZ: But, I think the record should show that, for example, this is an ACOG document, Standards for OB-GYN service--and I'm just reading--"The experience of many OB departments indicates that facilities, equipment, services and personnel adequate to maintain a consistently high standard of ordinary obstetric care and a reasonably economic operation generally requires more than 2,000 deliveries a year." Those are not our figures. They are ACOG's figures. "Annual deliveries of 1,000 or less are generally insufficient to support even a qualified, full-time nursing staff or to maintain separate beds sufficient for the widely varying obstetric services." I introduce this, Assemblyman, only to indicate that the plan and the numbers were not really leftfield numbers. They were the best that we could come up with in connection with trying to tie together the extraordinarily complex perinatal designation process of which, by the way, this is only one small part of the total health plan. I am interested to note that the doctors and the people who addressed this committee today were prepared to accept that they were flourishing under the certificate of need process in other areas. I gather you heard that as well. I think the record should show that a hospital went from 300 employees to 1710 employees under the certificate of need process, of which this is just another small facet. So, the planning, per se, is not the problem. The issue were are dealing with here happens to be a very complex one and the SHCC recognized that. When we got this final report that were not truly addressing what we perceived to be the facts in the community and it was for that reason that Commissioner Reilly was directed to come back in 90 days with, as you have used the word, a compromise solution.

ASSEMBLYMAN LESNIAK: I thank you for your comments and I do commend you for the work that you have done and the council has done. I think it is an area that is complex and is complicated and you certainly cannot satisfy everyone, nor should you have to satisfy everyone, other than the standard of health care to be provided in the State of New Jersey and I feel confident that the new action that may be taken will go a long way toward alleviating a lot of the problems. As I said, not everyone is going to be satisfied, but as long as it is the correct action and it is fair, then you will have the support of the Legislature.

I am now going to adjourn the meeting and it will be continued at a later date. Thank you.

(Hearing Adjourned)

JOHN F. KENNEDY
MEDICAL CENTER
Edison, New Jersey 08817
(201) 321-7000

STATEMEMT BY JOHN F. KENNEDY MEDICAL CENTER, EDISON, N. J., BEFORE THE NEW JERSEY ASSEMBLY'S INSTITUTIONS, HEALTH AND WELFARE COMMITTEE, TUESDAY, FEBRUARY 10, 1981:

Mr. Chairman and members of the Committee, my name is Michael Kornett, Deputy Executive Director of John F. Kennedy Medical Center in Edison. I am testifying in place of the Kennedy Medical Center Executive Director, Joseph Sherber, who was called at the last minute to be a witness at a court trial today.

I am here to testify on the Medical Center's behalf regarding the regionalization of perinatal facilities in the State of New Jersey and in particular, regarding Kennedy Medical Center's request to be designated a Level II perinatal facility for the care of mothers and newborn.

First, let me say that Kennedy Medical Center certainly agrees with the concept of regionalization and supports the efforts of hospitals to share services. We have worked for such programs.

We are also agreed that in order to improve perinatal care and to provide quality services that are also efficient, expensive perinatal facilities should not be needlessly duplicated.

We agree that designations granted to each hospital should reflect the needs of patients in the region. We agree with the health planners, for example, that most Level II designations should be placed in areas such as inner cities where there are a number of mothers at risk for bearing seriously impaired infants and where the birth rate is several thousand per year.

What we cannot agree with, however, is the manner in which the State Health Department --- judging from our own case so far and from other hospitals' experiences --- began implementing its regionalization plan.

The Health Department has apparently undertaken a course of forcible elimination or reduction of existing perinatal services wholesale and across the board, merely to make the numbers and levels of perinatal facilities in the state conform to its paper plan.

As our own case indicates, this course of action represents government in a vacuum, implementation of government policies without any serious consideration of the needs and the wishes of the governed --- the hospitals and the people they serve.

One goal of the perinatal regionalization plan is obviously to improve services statewide. But it is no help for mothers who must travel great distances in suburban areas to give birth because local hospitals have been forced to close perinatal units or mothers whose infants are transferred to another hospital for the kind of care the hospital has been forced to abandon to fit the plan.

That there will be many cases like these is certain if the state health planners continue to operate in this same manner of "social engineering" which has already failed dismally in other nations.

As you know, the State Health Coordinating Council on November 21, at the urgent request of the New Jersey Hospital Association, voted to defer further action on implementation of the perinatal plan for 90 days.

I am here to urge that state health planners not be allowed to plunge again into the disasterous course of closing or reducing perinatal facilities to make them conform to a paper plan, regardless of local needs or the hardship on mothers and their babies or far-reaching effects on other hospital services.

Kennedy Medical Center is a case in point.

We have been operating for several years a facility which completely meets State Health Department criteria for Level II perinatal facilities. This facility was carefully planned in accordance with government-mandated planning procedures and our occupancy and birth rates indicate that its services are definitely needed by our local residents.

As to the state's criteria, the number of deliveries at Kennedy Medical Center exceeds the level set by the Health Department, the number of board-certified obstetrics and gynecological specialists at Kennedy Medical Center is one of the highest in the state and nearly half of our newborn admissions come from outside our primary service area. This is a critical point because the state said we serve only our primary area. This was used as an argument against our receiving a Level II designation although we were never told about it.

We have also successfully completed every step in the HSA IV review process following our request for a Level II designation.

Even the site visits by the survey teams from the HSA and from the Health Department were completed without any indication of major problems.

Yet, just two days after the Health Department visit, we were told that although there are two Level II designations still available in our region, a subcommittee of the State Health Coordinating Council would recommend on November 21 that we not be given one of them.

If that recommendation had been accepted, for what reason did Kennedy Medical Center go through the expensive, time-consuming review process? For what reason have we so carefully planned and operated our perinatal unit thus far?

And, most importantly, how could it possibly become known that we would not get the designation we requested even before the report of the site evaluation committee --- which we understood would be favorable --- was completed, presented or reviewed?

I ask you on the committee to also consider the following: In our hospital and others the effects of such unfair decisions will be more far-reaching than just the impact on perinatal services and the patients.

At Kennedy Medical Center, for example, a reduction in services from the Level II type we now have to Level I will damage other programs.

1. The prospect of reducing us to basic services will discourage application by young physicians to our currently successful Family Practice Residency program now training 19 residents a year in this heavily demanded specialty.

2. Having fewer residents enrolled will also force us to cut back on the family medical services the residency unit supplies to area residents who do not have private family doctors.

3. If perinatal occupancy rates drop, many babies with abnormalities will be denied the chance for critically important early intervention pediatric rehabilitation programs. Through our Robert Wood Johnson Jr. Rehabilitation Institute, we are able to screen newborn and immediately bring those in danger of less than normal development into our early corrective programs.

4. Less than a Level II designation for Kennedy Medical Center also threatens other educational and patient service programs which depend upon or dovetail with its perinatal operations. This includes the pending residency program in obstetrics and gynecology with the School of Medicine at Rutgers University.

5. And denial of the Level II designation will seriously threaten our financial stability because:

We will be maintaining facilities on a par with Level II hospitals or at the very least losing valuable depreciation dollars on equipment that is ~~no longer~~ in place but we will be reimbursed only at a Level I rate.

Kennedy Medical Center will find it more difficult to meet bond obligations -- bonds which are issued by state agencies.

A prospective drop in our occupancy rate in the perinatal section as physicians admit patients instead to Level II facilities will also cause financial loss.

A reduction in services and revenue will represent a major deception to current bondholders and will threaten the forthcoming $9 million issue to finance other programs approved for the Medical Center by the State Health Department.

This is a brief summary of the effect such an arbitrary and unfair decision will have on Kennedy Medical Center. Other hospitals in this state face the same serious problems.

Before I close, I should like to make one more point about the review system. At recent meetings of the HSA subcommittees and committees, members of these review agencies criticized hospitals for attempting to rally so-called "political pressure" to win their case.

Those of you unfamiliar with this review system should be aware that hospitals are given no chance during these sessions to present our cases or to answer questions raised. It is far less than a democratic arrangement. We are never told what the findings of the HSA staff are in advance of the meetings and so because of lack of knowledge and this gag rule we cannot respond. Therefore, when we feel that our programs --- and thus the people whom we serve --- have been short-changed or wrongly curtailed we turn and properly so to our elected officials. You and other public officials are the ones who represent the public we serve. If it is using "political pressure" to seek such help from you, then I suppose we are guilty.

In this light, we urge this committee to look long and carefully at the planning for this particular program and to make sure that local needs --- in all communities you represent --- are not subverted to a master plan that has no flexibility or ignores the human factors.

#