FYI
Pam

Date: 08/16/96 Time: 08:53
DNew Moms in New Jersey Staying in Hospitals Longer

ATLANTA (AP) New mothers in New Jersey are making drive-through deliveries a thing of the past by taking advantage of a law that prevents hospitals from hustling them out the door, a federal study found.

Women in that state stayed in the hospital 10 to 12 hours longer after June 1995, when New Jersey enacted a law that requires insurers to pay for a minimum of two days in the hospital after vaginal deliveries and four days after Caesarean sections, the Centers for Disease Control and Prevention said Thursday.

New Jersey is one of 28 states with laws to ensure that new mothers won't be pushed out of hospitals before doctors can catch problems such as jaundice or dehydration, which sometimes don't show up immediately.

Since the 1970s, mothers' hospital stays have been shorter. This ``drive-through delivery'' concept began as a move to make childbirth less medical and more natural, but soon became a push by insurers to save money.

The CDC, which studied four New Jersey hospitals before and after the law took effect, said that women who had vaginal deliveries lengthened their stays from an average of 1.4 days before the law to an average of 1.8 days after. Women who gave birth by Caesarean section increased their average stay from 2.8 days to 3.3 days.

The increases occurred for women under all types of insurance. The information came from a new system in the state's hospitals that stores birth certificate information electronically.

``This is the first time we have seen legislation have such an impact on hospitalization in this area,'' said Dr. Mona Saraiya of the CDC's National Center for Chronic Disease Prevention and Health Promotion.

``But I think this is just one step,'' she added. ``Further research is needed about the impact of postpartum care and follow-ups and exactly how long is the optimum stay.''

Insurers argue that early release substantially cuts the cost of delivery and that there is no proof of lasting harm to either mother or child.

``We believe the best way to determine the appropriate length of stay for a normal delivery should be based upon the evaluation of the health-care provider rather than a one-size-fits-all government mandate,'' said Richard Coorsh, spokesman for the Health Insurance Association of America, which represents 250 insurers.

Dr. Leah Ziskin, deputy commissioner of the New Jersey Department of Health and Senior Services, said the CDC's study will give other states an idea of how the laws are working.

``The next step for us is to do a maternal satisfaction survey,'' she said. ``We want to see what that longer stay meant and see what they liked about their stay and how they would improve it.''

APNP-08-16-96 0901EDT

THE WHITE HOUSE
WASHINGTON

OFFICE OF THE FIRST LADY

TO Terry Edmunds

FROM Jennifer Klein

FAX # 6-5709

PHONE #

 # OF PAGES (including cover)

COMMENTS This seems to have different information on state laws. Do you want to check into this or should I?

Rx Women Weekly Report:

Wednesday, September 13, 1995

Drive-Through Baby Deliveries

A Senate committee is considering a bill that would mandate a minimum-length maternity hospital stay. Because of pressures to cut costs, the length of time a woman stays in the hospital after birth has gotten shorter and shorter over the last decade.

It is an issue that concerns many health care professionals as well as parents who blame short stays for the illnesses---and sometimes the deaths---of their babies. Michelle Bauman told the Senate Committee: "We were discharged 28 hours after my daughter was born---not enough time for the doctors to discover that Michelina was born with streptococcus, a common and treatable problem. Another 24 hours, her symptoms would have surfaced so that we could have planned a christening and not a funeral.

For Michelle Bauman, this hearing came far too late. Her baby daughter died just 2 days after being discharged from the hospital. What she and other parents told Senators Tuesday is that when a baby is allowed to go home too soon after birth, the result can be illness or even death.

The hearing was before the Senate Labor and Human Resources Committee. The objective: passage of a bill requiring insurers to cover at least a 48-hour stay after normal births, and 96 hours after cesarean sections. In the states of New Jersey and Maryland, laws requiring insurers pay for similar minimum stays have already been passed.

Senator Bill Bradley (D-NJ) said during the session: "I think the committee --if we thought about what these drive-through deliveries mean to millions of American mothers---we would take an action in an instant." He echoes concerns that doctors have had for a long time about the medical dangers of early discharge.

Doctor Paul Yellin, a Neonatologist, testified: The mother may need some intensive counselling with nursing to get breast-feeding established. Babies who have problems with jaundice---which is a significant problem in the newborn---will not have symptoms generally--for the first day or so."

The American Medical Association, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics have also expressed concerns about so-called "drive-through deliveries"---and are supporting the Senate bill. Quick deliveries are the product of insurance-industry and HMO pressure to save money----pressure obviously not felt in other countries where women spend significantly more time in the hospital after delivery. French women, for example, can spend up to two weeks under the care of doctors and nurses---and a 5-day stay is minimum.

As another mother asked at the hearing, "So why were my baby and I discharged. How much does one or 2 days in a hospital cost?

There have been no formal studies done on the impact of "drive-through" deliveries. Concern is based on stories like the one's heard in the hearing. But sponsors of the bill hope they can force the issue--by forcing insurers to put the health of babies ahead of the bottom line.

Dr. Emily Senay for CBS News, New York.

The length-of-stay issue

There's been a recent flurry of bad publicity about maternity length of stays in the national press. Some HMOs are being criticized for releasing women too early after their deliveries. Some indemnity carriers are being criticized for not covering a long-enough stay. Group Health's policy, however, is not tied to hours.

Our discharge criterion is simple: Mother and baby must be medically stable before they leave the hospital. That means we don't send anyone home until we're sure they don't need medical care. Quality of care is first and foremost.

In fact, our clinicians have found that most mothers and their babies are medically stable within 24 hours of a normal vaginal birth. Sending them home as soon as it's safe minimizes the risk of exposure to hospital-borne illness.

At Group Health, a new mom's hospital stay—however long it turns out to be—is really just one part of her maternity experience with us. From prenatal care and classes to follow-up nursing support, our system of care continues long after mother and baby head home.

11/95

Home Questions? Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Melissa T. Skolfield

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Date: 5/8 Total number of pages sent: 5

Comments:

Could you call me tomorrow re: Sat. radio address? See attached.

Thank you!

^BC-HEALTH-BIRTH@

^Babies can go home fast if follow-up care good@

WASHINGTON (Reuter) - Newborn babies who go home from the hospital 24 hours after delivery do not make more visits to the emergency room if follow-up care is available and well-coordinated, two studies showed Wednesday.

Related studies from the Cincinnati Children's Hospital Medical Center, presented at a pediatrics conference here, showed that inner city mothers and healthy newborns were able to go home in one day when in-hospital and post-discharge services were well-coordinated.

The studies involved healthy babies who were not premature and not delivered by caesarian section. They had home nursing visits and access to care at community clinics or a primary care center at the Cincinnati hospital.

Swift discharge of babies and their mothers has become a controversial issue, with several state legislatures moving to require insurers to cover up to 48 hours in a hospital. At the federal level, a similar bill is awaiting action in Congress.

In the first study, Dr Charles Schubert, an emergency room doctor, found that a well-coordinated early discharge program did not lead to more non-urgent use of the emergency room in the first three months of life. Hospitals are anxious to avoid costly emergency room visits when they are unnecessary.

The second study by Dr Uma Kotagal found that babies who were taken for an initial checkup when they were 2 weeks old did not make their first trip to the emergency room until they were about 7 weeks old. Those who missed their first checkup typically were taken to an emergency room when they were just 3 weeks old.

Kotagal, director of health policy at the hospital, said the study suggests that hospitals ''must work more closely at linking families'' with doctors to avoid unnecessary emergency room visits.

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MOTHER'S DAY TALKING POINTS

The Clinton administration is committed to helping mothers properly care for their children from pre-birth to young adulthood. We feel that one of the most important responsibilities we have is to provide mothers with information they need to raise healthy, happy children, not only by educating them on health issues, but also by supporting their parenting efforts.

I. PRE-NATAL Protecting pregnant women by helping them have healthy babies.

FOLIC ACID: Making sure that mothers are aware of the benefits of taking folic acid before and during pregnancy.

- Folic acid, when consumed in adequate amounts by women before and during early pregnancy, reduces the risk of birth defects such as spina bifada. That is why HHS has taken action that requires U.S. food manufacturers to add folic acid to most enriched breads, flours, corn meals, pastas, rice and other grain products.

PROPER NUTRITION: Spreading the word about he importance of proper diet and exercise.

- Through nutritional food labels, we are raising public awareness about the health benefits of a diet consisting of five vegetables and fruits a day, and that is low in fat.

II. EARLY CHILDHOOD We are working to ensure that mothers are able to care for their newborns properly by giving them access to proper child care. We also making sure that children are equipped to succeed in school through Head Start.

FAMILY LEAVE: By signing in the Family Medical Leave Act, we have ensured that families have the opportunity to take leave with job protection and a guarantee that their health insurance will be continued.

- A recent study found that more than nine out of ten employers find it "very" or "somewhat" easy to administer the FMLA. For more than 90% of those worksites, complying with the FMLA entailed little or no cost. 80% of leave is taken to care for a seriously ill child, spouse, parent or for one's own health condition.

INFANT IMMUNIZATION: The Administration's comprehensive Childhood Immunization Initiative is working to increase and sustain infant immunization rates by:

- Improving immunization services for needy families.
- Reducing vaccine costs for lower-income and uninsured families.
- Increasing community outreach, participation and partnerships.
- Improving systems for monitoring diseases and vaccinations.
- Improving vaccines and vaccine use.

CHILD CARE: Reliable, affordable child care is essential for mothers who are trying to hold jobs and care for young children.

- We are currently providing child care services for over 750,000 low-income children and families.
- A study released by NICHD in April found that child care does not weaken infants' attachments to their mothers.
- The availability of child care for low-income families is critical to maintain economic self-sufficiency and promote healthy child development. The FY 1997 budget request for the Child Care and Development Block Grant is $1.049 billion. In 1992, we spent $483 million on child care under the entitlement programs. In 1995, we more than doubled that to $893 million.

HEAD START: Head Start programs help establish a foundation for many disadvantaged children and families by providing comprehensive education, nutrition, health services and social services. We are committed to expanding enrollment and making that opportunity available for more children.

- Our 1997 budget increase of $350 million above the FY 1996 level of Head Start funding, will serve an additional 40,000 children.
- Because of this increase, 1,200 infants and toddlers will be able to participate in the Early Head Start Program.

ADOPTION TAX CREDIT: On May 4, in his radio address, the President announced his support for a bill currently in subcommitte in the House that gives an adoption tax credit for people who earn under $115,000 a year. He also announced his support for removing barriers of inter-ethnic adoption.

III. TEEN-AGE/ YOUNG ADULTHOOD The Administration supports mother's with teen-agers and knows that mothers cannot always be there to monitor their activities.

TOBACCO: The Administration's tobacco initiative is one of the boldest attempts to stop young people from smoking and using tobacco.

PROBLEM:

- More than 80% of adult smokers tried smoking by the age of 18 and more than half had become regular smokers by that age.
- 400,000 tobacco-related deaths per year in the U.S. - - most begin smoking as children.
- Tobacco culture: a third parent for American children -- playing upon their desire to be glamorous, and giving them easy ways to obtain cigarettes from vending machines, etc.

SOLUTION

- We are proposing to both limit the access and the appeal of tobacco products to children with some of the boldest public health proposals ever.

- We have teamed up with the Women's National Soccer Team to kick off the "Smokefree Kids and Soccer campaign" Message: You don't get to be a champion by taking cigarette breaks. Major League Baseball has also joined the fight with their campaign to break the link between spit tobacco and baseball.

- Three grocery store chains are also taking action to prevent kids from using tobacco by making it harder for them to buy tobacco products in their grocery stores.

TEEN PREGNANCY: Educating teenagers about the responsibilities of having a child and encouraging them to abstain from pre-marital sex.

- The Administration's FY 97 budget requests $30 million for a new Teen Pregnancy Prevention Initiative.

- On May 4, during his weekly radio address, the President gave an Executive Order to all states to submit plans to require teenage parents on welfare to stay in school, live with a parent or guardian and prepare for work.

ALCOHOL AND DRUGS: The Administration's drug effort, led by General Barry McCaffrey, is one of the most comprehensive drug strategies in American history. It moves aggressively in the areas of interdiction, law enforcement, prevention, treatment, research and public education about substance abuse -- with a particular focus on preventing substance abuse by young Americans.

PROBLEM:

- There has been a resurgence in marijuana use among 12 to 17 year-olds - - with rising usage rates every year since 1991.

SOLUTION:

- Our strategy targets methamphetamine, a dangerous and highly addictive drug that's popularity is growing. Deaths related to Methamphetamine use are on the rise.

- The Administration has strengthened and expanded the Safe and Drug Free Schools program -- now in 97 percent of school districts. We also support student athlete drug testing have and encouraged schools to adopt school uniform policies.

IV. SINGLE MOTHERHOOD We want to ensure that both parents assume financial responsibility for their children.

CHILD SUPPORT: Cracking down on non-paying parents by increasing funding for child support programs, and strengthening penalties for child support evaders.

- In 1995, the federal-state child support enforcement system collected a record $11 billion from non-custodial parents, an increase of about 60% since 1991.

- The Administration's comprehensive child support enforcement plan, part of our sweeping welfare proposa, could increase collections by $24 billion over 10 years. It includes streamlined paternity establishment, uniform interstate laws and tough penalties for evaders - such as driver's license revocation.

V. PRESERVING A MOTHER'S HEALTH

BREAST CANCER: Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer deaths among women.

- We have dramatically increased research, prevention and treatment efforts in response to a disease that is estimated to be developing in 1 out of every 8 women. Because of our human genome project, researchers are now able to identify genes that can lead to breast cancer. We are also developing a partnership with the CIA to use the imaging technology they use for missile guidance, to give us more accurate mammograms.

- We have dramatically improved the quality of mammogram facilities.

- The First Lady launched a campaign aimed at improving imaging technology and urging women, especially minority women, to get mammograms.

- Our active outreach program is spreading the message: Early detection and proper treatment saves lives.

American Academy of Pediatrics

AAP NEWS

Volume 11 Number 8 | THE OFFICIAL NEWSPAPER OF THE AMERICAN ACADEMY OF PEDIATRICS | August 1995

■ In Harm's Way: Part one of a child-violence series. Page 10.

■ Chapter Forum voting information. Page 20.

Current insurance policies might place newborns at risk

Minimum 48-hour postpartum coverage urged

by GERRY CLARK
Assistant Editor

Physicians and legislators are aiming to alter managed-care policies dictating maximum 24-hour postpartum hospital stays, claiming the practice might harm newborns and mothers.

In recent months, the insurance industry has come under fire for its postpartum hospital-stay coverage policies. Managed-care organizations frequently will only insure a 24-hour stay, which many medical experts regard as insufficient time to monitor potential newborn health problems as well as educate mothers on proper breastfeeding techniques.

American Medical Association (AMA) officials, with AAP input, passed a postpartum discharge policy at their annual meeting in late June. AAP officials are currently developing updated guidelines for determining when mothers and newborns should be discharged from hospital care after delivery.

Legislators also are interested in ensuring longer stays. Two states recently passed legislation requiring insurers to cover specific durations of postpartum hospital stays and other states are considering similar measures. Senators and representatives alike have recently introduced federal postpartum-stay legislation.

Current policy

Current AAP policy, contained in *Guidelines for Perinatal Care* (Third Edition), a joint effort of the Academy and the American College of Obstetricians and Gynecologists, states that the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean delivery, excluding the day of delivery and provided no complications exist. The guidelines spell out a list of conditions that should be met for early discharge, particularly if it occurs within 24 hours of delivery.

The earliest the proposed AAP policy

See Hospital stays, p. 8

Biff Bilsley

A mother and newborn leave the hospital. Federal and state legislators want to require insurers to cover postpartum hospital stays up to 48 hours.

Hospi stays

Continued from p. 1

statement, tentatively titled "Hospital Stay for Healthy Term Newborns," might be released in late August. AAP Committee on Fetus and Newborn Chairperson William Oh, M.D., said.

While providing a general outline of the proposed policy statement, Dr. Oh would not offer specifics on what the new guidelines might indicate.

"It's a little premature at this time," Dr. Oh said in early July. "The one thing I'm sure is we are spelling out the guidelines that must be fulfilled before discharge can occur."

"We'll be spelling out specific follow-up guidelines and who should be doing it," Dr. Oh said.

"Right now, it's not spelled out in the guidelines, so the insurance companies do what they want," he said.

Once a policy statement is in place, Dr. Oh predicts that insurance firms would face potential legal or medical risks if they establish policies significantly different from the Academy's stance.

Legislation

New Jersey legislators passed a bill in late June mandating that insurers provide coverage for at least 48 hours of inpatient hospital care following vaginal delivery, and a minimum of 96 hours of inpatient care after cesarean delivery.

Maryland officials recently approved legislation requiring insurers to cover maternity stays in accordance with "the most current version" of the *Guidelines for Perinatal Care*. Managed-care organizations may authorize shorter hospital stays provided the newborn child meets the criteria for medical stability as outlined in *Guidelines for Perinatal Care*.

Bills related to postpartum hospital stays have been introduced into the

Massachusetts and Pennsylvania state legislatures. States whose legislators are considering similar legislation when their sessions resume in 1996 are Illinois, California, Iowa and Georgia, AAP officials said.

At the federal level, Sen. Bill Bradley (D-N.J.) introduced legislation in late June titled "New Born and Mothers' Health Protection Act of 1995." Co-sponsored by Sens. Nancy Kassebaum (R-Kan.) and Jay Rockefeller (D-W. Va.), the bill would require insurers to provide coverage for a t of 48 hours of inpatient care after vaginal delivery and a minimum of 96 of inpatient care after cesarean delivery for a mother and newborn.

A proposed amendment to the Employee Retirement Income Security Act of 1974 (H.R. 1955), was introduced into the House in late June by Representative Peter DeFazio (D-Ore.) and several co-sponsors. It calls for the same coverage as Bradley's bill. Exceptions may occur if certain post-delivery care is provided, such as follow-up visits at home or in a physician's office.

A legally nonbinding House concurrent resolution, introduced by Rep. Bernard Sanders (I-Vt.) and others, has received AAP endorsement. The resolution states "the sense of the Congress" is that the Maternal and Child Health Bureau should "promptly" collaborate with national organizations to encourage studies to identify safe practices regarding hospital discharge of mothers and newborns.

Bradley introduced the Senate bill following discussions with the health-care union, Hospital Professionals and Allied Employees of New Jersey/AFT, according to Bradley spokeswoman Victoria Streitfeld. The union represents 3,500 New Jersey nurses.

"What we've seen is with the new rules of managed care, mothers and babies were being forcibly discharged after 24 hours," Ann Twomey, president of Hospital Professionals and Allied Employees of New Jersey/AFT, said.

Bradley recognizes that "there are potential health problems" with early discharges, Streitfeld said, and the senator regards the insurance industry as a source of the problem.

"(Insurance companies) have been the motivating force behind early discharge," she said.

Penalties would not be imposed on

"What we've seen is with the new rules of managed care, mothers and babies were being forcibly discharged after 24 hours."

– Ann Twomey, President, Hospital Professionals and Allied Employees of New Jersey/AFT

hospitals that discharge early under Bradley's bill, Streitfeld said.

"It just mandates that insurance pays for 48 hours," she said.

"Very brief" meetings have occurred between Bradley and the insurance industry, Streitfeld said, but she would not provide details on those discussions.

Physicians should decide

While AMA officials and Dr. Oh applaud Bradley's they say physicians, not legislators, should be in charge of making medical decisions.

"It's good that the legislator is getting into the act on this, but physicians should take care of the medical issues," Dr. Oh said. "I just don't think it's right to legislate medical practice. We should take the lead in medical practice."

Physicians should have the flexibility to exercise medical judgment outside of managed-care or legislative restraints, AMA Board of Trustees member John Nelson, M.D., M.P.H., said.

"What we're looking for is what I call 'clinical wiggle room,'" Dr. Nelson, an obstetrician-gynecologist in private practice in Salt Lake City, said.

"I think the intent (of Bradley's bill) is laudable," he said. "I simply argue it's the wrong vehicle."

But New Jersey nurses are happy with their state's postpartum legislation, Twomey said.

"We hope this becomes a model for the rest of the country," she said.

The recently approved AMA policy states that "in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgment of attending physicians and not by economic considerations." The document states that the AMA "is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe."

"In the last few years, I think managed care and HMOs have precipitated (early discharges) for the financial benefit," Dr. Oh said. "The insurance companies are having a field day right now. They can dictate, (with) a normal delivery, you have to leave in 24 hours."

No magic number

Health Insurance Association of America (HIAA) officials agree with the AMA that postpartum hospital stay legislation is a bad idea. Twenty-four-hour stays are often good medicine, HIAA leaders contend.

"We have a hard time with legislators making these decisions, when it should be a medical (decision)," HIAA spokesman Don DiFonzo said.

"This is the kind of a situation where there's not a lot of empirical data showing (an ideal hospital stay)," DiFonzo said. "There's no real magic number. They should be looked at on a case-by-case basis."

Several arguments exist for discharging women and newborns early, DiFonzo said. Evidence shows that women convalesce faster at home and that shorter stays reduce the risk of children contracting airborne diseases. Health-care workers should educate women about proper breastfeeding before delivery, not during hospital stays, he said.

Real-life demonstration is superior to anything mothers could read in a brochure, Twomey said. And since mothers don't begin lactating until after delivery, such education is impossible prior to their hospital stays.

"It should be done before as well as after," Twomey said.

Medical experts say that such conditions as jaundice or congenital heart

"It's good that (Sen. Bradley) is getting into the act on this, but physicians should take care of the medical issues. I just don't think it's right to legislate medical practice."

– AAP Committee on Fetus and Newborn Chairperson William Oh, M.D.

disease do not reveal themselves within 24 hours, and that longer stays are needed to monitor for such problems.

"Twenty-four hours is just generally too, too short," Twomey said. "We've had many mothers coming (back) in with complications, and it didn't have to be the case. It's a classic example of cost over quality."

HIAA officials question whether long hospital stays are needed to properly monitor newborns' potential health problems.

"Is it necessary for the baby to be in there three days, or is it OK to be home and go back in in two or three days?" DiFonzo said. "Do you keep a baby in the hospital a week to get those tests?"

Physicians who disagree with an insurance company's policy are not powerless, he said.

"Doctors can overrule the insurance companies," DiFonzo said. "They are in a position to appeal. It is their professional responsibility to do that."

However, appealing insurance company decisions is not an easy task, Twomey said, based on her experience dealing with New Jersey managed-care organizations.

"For the mother to stay, she would have to show complications such as high fever, bleeding," she said.

The proposed AAP policy should provide physicians with better negotiating power to obtain longer hospital stays for mothers and newborns, Dr. Oh said.

"They can use this as the guideline to negotiate or discuss with the insurance companies: 'This is what the Academy recommends. We have to do this.'"

REPORT 5 OF THE COUNCIL ON SCIENTIFIC AFFAIRS (A-95)
Impact of 24-Hour Postpartum Stay on Infant and Maternal Health
(Resolution 135, A-94)
(Reference Committee E)

EXECUTIVE SUMMARY

A variety of sociological and economic factors have converged to shorten dramatically the length of postpartum stays for most American women and infants. Some evidence exists that mothers may prefer shorter stays, and some researchers have concluded that complication rates for abbreviated postpartum stays are no higher than for traditional stays.

During the first 72 hours of life, a variety of important tasks must take place for mothers, infants, and families. Evaluating the impact of discharge in under 24 hours has been complicated by a host of factors. These include definitional problems, lack of randomized studies, and difficulty in operationalizing a good outcome. Most studies have focused on rehospitalization as the only outcome measure. Further, the available data have been collected on women prescreened for low medical risk and who volunteered to be discharged early.

The failure to find differences in readmission rates for perinatal complications has been interpreted by many authors to mean that shorter lengths of stay are safe. Sample sizes have, however, been too small to yield adequate power to accept the null hypothesis.

A group of interested experts, government agencies, and medical and health organizations have begun to examine the issue of early perinatal discharge as it affects the health of mothers and infants. The Council on Scientific Affairs supports this process and recommends that the following statements be adopted as policy:

1. The AMA is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe.

2. In the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischarge education, need for neonatal screening, and determination that adequate feeding is occurring. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.

3. The AMA urges all state neonatal screening programs to institute procedures that provide for timely follow-up screening for infants whose initial samples are obtained in the first 24 hours of life

4. Well designed experimental studies are needed to identify safe neonatal practices with regard to the hospital discharge of mothers and infants.

5. The AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other concerned national organizations to examine more thoroughly the issue of appropriate medical care during the perinatal period.

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 5 - A-95

Subject: Impact of 24-Hour Postpartum Stay on Infant and Maternal Health (Resolution 135, A-94)

Presented by: W. Douglas Skelton, M.D., Chair

Referred to: Reference Committee E (Howard A. Richter, MD, Chair)

Resolution 135 (A-94), introduced by the District of Columbia Delegation, was referred to the Board of Trustees. Resolution 135 called for the AMA to review existing data or, if such is insufficient, deliver a survey of the impact of insurance-driven discharge of mothers and newborns within 24 hours of delivery with particular emphasis on (1) health of the infant, (2) health of the mother (physical and emotional), (3) issues dealing with instruction/education, i.e., breast feeding, well baby care, immunizations, (4) effects on remainder of family members, and (5) personal and financial effects. In response, Board Report 24 (I-94) directed the Council on Scientific Affairs to study the issue of 24-hour postpartum discharge of mothers and infants, to evaluate the impact of this practice on infant and maternal health, and to report back to the House of Delegates at the 1995 Annual Meeting.

Background

A variety of sociological and economic factors have converged to shorten dramatically postpartum stays for most American women and infants. Typical hospital stays used to be four or five days for normal vaginal births and one to two weeks for cesarean births. Over the past decade this decreased, and in the last three or four years typical hospital stays have dwindled to 24 hours or less for uncomplicated vaginal deliveries and two to three days for Cesarean deliveries. The driving force behind these changes has been largely socioeconomic. However, some evidence exists that mothers may prefer shorter stays, and some researchers have concluded that complication rates for abbreviated postpartum stays are no higher than for traditional stays.

The first 72 hours of life are a time of significant transition and stabilization for newborn infants. It is during this period that a variety of important tasks must take place. The mother goes through a period of rest and recuperation and is further educated about infants, breastfeeding, and parenting. The child is observed for ductal and cardiac abnormalities, respiratory difficulties, infections, jaundice, adequacy of feeding, and gastrointestinal anomalies. Newborn screening occurs, and the mother-child dyad is assessed for evidence of biological and environmental risk factors. If any of these preventive measures do not occur, potential risk to mother or child increases.

The first issue in examining the question of "early discharge" is attempting to define it. The Guidelines for Perinatal Care, jointly published by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), define early

discharge as discharge within 48 hours of birth. It refers to discharge in less than 24 hours as very early discharge.[1]

Empirical studies have varied in their definition of early discharge. Most research examines the impact of discharge within 48 hours of vaginal delivery. Most expressions of concern have targeted discharges occurring in substantially less than 24 hours. Consequently, the available literature is limited and often does not focus on the populations of specific concern. Further complicating the analysis is the fact that most studies have had rigorous inclusion and exclusion criteria and have been conducted on mothers requesting early discharge. There is therefore only limited ability to evaluate scientifically the effects of shortening postpartum stays.

When evaluating the clinical effects of shorter stays, the following considerations are appropriate:

- health effects on and complication rates in the infant
- health effects (both physical and psychological) on the mother
- extent of opportunity for maternal and infant-care education
- physical and psychological effects on other family members
- extent of opportunity for maternal and child psychosocial assessment.

Available Research

Studies examining the issue of early discharge have tended to examine model programs that included a pre-screening process to identify low-risk mothers and infants, some degree of prenatal instruction or education, and some degree of follow-up care. The exact nature of these interventions, however, varied from program to program. Follow-up care, for instance, ranged from one home visit and a phone call to three home visits in the first three days home, and telephone consultation available 24 hours a day for two weeks.[2]

Methods of participant selection also varied from program to program. In almost all cases, however, the women chose whether they wanted early discharge or traditional hospital stay and the option was only available to a selected population. One study did use a randomized method of participant selection, but the authors acknowledge that "sample sizes were too small to detect significant differences in the outcomes."[3]

There are several factors that make interpretation of the available research tentative at best:

- discrepant definitions of "early discharge"
- exclusion of women and infants likely to have birth-related complications
- absence of random assignment
- no or flawed control groups
- provision of compensatory services in early discharge groups that may mask or alter the effects of more rapid discharge.

Type I vs. Type II Error

Another important question is the issue of where the burden of proof should lie. Is it sufficient that a change in practice fail to create significant adverse consequences, or should it be demonstrated to be "safe?" At the heart of this debate is the issue of Type I vs. Type II error--failure to reject the null hypothesis does not mean that the null hypothesis is correct. In other words, evidence that early discharge is not unsafe does not mean that it is safe.

In a review commissioned by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration, Paula Braveman concludes that insufficient statistical power is a methodological flaw common to all published studies of early discharge programs--"None of the studies in the literature had adequate power to detect even a doubling of the neonatal readmission rate."[4]

Despite this problem, most researchers in the field of early discharge have concluded that early discharge is safe, based on failure to demonstrate significant differences in neonatal readmission rates.

What is a Good Outcome?

One issue that bedevils outcome research is the difficulty in operationalizing a positive outcome. With regard to the issue of early discharge, the outcome variable generally selected is readmission of the infant within the first year of life. Information about morbidities not requiring rehospitalization is generally unavailable. Further complicating the issue is the economically driven trend to treat problems on an outpatient basis as much as possible, which may result in shifting criteria for readmission over the study period. An argument can also be made that readmission in the context of a follow-up visit is a good outcome, in that problems are being diagnosed and treated that might otherwise have been missed.

Health of the Infant

Within this shifting empirical landscape, a few studies have drawn conclusions about the impact of abbreviated postpartum hospital stays. The preponderance of available literature addresses the health status of infants going home after shorter vs. longer hospital stays.

Clearly, early discharge minimizes the risk of nosocomial infection (for both infant and mother).[5] However, it may not provide adequate time for routine medical and social assessment of the dyad.[6] Most researchers have concluded that early discharge (discharge within 48 hours of delivery) is generally safe for low-risk infants, based on a lack of "significant differences in the levels or types of mortality or readmissions for the early discharge and control groups."[2]

A review of all postpartum early discharge program outcomes in the United States published between 1960 and 1985 concluded that discharge prior to 48 hours (most within 24 hours) was not associated with an increase in neonatal morbidity.[2] None of the programs included in this review, however, had adequate sample sizes for good statistical power, and at least two thirds of the programs lacked a control group.[4] A more recent study (1990) found no significant difference in infant morbidity between infants randomly assigned to be discharged after 12-24 hours, 25-48 hours, and four days. However, small sample size limits the utility of these

results.[3]

Almost all instances of infant readmission (in all studies) were due to hyperbilirubinemia, with variability due to differences in the definition and treatment of hyperbilirubinemia. Complicating this finding is the fact that hospitalization is no longer considered to be the gold standard for treating moderate hyperbilirubinemia in neonates. Norr and Nacion report that "of a total of 84 infant readmissions reported by all of [the] studies, 71 were for hyperbilirubinemia and only 13 were for all other causes, including transient tachypnea, bradycardia, and hypothermia, with no one cause predominating." Norr and Nacion further report that morbidity from causes other than hyperbilirubinemia is low. Superficial skin infections, feeding problems (lack of weight gain), and hypothermia are cited as the most common problems. Less common problems include diarrhea, pneumonia, convulsions, and respiratory difficulties.[2]

There are many anecdotal reports about other serious problems such as failure to thrive, missed diagnoses of metabolic disorders such as phenylketonuria, and serious bleeding from circumcision wounds, but these have not as yet been documented empirically.

Perinatal Screening

Mandated neonatal screening varies from state to state, but all screening programs are designed to prevent morbidity and mortality through early diagnosis of medical problems and congenital disorders that can have serious sequelae. Adequate screening programs require universal participation, prompt diagnosis, and mechanisms for parental notification and education. Common screening tests include those for persistent hyperphenalalaninemias, including phenylketonuria, galactosemia, maple syrup urine disease, congenital adrenal hyperplasia, and congenital hypothyroidism. Some states also mandate screening for sickle cell disease and various sexually transmissible infections.

Historically, these screening samples have been taken on the second or third day after delivery. This time period was established to optimize the sensitivity of the tests. PKU screening, for example, has a false negative rate that is quite high (about 33%) during the first 12 hours of life and drops to less than 1% after 48 hours. In contrast, early screening for congenital hypothyroidism, especially using thyrotopin (TSH) as the primary screen, may have a high false positive rate because of the normal TSH surge that accompanies parturition. Some experts argue that screening samples taken in the first 24 hours of life serve merely to notify the system of the existence of the infant. Follow-up screening for PKU or congenital hypothyroidism, for example, must then be completed in a timely fashion, no later than two weeks after birth.[1] Loss of infants to follow-up screening is a serious concern, but data regarding the rates of missed rescreening are not yet available.

Health of the Mother

Methodological flaws also plague the few studies examining the impact of early discharge on the physical health of the mother. Research has shown that very few mothers (less than two percent) require rehospitalization after discharge.[3,7] When they do, the problems are often fairly serious, including significant infection and hemorrhaging. The majority of mothers who did require readmission in one review suffered from endometritis.[2] In that review, six of the ten readmissions reported in four studies were for endometritis. (Two of the other four

women were readmitted for postpartum hemorrhages, one for severe postpartum depression, and one for a severely abscessed episiotomy.)[2] Again, however, these findings are not necessarily conclusive

The MCHB report points out that these studies had "comparison groups . . . [that] were likely to differ on relevant characteristics . . . [and/or] sample sizes were inadequate."[4] The data on maternal morbidity treated on an outpatient basis are even less certain. Many studies do not provide specific information about complication rates; others provide no information at all.[2,3] Of the studies that did offer information about morbidity that did not require hospitalization, the most common problems included mild hypertension, anemia, breast or episiotomy problems, and fatigue.[2,3,7] In a 1990 study that included a control group, the mothers experienced a generally healthy postpartum course, regardless of the time of discharge.[3]

The impact of early discharge on the emotional health of the mother is a similarly important area of concern. Emotional health includes such things as postpartum depression, mother-child separation, the mother's confidence in her ability to be a good parent, stress management, and the need for external support. In the randomized, controlled study that compared discharge at 12-24 hours, 25-48 hours, and four days, the mothers discharged 12-24 hours after giving birth reported themselves to be significantly less depressed at one month postpartum than the two later groups. In addition, the earliest group reported higher levels of confidence at one week postpartum than the other two groups. At one month postpartum, however, the three groups did not differ significantly with respect to levels of confidence. This suggests that women who assume total responsibility for their baby sooner after delivery may feel more confident initially than those who do not, but the direction of causality is unclear.[3]

Another study, which compared women who had domiciliary care after early discharge to women who had hospital care until discharge, found that the difference between the emotional health of mothers in both groups was not statistically significant.[8]

Although many of the studies mention other aspects of emotional health such as mother-baby bonding and the mother's support system, they do not provide data. A second document commissioned by MCHB reports on an October 1994 consensus meeting in Boston. There, a group of experts with "intimate knowledge of both hospital and community based care for mothers and newborns" found that "women who are from high risk social environments and with limited social support structures may not be best served by a one-day stay." In addition, "separation due to the need to observe either the mother or the newborn was deemed unacceptable. Policies that would result in increased rates of separation were viewed by the group as detrimental to mother infant bonding, infant and maternal health, and threatening to breastfeeding. Clinicians recognized a distinction between 24 hours and 72 hours because mother/infant bonding occurs during this early and critical time period."[9]

Education

Many experts express concern that early discharge will reduce the degree to which health care providers can offer parental education and instruction. The decreased length of hospital stay associated with early discharge significantly increases the importance of comprehensive and continuous prenatal and postpartum care.[10] Such care includes breastfeeding instruction, early discharge planning, and educating the mother about immunizations, well-baby care, and bodily changes

All of the studies reported in the literature included fairly extensive prenatal and follow-up care. No data are available about the relative educational needs of women who present for delivery without benefit of prenatal care, regardless of length of hospital stay.

Impact on Other Family Members

The impact of early discharge on the rest of the family is not as well documented as the impact on the mother and the infant. The studies do cite family togetherness and the involvement of the father in caring for the new baby as sources of parent satisfaction.[5,8,11-13] These studies, however, focus on the effect of early discharge on the mother and not on the rest of the family. The existing research does not sufficiently examine the impact of early discharge on other family members.

Cost-Effectiveness

The cost-effectiveness of early discharge programs is the final consideration examined in the literature. The literature only investigates the cost-effectiveness for the hospital. It does not address the impact on the patient's costs. Some studies conclude that reduced lengths of stay and the resulting increase in the number of beds available for other patients render early discharge programs cost-effective.[1,14] Other authors claim that no one has thoroughly analyzed whether early discharge programs truly provide a way to contain costs.[12] Again, the existing data are sketchy and inconclusive.

Conclusions

We still do not know how much and what kind of follow-up is needed for maternal and infant safety.[15] In the MCHB review, Braveman "categorized studies of early discharge according to the type of compensatory service provided in the early post-discharge days . . . [b]ecause conclusions from studies about early discharge in the presence of a given compensatory service cannot be generalized to early discharge in the absence of that service."[4] The reviewed studies that included post-discharge services did indicate that most women were generally satisfied with the care they received for both early discharge and traditional stay. At least two studies (both with postpartum home visiting) report that mothers who were discharged early were more satisfied than mothers who had traditional hospital stay.[3,8] Satisfaction, however, depends upon expectations, and studies show that the expectations of women who choose early discharge often differ from those of women who choose a traditional hospital stay. This suggests that women should be allowed to choose the maternity care which best suits their individual needs.[8]

While we can therefore conclude that some women prefer to be discharged sooner than later, definitive studies regarding the safety of doing so are not available at this time. The limitations of the existing research are significant. Inadequate statistical power, absence of random assignment, careful participant selection, and unstable definitions of "early" and "good outcome" render scientific conclusions highly unreliable. One of the major limitations of the studies is that most of the early discharge programs were voluntary. Norr and Nacion acknowledge that "it is likely that families who choose early discharge not only have favorable attitudes about coming home early, but also the resources and social support needed to make the discharge go smoothly."[1] Second, very few researchers have studied the effects of early discharge on disadvantaged populations -- most participants are either middle-class or upper

middle-class, healthy, well-educated, and living in a stable home environment.[2,3] The outcomes of the studies, therefore, cannot be generalized to high-risk populations. Further, there is no national consensus on what constitutes "low-risk" versus "high-risk." The October 1994 consensus meeting concluded that "neither the AAP/ACOG Guidelines for Perinatal Care regarding eligibility for 24 hour discharge nor the specifications concerning follow-up seemed adequate from the perspective of clinicians."[9]

Some physicians worry that the current trend toward reduced hospital stays will have dire results. Arthur Eidelman, MD, for example, notes that "it is assumed [that] the mother will be discharged into a supportive family unit where another responsible adult is present and where there exists an accessible medical care system for follow-up and ongoing care." Fully aware that many women do not enjoy such luxuries, Eidelman warns that allowing high-risk mothers such as "an adolescent primipara, or a single mother subsisting on welfare . . . into a system that does not have any backup visiting nurse program or community health clinics is simply committing medical and social suicide."[6] Eidelman's concerns reinforce the necessity of limiting early discharge to low-risk mothers or providing comprehensive care that would ensure a safe and healthy discharge for high-risk patients.

The commissioned MCHB review concludes, "Although many studies have examined early discharge, when standard scientific criteria are applied it becomes clear that the currently available literature provides little scientific knowledge to guide discharge planning for apparently well newborns and their mothers. . . . Rigorously designed studies are needed to examine the impact of early discharge and a range of post-discharge practices not only on newborns but on mothers and families. . . .[I]nformation from sound research is needed to inform policy addressing third party reimbursement as well as clinical care standards."[6]

In December 1994, the MCHB convened a group that included the American Medical Association and other concerned organizations, academicians, and experts to begin the process of examining the issue of early perinatal discharge. It was agreed that there may be cause for concern in the present trend toward more and more rapid postpartum discharge. Principles agreed upon at that meeting include:

- Discussions of an acceptable vs. unacceptable number of postpartum hours are unproductive and should be replaced by work to identify the essential prerequisites for timely and appropriate perinatal discharge of mother and infant

- Discharge policies that result in separations between mothers and infants due to staggered hospital releases are undesirable

- There needs to be concentrated work on developing national standards for adequate and sufficient care during the early neonatal period

Recommendations

The Council on Scientific Affairs recommends that the following statements be adopted in lieu of Resolution 135 (A-94) as policy and that the remainder of this report be filed.

1. The AMA is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe.

2. It is the policy of the AMA that in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischarge education, need for neonatal screening, and determination that adequate feeding is occurring. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.

3. The AMA urges all state neonatal screening programs to institute procedures that provide for timely follow-up screening for infants whose initial samples are obtained in the first 24 hours of life.

4. The AMA should encourage well-designed experimental studies are needed to identify safe neonatal practices with regard to the hospital discharge of mothers and infants.

5. The AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other concerned national organizations to examine more thoroughly the issue of appropriate medical care during the perinatal period.

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(11) REPORT 5 OF THE COUNCIL ON SCIENTIFIC AFFAIRS - IMPACT OF 24-HOUR POSTPARTUM STAY ON INFANT AND MATERNAL HEALTH (Resolution 135, A-94)

* Adopted changes to orig: Report

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Recommendation 2 of Report 5 of the Council on Scientific Affairs be amended by insertion and deletion on page 8, lines 9-10, to read as follows:

2. It is the policy of the AMA that in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischarge education, need for neonatal screening, ~~and~~ determination that adequate feeding is occurring, and with consideration of the mother's social and emotional needs and preferences. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by AAP and ACOG.

HOD DECISION: Adopted recommendation of Reference Committee

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that the Recommendations contained in Report 5 of the Council on Scientific Affairs be adopted as amended in lieu of Resolution 135 (A-94) and the remainder of the report be filed.

HOD DECISION: Adopted recommendation of Reference Committee

CSA Report 5 discusses available research data concerning shorter postpartum hospital stays along with the limitations of these studies. The CSA recommends adoption of the following policy statements: 1) the AMA is concerned about the trend toward shorter routine perinatal hospital stays in the absence of data to demonstrate safety; 2) time of perinatal discharge should be based on the attending physician's clinical judgement and not economic considerations; 3) all state neonatal screening programs should institute procedures to provide follow-up screening for infants whose initial samples are obtained within the first 24 hours of life; 4) the AMA should encourage well designed studies to identify safe postpartum stay hospital discharge practices; 5) the AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other organizations to examine the issue of appropriate medical care during the perinatal period.

Your Reference Committee heard considerable support for this report and its recommendations. Testimony provided information on New Jersey's new state law which requires insurers to pay for a minimum of 48 hours of hospital care after a vaginal delivery and 96 hours after a Caesarian section (Chicago Tribune, Sunday, June 18, 1995). The CSA did not wish to include these specific times in its recommendations because, as noted in Recommendation 2, definitive empirical data is not available to support such specific lengths of stay. The CSA did agree, however, to amend this recommendation to include the importance of consideration of the mother's social and emotional needs and preferences.

Several speakers mentioned the need for appropriate action and implementation of these recommendations. Your Committee did not feel that an additional recommendation requesting a report back at I-95 on implementation was required, since this information already is provided to delegates in a memo on the implementation of business from the previous House of Delegates meeting. In addition, the CSA is directed to monitor the implementation of these recommendations.

74TH STORY of Level 1 printed in FULL format.

Chicago Tribune

November 26, 1995 Sunday, DU PAGE FINAL EDITION

SECTION: TEMPO DU PAGE; Pg. 3; ZONE: D; DuPage Spotlight.

LENGTH: 1340 words

HEADLINE: MATERNAL CARE;
HOSPITALS HELP NEW MOMS SENT HOME A DAY AFTER GIVING BIRTH

BYLINE: By Mary Peterson Kauffold. Special to the Tribune.

BODY:

A quarter-century ago, it took nine months and four days for a human embryo to grow from a single cell to full-term infant and for the mother to recover sufficiently from childbirth to leave the hospital. Today it typically takes nine months and a day.

There has been no change in gestation, but maternal recovery time has shrunk dramatically by 75 percent. The former is dictated by evolution, the latter by health insurance companies.

Nationally, hospital maternity stays that in 1970 had averaged 3.9 days after an uncomplicated vaginal delivery dropped to 2.1 days by 1992, according to the U.S. Centers for Disease Control. Since then, health insurance companies have yanked the medical-benefits purse strings even tighter, sending mothers still exhausted from giving birth packing from their hospital beds 24 hours or less after normal vaginal birth and three days after Caesarean-section.

Terry Parker works on the front line of so-called drive-through-delivery obstetrical care that, she says, often leaves mothers desperate for rest, relief and reassurance. "If a new mother bursts into tears when I call and tell her who I am, I'm real sure I'll be going out to her home the next day," said Parker, a registered nurse at Edward Hospital, Naperville, who splits her on-duty time between the postpartum unit and visiting mothers and their babies in their homes two to six days after they're discharged from the hospital.

Contrary to the budget slashing that currently dominates the health industry, a few hospitals are giving away their maternity services in an effort to reduce the risk of undetected postpartum complications to mothers and babies.

Edward Hospital and Delnor-Community Hospital, Geneva, offer free home visits by staff nurses to women two to six days after they are discharged from the hospital, and in September, St. Joseph Medical Center in Joliet began tacking on a free day of room and board to the stay of every mother who wants it.

"We need to do things for the right reason in these days of economic pressures," said Connie Hardy, director of maternal-child services at Edward. "And what is the right thing? Does that mean having mothers stay in the hospital where they can rest, or does that mean providing support in their homes? . . .

What's driving this situation is who's going to pay for what and how can insurance companies get the biggest bang for their buck."

Judy Smith, director of maternal and child services at Delnor-Community, which introduced the Mother-Baby Home Visit Program in 1992, said: "We don't have whole families all living on the same block anymore. We have transplanted families. Grandma lives a thousand miles away, and Sister lives in California. Mom may have moved here six months ago and not have had time to make new friends.

"If she's a working mother, she may have stayed on the job right up to the day of her delivery. She doesn't know her neighbors and hasn't got anyone to help her with her 2-year-old when she gets home."

In May, the American College of Obstetricians and Gynecologists (ACOG) called the trend toward earlier dismissals "a large uncontrolled, uninformed experiment that may potentially affect the health of American women and their babies."

Among the problems that may not be apparent in the first 24 hours after birth are infection, certain congenital heart defects, infant dehydration (often related to breast-feeding problems) and newborn jaundice (yellowing of the skin), which in serious cases can cause brain damage. Newborn jaundice is caused by a buildup of bilirubin, a yellowish-red byproduct of the normal breakdown of red blood cells in the bloodstream, which is processed in the liver and excreted. Immediately after birth, a baby's immature liver may not be able to break down the bilirubin as fast as it's produced, resulting in a yellowing of the baby's skin. ACOG says it has collected "anecdotal reports of serious problems in newborns such as dehydration and jaundice following early discharge."

The Cradle Connection at Edward Hospital was started 10 years ago as a goodwill gesture when maternity hospital stays were typically three days and nurses had more time to mentor new mothers in baby care, but it has evolved into a vehicle for much-needed follow-up care.

"I visited a baby yesterday that was jaundiced," Parker said, "and neither the mother nor the grandmother had noticed. . . . The kid was flaming yellow!"

If a newborn develops potentially serious problems and the mother doesn't recognize the symptoms, the infant's condition can quickly become life-threatening, said Pam Forster, a staff nurse at the New Life Maternity Center at Delnor-Community who began making home visits two years ago. Case in point: "I visited this mom who lived way out in the country. Her baby was real little, just about 5 pounds (at birth)," Forster related. "The baby was only nursing for five minutes every four hours and was very, very dehydrated. The infant hadn't wet a diaper in 36 hours. If I hadn't come out, that baby could have been in big danger."

Hardy said it costs up to $100,000 a year to operate Cradle Connection, and Smith said the annual tab for the Mother-Baby Home Visit Program is about $112,500. Mothers interviewed insisted that the home visit investment paid invaluable dividends in peace of mind.

"I felt very reassured knowing that no matter what, somebody was going to

come here and see how things were going," said Laura Lutz, 28, of St. Charles, who gave birth to her first child, Brent, at Delnor-Community April 29. She went home the next day.

The home visit a few days later was the right support at the right time, Lutz said. "The nurse gave Brent and me a mini-physical. Brent was a little jaundiced, so she took a blood sample on the spot. . . . I was getting so frustrated with breast-feeding, but she really helped me. My milk came in that night, and I knew just what to do." When the 90-minute visit ended, "I felt like the nurse was one of my good friends. I could talk to her about anything."

The day after Katharina Linder, 34, Naperville, went home from Edward Hospital with her first child, Alexander (born Oct. 10), she got a phone call from Parker asking how she and her son were faring. "I especially appreciated that call; it really eased a lot of my fears," Linder said.

The home visit a few days later proved to be an eye-opener. "Here was someone who is a professional saying, 'Why don't you try this?' or, 'This might work better.' Thanks to her prodding, I got answers to questions I didn't even know I had." Without the 90-minute visit, "I wouldn't feel as confident of what I'm doing."

Federal and state legislation that would require longer maternity-stay health benefits is pending. State Rep. Lauren Beth Gash (D-Highland Park) introduced a bill in June that would prevent insurance companies and health maintenance organizations from restricting a woman's hospital stay to less than 48 hours after normal vaginal delivery and less than 96 hours after Caesarean-section. If the woman chooses to leave the hospital sooner, she would have the option of receiving up to four post-delivery home visits by a maternal-child registered nurse.

In July, State Sens. James DeLeo, Arthur Berman and John Cullerton, Democrats from Chicago, introduced a similar bill in the Senate. U.S. Sens. Bill Bradley (D-N.J.) and Nancy Kassebaum (R-Kan.) are cosponsors of federal versions.

Insurance companies oppose any legislation that would mandate an increase in the time mothers and babies spend in the hospital. "We do not think these decisions are the province of legislators," said Richard Coorsh, spokesman for the Health Insurance Association of America.

"It's not appropriate for legislators or insurance companies to be dictating medical care," Smith said. "The practice of medicine belongs in the hands of medical professions. The physician should be making those decisions."

GRAPHIC: PHOTOPHOTO: Nurse Terry Parker of Edward Hospital visits with new mom Katharina Linder and Alexander. Tribune photo by John Dziekan.

LANGUAGE: ENGLISH

LOAD-DATE: November 26, 1995

65TH STORY of Level 1 printed in FULL format.

St. Louis Post-Dispatch

December 22, 1995, Friday, FIVE STAR LIFT Edition

SECTION: EDITORIAL; Pg. 16C

LENGTH: 368 words

HEADLINE: MOTHER'S DAY: 24 HOURS AND OUT

BODY:

On health matters such as the length of a hospital stay following childbirth, a doctor's opinion once reigned supreme. Not anymore. Decisions about the length of maternity stays have shifted to cost-conscious health insurance companies and others seeking to reduce payouts and improve their own bottom lines.

Consider the changes these forces have wrought: The average hospital stay for childbirth has dipped from roughly four days in 1970 to two days in 1992. Moreover, it isn't uncommon for hospitals to release women and babies less than a day after vaginal delivery or two days in the case of a Caesarean section.

On the matter of maternity policies, insurers say they continue to be guided by doctors. Doctors, in turn, point to the shorter maternity stays as an example of how medical decisions are gradually moving further away from their reach.

Some states are mandating longer stays as more and more women complain about being discharged from hospitals much too soon after childbirth. New Jersey, North Carolina and Maryland have required insurers to pay for 48-hour hospital stays - at least - in cases of childbirth. Other state legislatures are certain to adopt similar policies, though such rules are more easily enacted than enforced. Companies that self-insure, for example, are exempted from state insurance laws. Federal legislation would seem best to address this maternity-related issue.

Another option is for hospitals to allow mothers and infants longer maternity stays than what insurance companies permit. George Washington University has adopted a policy of allowing mother and child to remain in the hospital an extra day. The program is so popular that the hospital's added costs are offset by the rise in maternity business.

Not all women need an extra day in hospitals after giving birth. But those who do should have that option. Discharging infants before hospitals are given time to screen them properly for metabolic disorders, for example, is shortsighted. In some cases, insurers will have to pay for the treatment of such disorders at a later date. This means the costs could eat up whatever savings insurers project from shorter maternity stays.

LANGUAGE: English

LOAD-DATE: December 22, 1995

8TH STORY of Level 1 printed in FULL format.

April 17, 1996, Wednesday, BC cycle

LENGTH: 392 words

HEADLINE: Senate panel passes bill for longer maternity stays

BYLINE: By Sue Kirchhoff

DATELINE: WASHINGTON

BODY:

The Senate Labor Committee Wednesday voted to require insurance companies to provide longer hospital stays for new mothers, seeking to end what critics have dubbed "drive-through deliveries."

The bill, which could be debated by the full Senate this summer, requires health plans to provide a mininum 48 hours of hospital coverage after a normal delivery and 96 hours following a cesarean section.

Many insurers now allow 24 hours after a regular birth and some only 12 hours. Advocates of the bill say health problems faced by newborns such as dehydration or jaundice may not be detected during such short hospital stays.

"These decisions need to be made in the delivery room and not the board room," Sen. Barbara Mikulski, a Maryland Democrat, said.

New mothers could be discharged earlier on a doctor's advice under the bill as long as health plans provided follow-up, post-delivery services within 72 hours.

Committee head Nancy Kassebaum, a Kansas Republican, said the measure would "assure that mothers and their newborn children will not be forced for financial reasons to leave the hospital in the first few critical days following birth."

Kassebaum and New Jersey Democrat Bill Bradley were the chief sponsors of the bill.

A growing number of states including Maryland and New Jersey have passed similar laws. But state laws do not cover self-insured plans or women whose health coverage crosses state lines. State laws setting tougher requirements for insurers would not be pre-empted by the new legislation.

Insurance officials are not happy with the proposal.

"In the past health care providers have had the authority to recommend an extended stay based on medical necessity. We think that rather than dictating from a legislature, the status quo should be able to continue," said Richard Coorsh of the Health Insurance Association of America.

Childbirth is the most common reason for hospitalization, with more than 4

million babies born in the United States each year.

The bill, based on recommendations by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists, passed by voice vote. The committee rejected an amendment to limit the new requirements to five years but voted to carry out studies to assess the bill's impact.

Similar bipartisan legislation has been introduced in the House.

LANGUAGE: ENGLISH

LOAD-DATE: April 18, 1996

22ND STORY of Level 1 printed in FULL format.

The Herald (Rock Hill, S.C.)

March 31, 1996 Sunday 1ST EDITION

SECTION: LIFESTYLES; Pg. 1C

LENGTH: 1337 words

HEADLINE: Home too soon?

BYLINE: By Jennifer Becknel The Herald

BODY:

When Ann Jaeck gave birth to her first child last month, she figured her hospital stay would be a short one - not by choice, but because of her insurance.

Jaeck, 22, and husband Todd welcomed their daughter Sara around 10 a.m. Feb. 22. Her insurance plan covered one day for a normal delivery, she says. So the next day around noon, mom and baby went home.

"I could have handled another night," the York woman says, because she was still sore from the delivery and felt a bit rushed. Jaeck and her baby were fine, but she still says the one-day stay "is too soon."

But doctors say it's not uncommon for mothers to be discharged after 24 hours, especially among mothers covered by managed health care plans that often cover only one night in the hospital following a normal birth.

In the first six months of 1995, almost half of mothers and newborns delivered in South Carolina hospitals who were covered by private insurance went home just one day after delivery, according to a study issued in February by the S.C. Budget and Control Board. The one-night stays saved an average of $ 1,077 in hospitalization costs for mother and baby, compared with a two-night stay, the study shows.

Some health officials say the early discharges are starting to become less common as insurance companies become more willing to pay for a second night in the hospital - and in the face of legislative proposals that would regulate the stays.

Recent legislation introduced in the S.C. General Assembly would require health insurers to cover at least two days in the hospital following a birth. And on Thursday, congressional legislation was proposed that would allow doctors and new mothers, rather than insurance companies, to decide the length of hospital stays after a birth.

The one-day maternity stays have "become a pretty common practice with managed care," says state Sen. Linda Short, D-Chester, sponsor of the pending legislation in South Carolina.

"I just hate to see that kind of thing happen, having had two children. I know childbirth is a very normal part of life, but it's not the easiest thing anybody does. I think that decision should be up to the doctor, not the insurance company."

Doctors say the risk is primarily to newborns, who may not begin to show serious heart, lung or other problems until the second day. The American Academy of Pediatrics came out against insurance-driven discharge policies last fall.

"So far we've been fortunate, but we realize that there is a potential for problems," says Dr. Richard L. McCoy, a pediatrician with Herlong Pediatrics in Rock Hill.

"We really feel it's good to observe babies for 48 hours," he says. "Things are not always real clear at first. Particularly among new parents going home with a new baby, it's just a whole new world to them. They're not sure what's abnormal and what's just a normal variation."

Many newborns have no problems, doctors say. But among those that do, the most common are feeding difficulties, unacceptable weight loss and jaundice, a yellowish discoloration of body tissues caused by the abnormal accumulation of the bile pigment bilirubin in the blood.

"Some of them have a difficult time getting adjusted to breastfeeding and it ends up with unsuccessful breastfeeding, the baby being put on formula," says Dr. Hal Anderson, a pediatrician with Rock Hill Pediatrics.

"And jaundice typically occurs on the second, third, fourth day and sometimes that may get higher than you like before the baby is checked in the office," he says.

Anderson says early hospital discharges are often difficult for first-time parents, teen-age mothers and mothers who don't have a strong support system at home.

"I don't think the insurance companies should be pushing people out" of the hospital, Anderson says. "I think the baby gets left out."

However, some mothers choose an early discharge if they're able to leave the hospital, usually because they're anxious to get home.

Sue Sherer of Rock Hill, who gave birth to her second child Corrie Evan last week at Piedmont Medical Center, says she chose an overnight stay for both deliveries.

"I wanted to (leave the hospital the next day) just because I knew I would get more rest," says Sherer, 29. "I didn't feel I would get a lot of rest" at the hospital.

Husband Todd, 29, says the key to a successful early discharge "is having people around you. If you don't have people around you (to help) it's difficult."

Some insurance companies say the early discharges are an option rather than a

requirement, and that the ultimate decision rests with doctors.

Blue Cross/Blue Shield, the state's largest health insurance provider, covers up to 48 hours following a delivery, says Donna Thorne, vice president of corporate communications. Mothers who choose the early discharge receive a $ 75 check as an incentive, she says.

However, the company's Companion Healthcare plan didn't routinely inform mothers that the 48-hour stay was an option until late last summer, says Thorne.

"They realized that they needed to make sure (mothers) were aware that 24 hours is voluntary," she says. Now that information "is in the literature," she says.

But McCoy says many insurance companies refuse to pay for more than one night for a normal birth. "We realize the insurance companies are the ones calling the shots now."

He says the typical hospital stay of mothers and newborns he sees is one night, or around 36 hours, although the time of birth often affects the length of stay. Babies born late at night or in the early morning hours, for example, often stay a second night, or a total of nearly 48 hours.

Karen Adkins of Rock Hill expected to be in the hospital just overnight for the birth of her son because she says her insurance only covered a day for a normal delivery.

But her son Christopher was born around 11 p.m. March 12, so her doctors wanted her to spend the following night in the hospital so the baby could be observed.

"I really thought after 24 hours, we'll be out," she says. "It made me feel better, knowing I could spend an extra night and recuperate. In case anything went wrong, I think 24 hours is not enough."

At PMC, about 40 percent of mothers and newborns had early discharges through February, but that is becoming less common, says Karen Ginsberg, clinical director of women's services. Early discharge is one day for a normal vaginal delivery and two days for a caesarean section, she says.

"We do have some insurances that require they leave at 24 hours, but that is the exception rather than the rule," Ginsberg says.

More typical stays are 36 to 48 hours, says Ginsberg, who attributes the change to the pending state legislation. "Most insurance companies are starting to lean toward paying for the 48 hours," she says.

As South Carolina moves toward more managed health care plans, "you would probably see a trend more toward 24-hour stays" unless legislation is passed regulating the length of stay, says Leonora Stallings, vice president of business services for the hospital.

Mothers and newborns who were discharged early had a home visit from a hospital nurse within a day or two, Ginsberg says. Last month, that program was

contracted to the state Department of Health and Environmental Control. Some insurance companies also pay for home nursing visits.

Ginsberg says she believes the early discharges are safe, as long as they are followed by a maternal home visit to assess the mother and baby.

Yet many mothers still prefer to stay an extra day.

Debra Riggs of Rock Hill spent about 36 hours at PMC when her second child was born March 19 because she had an evening delivery. She had expected to leave after a night because of her insurance, and was glad to stay a second night.

"I don't think very much of it," she says of the early discharges. "I don't think it's really good for the baby or mother. Babies, especially, I think they need more time for the doctors to check them out."

GRAPHIC: Jim Stratakos / The Herald ;Sue and Todd Sherer of Rock Hill welcomed their daughter Corrie Evan last week at Piedmont Medical Center. Sue Sherer wanted to go home the day following the birth.

LOAD-DATE: April 01, 1996

NEWSLETTER

VOL. 39 NO. 8 AUGUST 1995

A historical look at alcohol and pregnancy

According to ACOG-Ortho History Fellow Janet Golden, PhD, the social mores of the early 19th century led to assumptions that women did not drink alcohol to excess. As a result, the effects of drinking during pregnancy were not readily considered by their physicians.

Dr. Golden is conducting a historical analysis of how medical ideas are shaped by the culture's view of women. Her research project, entitled "From Relief from Breeding Sickness to Fetal Alcohol Syndrome: Implications of Alcohol Use During Pregnancy and Lactation, 1790–present," is slated to culminate in a book. Dr. Golden is an assistant professor of history at Rutgers University in Camden, NJ.

Dr. Golden contends that, despite early knowledge of the detrimental effects of alcohol on pregnancy outcomes, these effects were ignored. "There were early reports in the medical literature that alcohol had bad outcomes for pregnancy and there was a relationship between maternal inebriety and mental retardation in the offspring," Dr. Golden explains. "I suspect, however, that there was an assumption that women didn't drink. It was assumed that alcohol abuse was a male problem—that men drank up the family wage, and beat their wives. Additionally, physicians did

Continued on page 2

States join effort to oppose insurer-mandated early postpartum discharge

Maryland and New Jersey enact laws requiring insurers to allow a 48-hour minimum stay.

The issue of third-party payers dictating inappropriately short lengths of hospital stays following labor and delivery has been a growing concern among physicians and patients. In an effort to curb this practice, legislation was recently passed in two states, New Jersey and Maryland. Legislators in other states, among them New York and California, are considering similar laws. Many view this legislation as an effective effort to reduce insurer intrusion into accepted medical practice. At the same time, however, others feel that legislation should remain a remedy of last resort for these types of concerns, lest laws interfere too far into medical practice and patient care.

Medical consensus—as spelled out in the ACOG-American Academy of Pediatrics joint publication, *Guidelines for Perinatal Care*—recommends hospital stays of up to 48 hours following uncomplicated vaginal delivery and up to 96 hours following uncomplicated cesarean delivery. Nevertheless, some insurance companies now specify lengths of stay of up to 24 and 72 hours respectively, and some insurers are reported as recommending discharge at 12—and even as early as 6—hours after delivery.

Current state legislation

New Jersey's response to this troubling trend takes the form of a bill approved last spring by the state's senate and assembly and signed into law by Governor Christine Todd Whitman on June 28. It requires all health plans—except those that provide benefits for in-home postpartum care—to allow a woman to stay in the hospital for a minimum of 48 hours after an uncomplicated vaginal delivery and 96 hours following cesarean delivery. Prior to the signing, the governor's office was besieged with calls from new and expectant mothers supporting the bill.

In Maryland, a similar measure has also been signed into law. It is considered the preferable of the two laws because, unlike New Jersey's, it forgoes the naming of specific time lengths and simply states that postpartum hospital length of stay should conform to *Guidelines for Perinatal Care* (thereby obviating the future need to pass another law if those guidelines change). Also unlike New Jersey's, the Maryland law applies only to health maintenance organizations. Both laws allow for earlier discharge if the physician and mother see fit.

Michael T. Mennuti, MD, Chair of ACOG's Committee on Obstetric Practice, doesn't see any other easy answers to this problem. "Apart from legislating medical practice," he says, "a process to pressure in-

Continued on page 8

Inside:

State legislation aimed at insurers mandating shorter hospital stays

Continued from page 1

surers, with consumers joining forces with providers, might have been effective," he says. "However, this would be a difficult effort to organize and would likely take an inordinately long time."

ACOG's efforts

College Fellows and staff have worked hard to convey the desire that postpartum length of stay follow accepted guidelines, and that changes in this practice be based on sound scientific data. The Department of Public Information held a press briefing on the issue (with Dr. Mennuti and ACOG Executive Board Public Member Sarah S. Brown, MPH) at the Annual Clinical Meeting, and later released a press statement. On the legislative front, ACOG's New Jersey Section was heavily involved in getting that state's law enacted.

Pointing to a recent analysis by the Centers for Disease Control and Prevention, the ACOG statement explains that "between 1970 and 1992 the median length of stay for women who gave birth vaginally decreased by 46 percent (from 3.9 to 2.1 days), and for those who had a cesarean delivery by 49 percent (from 7.8 to 4 days)." (1)

This shift toward earlier discharge began in response to consumer demand during the 1970s, to decrease medical interventions surrounding childbirth and provide a more family-centered birth experience. More recently, however, the trend to even shorter lengths of stay following delivery "appears to be driven primarily by financial motivations," says the statement.

ACOG's concerns revolve around the effects such mandated early discharges might have on the detection of maternal and newborn complications. In addition, many mothers who go home early are deprived of instruction in basic infant care and breast feeding.

The statement concludes: "ACOG believes that the American health care system should call for a moratorium... on further reduction in hospital stays following delivery, until we have the data that clearly demonstrate the safety of early discharge for women and their babies."

At its annual meeting last June, the American Medical Association concurred with ACOG, releasing a statement that said in part, "Discharge of mothers and infants should be determined by the clinical judgement of attending physicians, and not by economic considerations."

For now, legislation appears to be the only way to force insurers to recognize the needs of patients and the clear consensus of physicians on the issue of postpartum hospital stays. Nevertheless, Dr. Mennuti and others hope that such laws will not always be required. "While the New Jersey and Maryland laws are good pieces of legislation, I find it unfortunate that this change could be brought about in this manner," he says. Among his concerns is that a state might unintentionally misinterpret the guidelines and suggest that women must be made to stay for 48 hours, in his words, "essentially incarcerating them."

1. CDC. Trends in length of stay for hospital deliveries: United States, 1970–1992. MMWR. 44:335–337

Additional ACM Awards

In addition to those announced in the July *Newsletter*, the following awards were presented during the 1995 Annual Clinical Meeting.

SYNTEX "ISSUE OF THE YEAR" AWARD
For a thoroughly researched and referenced background paper on a specific issue in ob-gyn

Richard E.N. Sedwick, MD, Harrisonburg, VA
"Models of Primary Care Practice"

COMMITTEE ON SCIENTIFIC PROGRAM AWARDS
For the highest-caliber scientific paper presentations

First Prize: "Pregnancy Outcomes Following False Positive Marker Screening Tests"
Shelley J. Chapman, MD; Cynthia G. Brumfield, MD; Katherine Wenstrom, MD; Mary B. DuBard, MA
The University of Alabama at Birmingham

Second Prize: "Immunohistochemical Characterization of Oncoprotein (P35, HER2/NEU) Expression and Proliferative Activity (PCNA) in Uterine Papillary Serous Carcinoma"
Susanna M. Walsh, MD; Michael Jones, MD; Hector Tarraza, MD
Maine Medical Center, Portland

Third Prize: "Salpingo-Oophorectomy Following Previous Hysterectomy: Clinical, Surgical and Pathologic Findings"
John C. Jennings, MD; Jay Moodley, MD; Robert Chin, MS
University of Texas Medical Branch, Galveston

ACOG ANNUAL AUDIOVISUAL AWARDS
For the highest-caliber films

ACOG-Davis and Geck Film Festival Award
"Management of Multiple Gestation"
Frank A. Chervenak, MD, New York, NY

Committee on Scientific Program Film Awards
"Office Laparoscopy (Optical Catheter) and Laparoscopic Presacral Neurectomy Techniques"
Joseph R. Feste, MD, Houston, TX

"Shoulder Dystocia Drill"
William W. Young, MD; Joan Crane Barthold, MD; Michelle Dion, RNC, BS; Eileen Kirk, MD; Deborah Piper, CHM, MPH; Mindy Schorr, CNM; Lebanon, NH

This Patient Education Pamphlet was developed under the direction of the Committee on Patient Education of the American College of Obstetricians and Gynecologists. Designed as an aid to patients, it sets forth current information and opinions on subjects related to women's health. The information in this pamphlet does not dictate an exclusive course of treatment or procedure to be followed and should not be construed as excluding other acceptable methods of practice. Variations taking into account the needs of the individual patient, resources, and limitations unique to the institution or type of practice may be appropriate.

The American College of Obstetricians and Gynecologists
409 12th Street, SW
Washington, DC 20024-2188

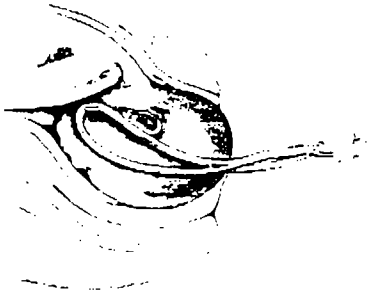
12345/87654

thetic. This is called an ***episiotomy***. It is one of the most common operations in the United States.

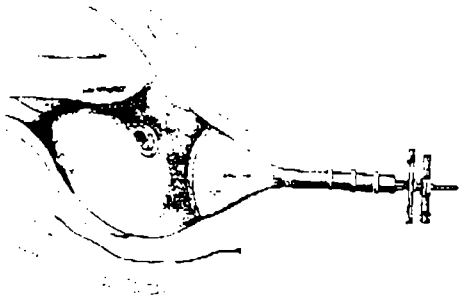
Sometimes the doctor needs to help delivery along. In these cases, forceps or vacuum cups can be used.

A forceps looks like two large spoons. The doctor puts the forceps into the vagina, places it around the baby's head, and gently delivers the baby.

Vacuum cups can be used instead of forceps. In this method, a plastic cup is attached to the baby's head by using a vacuum pump. The baby is gently pulled from the vagina.



Delivery may be assisted with forceps (above) or vacuum cups (below).



Cesarean Delivery

In some cases, a cesarean birth may be needed. Cesarean birth is delivery of the baby through a cut made in the abdomen and uterus.

Sometimes the decision to have a cesarean birth can be made before labor begins for several reasons:

- The position of the fetus in the uterus makes it difficult to come through the vagina.
- A woman may have a medical condition that would make it harmful for her to go through labor.
- A certain type of cut was used to deliver the baby in a past cesarean birth.

Sometimes a cesarean birth may be needed if labor is not going well. The baby may be too large for vaginal delivery. Sometimes, opening of the cervix may be slow or incomplete. Some babies have a problem coping with the stress of labor. The fetus's heart rate may drop or slow for a long time. Cesarean birth may also be needed because of a problem for the woman, such as heavy bleeding.

At one time, it was thought that once a woman had a cesarean birth, she would have to give birth the same way in any later pregnancies. Today, though, most women who have had cesarean births are being urged to try to give birth through the vagina. Most of these women have vaginal births with no problem.

Postpartum

Right After Delivery

After delivery you will be watched closely to be sure that there are no problems. Your temperature, pulse, breathing, and blood pressure will be checked often. During this time, you can begin getting to know your new baby.

Unless you or your baby are having medical problems, you will be able to hold the baby. If you had planned to breast-feed, you may be able to start now. It

is good for you and your partner to look at, hold, and talk to your baby just after birth.

Hospital Stay

Most women spend about 1 - 2 days in the hospital after a vaginal birth. If you had a cesarean birth, or if problems occur, you will likely stay longer.

Hospitals vary greatly on visitor rules. Some allow only the baby's father and grandparents to visit. Many also will allow brothers and sisters to see the new baby. Others may let anyone visit. You may choose not to have visitors for a while. This gives you more time to rest and to learn about your baby.

Help may be available to teach you some of the beginning skills of being a parent. You may learn about feeding, bathing, and changing the baby. This can help you to feel more comfortable in the way you handle your newborn.

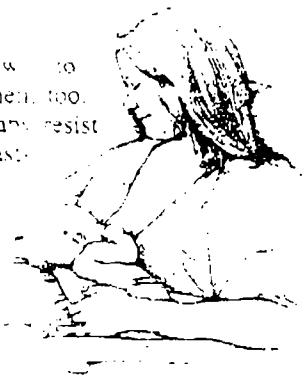
Before you go home your baby may begin to get vaccines. They protect against diseases like rubella and hepatitis. Be sure you know what shots your baby should receive, and when.

Car Safety Seats

Plan to bring your baby home from the hospital in a special safety seat. Child safety seats and belts decrease the chances of an injury in an accident by over 80%. Because of this, these seats are required by law. Check with your doctor, hospital, car dealer, baby stores, or local consumer safety group about buying or renting one before you go into the hospital. Be sure the seat is approved for use by newborns.

Breast-Feeding

Breast-feeding is the best way to feed newborns. It protects them, too. Mother's milk helps the baby resist disease and allergies. Breast-feeding is also more convenient and cheaper than bottle-feeding. It can form a bond between mother and baby.



Don't be upset if nursing is not easy right away. Both you and the baby need to get comfortable. If the baby calms down after nursing, makes urine, and is growing, he or she is getting enough milk.

Some women supplement breast-feeding with bottle-feeding. Once breast-feeding is established (a few weeks after birth), you can keep producing breast milk by breast-feeding the baby at least twice a day.

If you are breast-feeding, you will have special nutrition and calorie needs. Now is not the time to try to lose weight. You need food for your own body plus extra food to produce milk for your baby. This means you need about 500 more calories a day than before pregnancy. This is about 200 more calories than you needed during pregnancy. It is easy to add the extra food you need if you are already eating a healthy diet.

Calcium is very important for nursing mothers. It is found in milk used as a drink or in cooking. Yogurt, cheese, cottage cheese, and ice milk are other good sources. If you do not like milk products or if they make you sick, your doctor can suggest other sources of calcium. Tobacco, alcohol, and other drugs can hurt the baby if you breast-feed. If you smoke, drink alcohol, or take drugs, be sure to discuss this with your doctor. Do not smoke around the baby.

Breast-feeding may not be for all women. Many factors are involved in each woman's decision: life style, desire, attitude, time, and support. Even breast-feeding only for a few weeks has health benefits for the baby.

Discomforts

During your first days after birth, you may feel uncomfortable at times. These discomforts are common and often don't last long.

Afterbirth Pains. The uterus contracts and relaxes as it begins to return to normal. This can cause afterbirth pains. These pains may be increased by breast-feeding. The contractions usually are mild with first babies. They are stronger with the next babies. They last only a few days. To feel more comfortable:

- Change your position.
- Lie with a pillow under your abdomen.

- Empty your bladder often.
- Take medication if prescribed by your doctor.

Breast Swelling. Your breasts may be full and hurt a bit about 2–4 days after delivery. Wearing a well-fitting support bra will help. If you are not breast-feeding, ice packs may also be used. Some doctors may give medication that keeps milk from being produced. Do not stimulate or pump your breasts. This will only make the problem worse. The discomfort will go away in about 3 days.

Constipation. Constipation may still be a problem after you give birth. An episiotomy or hemorrhoids may make a bowel movement painful. A diet high in fiber and plenty of water, milk, and juices—such as prune juice—can help.

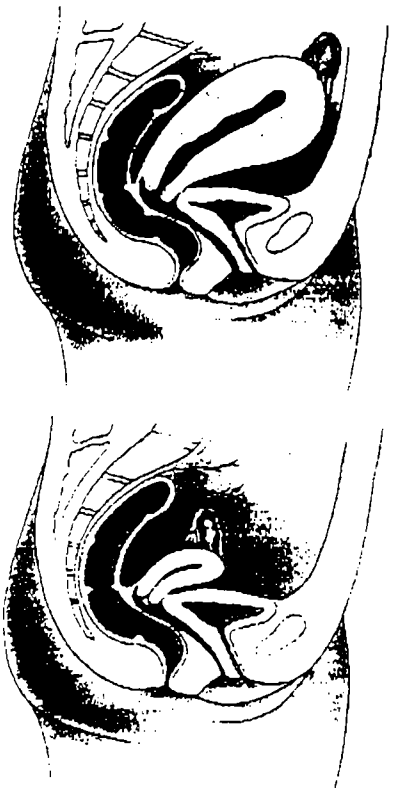
Episiotomy. Use of cold packs right after delivery can help ease discomfort. Later, heat can also make you more comfortable and help you heal. Either a heat lamp or warm sitz baths (sitting for a short time in warm water) can help. You will be taught how to clean this area very carefully to help prevent infection.

Hemorrhoids. Hemorrhoids can stick out or swell and hurt during pregnancy, labor, and delivery. Sprays, creams, and dry or wet heat (as for the episiotomy) provide some relief. Witch hazel compresses are also very soothing. The hemorrhoids will gradually shrink and may possibly disappear.

Physical Changes

While you were pregnant, changes in your body and the growth of the fetus took place over 40 weeks. Now that your baby has been born, your body goes back to its usual state much more quickly. Many changes begin right after delivery. Following are some of the changes that may be happening to you.

Abdomen. After delivery, your cervix is still open and stretched. In the first week, the size of its opening will be about the size of a dime. Your uterus is still hard and round. It can be felt around your navel and weighs about 2½ pounds. In 6 weeks, it will weigh only 2 ounces. It will no longer be felt by pressing on your abdomen. But,



Just after birth, the uterus measures about 7 inches long and weighs about 2 pounds (top). It can be felt just below the navel. In 6 weeks (bottom), it has returned to its normal size of about 3 inches long, weighing about 2 ounces.

it will take some time for the stretched abdomen muscles to become tight again. Doing simple exercises will help. You may tend to get a backache until the abdominal muscles tighten up and once again help your back muscles to keep an erect posture.

Hair Loss. A few weeks after delivery, you may find that you are losing large amounts of hair. This is not unusual. Your hair will soon return to its normal growth cycle.

Lochia. After delivery, you will have a vaginal discharge. This is called lochia. It is made mostly of blood and what is left of the uterine lining that was needed during the pregnancy. For the first few days, the discharge is bright red. After 2 or 3 days, it becomes pinker and decreases in amount. In about 10 days or so, the discharge changes to a white or yellow color. It gradually decreases until the flow has stopped. (Some women, however, may have a brief period of increased bleeding 7–10 days after delivery.) The length of time the discharge lasts is different for each woman. Do not use tampons while the flow is heavy.

Menstrual Periods. Your menstrual periods will usually return 7–9 weeks after delivery. They may be shorter or longer than before. Gradually, they will return to what is normal for you. If you are breast-feeding, your periods may not return for several months, maybe not until you stop breast-feeding. Your ovaries may begin to function soon after delivery, though. You can become pregnant even if you do not have a period, so you should use some form of birth control.

Warning Signs

Watch for any odd changes in your health. Call your doctor if you notice any of the following:

- Fever over 100.4°F (38°C)
- Nausea and vomiting
- Painful urination, burning, and urgency (sudden, strong need to urinate)
- Bleeding heavier than your normal period
- Pain, swelling, and tenderness in the legs
- Chest pain and cough
- Hot, tender breast
- Pain between the vagina and rectum that gets worse with time

Emotional Changes

After the first week or so, you may begin to notice mood changes. Changes in hormones, being tired, and feeling overwhelmed with all the new responsibilities can make you feel depressed. This is called postpartum or baby blues. These are normal feelings that will go away in a few weeks. Some women, though, develop a more serious condition called postpartum depression. If the blues last longer than 2 weeks or if they seem serious, you should discuss them with your doctor and take steps right away to get the support and help you need.

Sex and Birth Control

You can usually have sex again when everything, including your episiotomy, is healed and you feel comfortable. This usually takes about 3–4 weeks. You may need to use some type of lubrication, especially if you are breast-feeding.

You can get pregnant even if you are breast-feeding or your periods have not yet started. This means that you need to choose some form of birth control before you have sex for the first time.

Discuss birth control options with your partner and doctor. Choose a method that meets your needs:

- Birth control pills
- Contraceptive implants
- Contraceptive injections
- Intrauterine device (IUD)
- Barrier methods
  - — Diaphragm
  - — Cervical cup
  - — Condom
  - — Female condom
  - — Vaginal sponge
  - — Spermicidal cream, jelly, foam
- Periodic abstinence (also called natural family planning)
- Sterilization
  - —Male (vasectomy)
  - —Female (tubal ligation)

Keeping Healthy

Getting enough rest is one of the most important things to do—and often the hardest. Try to nap when the baby does, even if it means not doing something else. You may need help around the house so that you do not become too tired. Ask your partner, a friend, or a relative to take over some chores, such as laundry, dishes, or meals, until you are back on your feet.

You may weigh a few more pounds than you did before pregnancy. Good eating habits and exercise will help you regain your shape and lose weight gradually. Cut calories from junk foods, not from basic nutrients. Drink plenty of fluids. If you are breast-feeding, you need even more calories than when you were pregnant. Do not try to lose weight until you stop breast-feeding.

Exercise can help you get your muscles get back in shape. Easy exercises can be done as soon as 24 hours after delivery. Harder exercises are started later. If you had a cesarean birth, talk to your doctor or nurse before you start to exercise. As always, exercise must be started slowly and increased gradually. Your doctor may suggest some exercises or you may learn some in a childbirth class.

Finally...

You can improve your chances of having a healthy baby by leading a healthy life style during pregnancy and getting proper prenatal care. Learn as much as you can before the birth of your baby. Know your own body and what to expect during pregnancy, labor, and delivery.

Glossary

Amniotic Sac: Fluid-filled sac in the woman's uterus in which the fetus develops.

Areola: The darker skin around the nipple.

Birth Control (Contraception): Method to prevent pregnancy.

Cervix: The lower, narrow end of the uterus.

Chloasma: The darkening of areas of skin on the face during pregnancy.

Down Syndrome: A genetic disorder caused by the presence of an extra chromosome and characterized by mental retardation, abnormal features of the face, and medical problems such as heart defects.

Episiotomy: A surgical incision made into the perineum (the region between the vagina and the anus) to widen the vaginal opening for delivery.

Fallopian Tubes: Tubes through which an egg travels from the ovary to the uterus.

Fetus: A baby growing in the woman's uterus.

Hormones: Substances produced by the body to control the functions of various organs.

Induced Abortion: The planned termination of a pregnancy before the fetus can survive outside the uterus.

Miscarriage: The spontaneous loss of a pregnancy before the fetus can survive outside the uterus.

Neural Tube Defect (NTD): A fetal birth defect that results from improper development of the brain, spinal cord, or their coverings.

Nutrients: Nourishing substances supplied through food, such as vitamins and minerals.

Obstetrician–Gynecologist: A physician with special skills, training, and education in women's health. The initials FACOG mean that he or she is a Fellow of the American College of Obstetricians and Gynecologists.

Ovaries: Two glands, located on either side of the uterus, that contain the eggs released at ovulation and produce hormones.

Placenta: Tissue that connects woman and fetus and provides nourishment to and takes away waste from the fetus.

Uterus: A muscular organ that is located in the female abdomen and contains and nourishes the developing embryo and fetus during pregnancy.

Vagina: A passageway surrounded by muscles leading from the uterus to the outside of the body.

Jen -
This is the
one other
wrote the
New Yorker (newsgroup?)
health care
epitaph
Pam

The Washington Times
TUESDAY, OCTOBER 24, 1995 ★

Don't send babies home so soon

By Betsy McCaughey

If you're expecting a child or a grandchild, beware of the danger ahead.

In 1970, the average hospital stay for mother and newborn, after a normal delivery, was four days. By 1992, it had been cut to two days. Now, one day is the rule, as insurers intercede aggressively to slash hospital time and costs, and some health maintenance organizations (HMOs) are ordering mother and baby out after eight hours. Women in labor are being told to wait in the hospital parking lot, as long as they can bear it, so that the clock doesn't start ticking on the hospital stay their HMOs allow.

The danger is to your baby. Early discharge means infants are sent out of the hospital nursery before the doctor can be sure they are healthy. Doctors used to spot congenital heart defects, jaundice, dehydration and streptococcal infections during a newborn's second or third day in the nursery. Detection on the first day often isn't possible. Now, by day two, babies and mothers are out of the hospital and on their own when the symptoms finally appear.

"You don't catch the babies who need help," worries Dr. Rita Harper, chief of neonatology at Northshore University Hospital in Manhasset, N.Y. Dr. Harper knows that before the days of early discharge, almost 9 percent of the newborns moved into intensive care from the well baby nursery were transferred during their second day of life. Their need was not apparent until the second day. Now, babies are out of the hospital by the second day.

Dr. Augusto Sola, professor of pediatrics at the University of California, San Francisco, is heartsick over the consequences. Since early discharge took hold in California in 1992, he has seen six otherwise healthy, full-term newborns rushed to his neonatal intensive care unit with permanent brain damage due to severe jaundice (bilirubin encephalopathy).

Medical science had virtually eliminated this tragedy two decades ago, because doctors were able to diagnose jaundice, usually in the second or third day of life, and treat it with special lights to stop the damage. Surveying data from all the hospitals in California, he found that in 1992 alone, nine full-term newborns discharged early as healthy suffered irreversible brain damage because of severe jaundice.

Mental retardation is also a small, but serious risk. For decades states have required that all newborns be given a simple test for PKU, a metabolic disorder that can cause lifelong mental retardation if it is not treated soon after birth. In the 1940s, 1 percent of all people in institutions for the retarded in the

U.S. had PKU. "Preventing the mental retardation that goes along with PKU has been a major success story," says Dr. Harry Ostrer, Director of Human Genetics at NYU Medical Center. "Now kids are falling through the cracks," for the first time in decades, and the culprit is early discharge.

For screening to be reliable, babies must be older than one day and younger than 21 days. In Maryland last year, one third of babies were taken from the hospital too young for an accurate screening, 18 percent of these babies were never brought back for retesting, and many others were brought back too late for a reliable test. Dr. Ostrer calls the lapse in newborn screening "a major source of alarm."

The American College of Obstetricians and Gynecologists recently cautioned that early discharge is "a large, uncontrolled, uninformed experiment." Imposing an experimental practice, such as early discharge, on new parents without their informed consent is "highly unethical," Dr. Sola explained at a recent Senate hearing. There have been no clinical trials to evaluate the risk of early discharge.

Last spring the American Medical Association called for a moratorium until the risks are known. Insurers balked, but hospitals from St. Louis to New Rochelle, New York and Greenwich, Conn., acted to put patients ahead of profits, announcing that women and newborns can spend the second day free, if insurers won't pay. The irony is that highly profitable HMOs are reaping millions, while publicly supported hospitals are picking up the tab.

People around the world are striving to curb health care costs, but in the United States newborns are bearing the brunt. Not so in Canada, Japan, Great Britain or Germany where hospital stays after birth average from 2.5 to 7 days. These countries control health consumption far more aggressively than the United States, but even they draw the line at discharging newborns too early.

New Jersey, Rhode Island, North Carolina and Maryland have changed their insurance laws to require 48-hour coverage for normal births and extended coverage for difficult and Caesarean births. Recently, New York's Gov. George Pataki announced support for similar legislation, and other states are following. If babies in these states deserve a safe start for the first 48 hours of life, how can it be that babies in all 50 states don't deserve it?

Insurers across the nation should support the federal Newborns and Mothers Health Protection Act of 1995. This bill, introduced by Sens. Nancy Kassebaum and Bill Bradley requires insurers to provide coverage for a 48-hour hospital stay for normal births. The goal is to ensure that doctors and their patients, not the insurance company, decide when it is safe to leave the hospital. Democrats and Republicans in the House of Representatives have introduced several similar bills. Partisanship is taking a back seat to the safety of our youngest children. Federal action is also needed to safeguard families whose health coverage would not be affected by state legislation due to the Employee Retirement Income Security Act (ERISA).

The Newborns and Mothers Health Protection Act will help make sure that your next child or grandchild has a safe start for the first two days of life. Only insurance companies are against it.

Betsy McCaughey is lieutenant governor of New York State.

FOCUS

THE BOSTON SUNDAY GLOBE • JULY 2, 1995

HEALTH CARE

Braking the OB Express

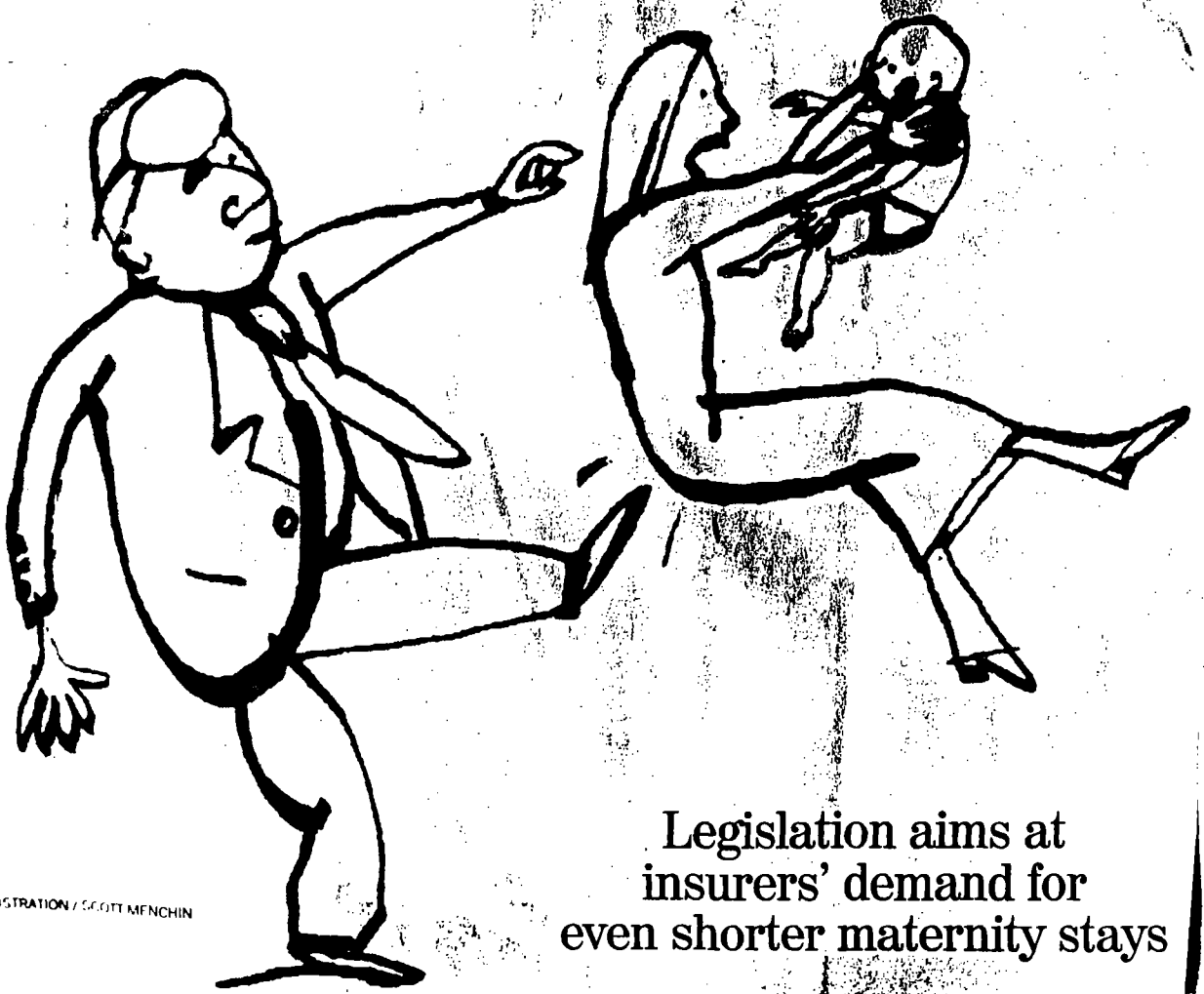


ILLUSTRATION / SCOTT MENCHIN

Legislation aims at insurers' demand for even shorter maternity stays

Putting the brakes on the OB Express

BY SUZANNE GORDON

The quintessential women's health issue – childbirth – is quickly becoming the rallying point for one of the toughest challenges yet to insurance industry control over patient care.

New mothers, tired of being rushed out of hospitals with their newborns as soon as 12 hours after giving birth, have joined health activists, nurses and doctors in demanding that insurers end the practice.

They say that "drive-through delivery" and the "OB Express" – imposed by insurers in the name of cost-cutting – must stop. In recent days and weeks, their efforts have begun paying off on several fronts:

New Jersey Gov. Christine Todd Whitman signed into law Wednesday a bill allowing new mothers to stay in the hospital for 48 hours after a normal delivery, double the previously allowed time. And, in this era of managed care, a nearly revolutionary provision allows women and their doctors to determine when a longer than 24-hour stay in the hospital is medically necessary.

The New Jersey bill follows a similar measure enacted in April in Maryland. On the home front, it inspired two Massachusetts lawmakers to introduce an even stronger version on Beacon Hill last week.

Meanwhile, on Capitol Hill, the issue made its debut last week as an influential Republican, Sen. Nancy Kassebaum of Kansas, teamed up with an influential Democrat, Sen. Bill Bradley of New Jersey, and introduced legislation ending "drive-through delivery" by allowing a 48-hour hospital stay for new mothers who desire it.

And two weeks ago, the American Medical Association's annual policy-making body endorsed this growing consumer revolt in a strongly worded attack on insurance policies that place "economic considerations" above medical ones.

All together, the actions of those opposed t the "OB Express" add up to a broad challenge to insurance companies' ability to dictate not only the terms of patient care but also the practice of medicine and nursing. It represents a new effort to roll back "managed care," the phrase used to describe insurance companies' micromanagement of every aspect of health care, from which doctor a patient may choose t how long a patient may stay in the hospital. Critics say a better route to cost-cutting would

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Suzanne Gordon is a free-lance writer based in Arlington. She is the author of several books and is writing a book on nursing.

■ CHILDBIRTH
Continued from Page 57

be a more fundamental overhaul of the health care system.

The challenge was sparked by insurers' recent practice of radically limiting hospital stays for women having babies – the most frequent cause of hospitalization in the United States.

As recently as 1970, women stayed an average of almost four days in the hospital after delivery, unless it was by Caesarean section. By 1992, the median length of stay was about half that, or just over two days. In the last three years, it's been almost halved again, as insurance companies and health maintenance organizations have routinely imposed the one-day limit for normal deliveries, unless an extended stay is deemed "medically necessary."

In some states, such as California, insurers send maternity patients home as shortly as 6 hours after a normal delivery. In all states, a longer stay, such as three days, is allowed after delivery by Caesarean section.

Insurers have argued that besides cutting costs, limiting hospital stays for newborns has a health benefit: It's not good, they say, to expose babies to the germs that necessarily are present in a hospital. Thus it makes sense, they say, to limit hospital stays to 24 hours or less – in California, it's sometimes held be- 6 12 hours – for women who have a rmal delivery.

But for some families, taking home a baby less than a day old has had tragic consequences. For New Jersey lawmakers, it was the wrenching testimony of mothers and family members that most powerfully translated the real costs of managed care. Dominick A. Ruggiero Jr., 62, a retired bus driver, described how his 2-day-old niece died from a massive, treatable infection.

The baby's insurer was US Health Care, a national HMO that reportedly spends less on actual care than any other company – 72.9 cents of every dollar rather than 78 – yet pays its chief executive $9.8 million a year. According to Ruggiero, US Health Care told Michelle Bauman that she and her 24-hour-old baby, Michelina, would have to leave the hospital. The night of her discharge, the baby became increasingly uncomfortable. The next day, their US Health Care nurse was supposed to arrive for a follow-up visit, Ruggiero testified, but she neither called nor came to the Bauman home. Alarmed by the baby's condition, the Baumans repeatedly telephoned their US Health Care pediatrician. Absent any examination, he declared, Ruggiero said, that the baby's discomfort was "normal." Michelina Bauman, 2 days old, died at 5:30 p.m.

"As far as I'm concerned," Ruggiero said, "her death certificate should read: killed by

the health care system."

Ruggiero's account helped convince New Jersey lawmakers to join in a bipartisan effort to extend hospital stays for new mothers. The battle began there last year, when two legislators introduced a bill to regulate the "OB Express." For want of public and legislative support, the bill languished until veteran Assemblywoman Rose Heck, a Republican who chairs the Assembly Advisory Council's Women's Health Group, held a hearing on women's health.

According to Myra Terry, president of the New Jersey chapter of the National Organization for Women, the hearing was the opening many women's health activists had been waiting for. NOW and other groups used the event to raise public and legislative consciousness about what it's like to ride the OB Express.

"Insurers say that a mother and newborn can stay in the hospital for 48 or 96 hours if it's medically necessary," Dr. Holly Roberts, an obstetrician, explained. But to insurers, Roberts said, "medically necessary" only seems to apply when a woman is hemorrhaging or has a high fever. "The fact that a woman has just fainted in the bathroom; that she [illegible] a rip from her vagina to her rectum and can barely walk; or is a single mom and has no help at home, none of that matters," Roberts said angrily.

Heck said she was deeply shocked by what she learned at the hearing. "The happiest day of a woman's life was being turned into a nightmare. We felt completely incensed and that we had to move quickly," she said.

The Massachusetts legislation, just introduced by Sen. Lois Pines of Newton and Rep. Harriet Chandler of Worcester, both Democrats, is stronger than the New Jersey law. It would automatically guarantee mothers a 48- or 96-hour hospital stay. It also allows women and their doctors to decide what is medically necessary. If neither asks for a longer stay, insurers may provide less time in the hospital if they offer mothers and babies specific in-home services, including three visits by a nurse.

"I believe that the insurance industry's policies of drive-through deliveries are undermining the health and well-being of infants and their mothers," Pines said.

Many doctors agree, and resent what some call economic blackmail by insurers. "We're all under enormous pressure to get patients out of the hospital," Roberts said.

She said that recently a representative of one of the largest HMOs in her area appeared in her office. He bluntly informed her that she would be eliminated from the HMO network if she didn't get her patients out of the hospital more quickly. The message, Roberts said, was clear: It's either you or your patients.

The New York Times DATE JUN 29 '95

New Mothers Gain 2d Day In Hospital

Whitman Signs a Bill To Fight Curbs on Care

By JON NORDHEIMER

TEANECK, N.J., June 28 — Gov. Christine Todd Whitman came to Holy Name Hospital today to sign a bill requiring insurers to pay for a second day of hospital care for mothers and their newborns, making the state the second in the nation to regulate what critics have called "drive-through deliveries."

It was the latest result of the growing public backlash against the decision by health maintenance organizations to cover only 24 hours of hospital care after normal births. A decade ago, most women and their infants remained in a hospital for three or four days for rest, observation and tests.

Pressure for political action is spreading. On Tuesday, Senator Bill Bradley, Democrat of New Jersey, filed a bill to make 48-hour maternity stays the national minimum. But the medical world is divided on when discharge is safe and practical. Several physicians' groups, including the American College of Obstetricians and Gynecologists, have recently called for curtailment of early discharge until more hard research is collected on the safety issue.

"The plain facts are no one knows exactly what is happening," said Rachel M. Schwartz, director of research for the Perinatal Information Center in Providence, R.I. "Early discharge has happened so quickly, the community of payers has gotten ahead of clinicians and everyone is now scrambling to play catch-up with the facts,'

Dr. Ciro V. Sumaya, head of the Federal Health Resources and Services Administration in Washington, said he will soon seek approval to develop a more comprehensive investigation into problems associated with shortened stays, especially incomplete screenings of babies to detect genetic diseases, breast feeding difficulties and inadequate follow-up care at home.

"This issue is moving very fast and all we have to work with is anecdotal information that point to potential problems," Dr. Sumaya said in a telephone interview.

After visiting the maternity ward here, Mrs. Whitman spoke to a crowd of about 200 physicians, politicians, parents and stomping and crying children. "I have two children — one by C-section — and I know that 24 hours is not enough," she said, adding that the bill uses "common sense to give women a chance to recover and babies a chance to get a good head start."

A woman discharged too early after birth, she continued, "is going to come back to the hospital time and time again with more serious problems."

Last month, Maryland became the first state to extend the 24-hour stay to two days. But the New Jersey law is the first to give a mother, not her physician, the final say on whether to stay one or two days. Sponsors of the bill said they added that clause because it was felt H.M.O. physicians labored under too much pressure to cut costs.

In addition to the 48 hours for routine births, the bill, which becomes effective immediately, extends the minimum insurance-financed hospital stay to 96 hours after a Cesarean section.

The bill provides that a one-day hospital stay is sufficient if an insurer covers three visits by a registered nurse to a family's home. A single day in a hospital may cost $1,000; three home visits by a nurse may be half that sum, medical officials said.

Proponents of the new laws tell of babies dying shortly after returning home from one-day hospital stays. A case often cited is the death last month of Michelina Alanna Bauman, who succumbed to a strep infection two days after birth and a day after her mother brought her home from a Gloucester County Hospital.

Insurers counter that these are rare incidents in an otherwise safe process, and point to available studies that indicate there has not been an increased in the readmission of mothers and babies after early discharge.

Critics point out, however, that these studies were limited in scope and dealt chiefly with middle-class women who chose to leave the hospital and had help at home from family, friends or medical professionals.

"The essential ingredient is an appropriate support system once a mom and newborn check out of a hospital," said Robert A. Knuppel, chairman of the obstetrics and gynecology department at Robert Wood Johnson Medical School in New Brunswick. "If discharge is only after eight hours, it can be done if proper support is there."

Dr. Knuppel said that a second night in the hospital is particularly helpful to first-time mothers and those from disadvantaged homes whose babies run a disproportionate risk of being readmitted with medical problems days after discharge. "The mother's stay in the hospital may be the only access she has to this information," he said.

Elaine Deigmann, director of nurse midwifery program at the School of Health Related Professions in Newark, agreed. "A 14-year old inner city mother from an unstable home environment — how can you think about sending someone like that home without a lot of help?"

Until today, Medicaid patients stood a better chance of getting an extended maternity stay than those covered by many health maintenance organizations, Dr. David Butler, chief of obstetrics and gynecology at Holy Name, said. The hospital was chosen for the bill signing because it was the site of a rally against early discharge in March rally.

Dr. Knuppel and others said a 48-hour hospital stay is no magic answer. Jaundice, a problem for some newborns, is usually not observable until 72 hours, they pointed out, and dehydration caused by breast feeding difficulties may not be observable until after the third day, when a mother's milk becomes abundant. For these reasons, they added, nursing care at home over a three-day period may be preferable to two hospital days if mother and child are healthy enough to go home after 24 hours.

Managed care companies say they are as interested as parents in preventing complications that return discharged patients to expensive hospital care. "But these decisions shouldn't be made on a cookie-cutter basis by legislators," said Susan Pisano, director of communications for Group Health Association of America, a trade group for health maintenance organizations. "There are times when health care can be provided safely and more appropriately in the home."

Whitman joins the fight against 'drive-through deliveries' in maternity cases.

Biotechnology Gets a Boost

TRENTON A bill intended to stimulate the development and expansion of biotechnology and other high-tech industries in New Jersey was signed into law yesterday. The bill authorizes the State Economic Development Authority to establish a financial assistance program for new and growing companies that are often considered too high-risk to meet the agency's criteria for loans, said State Senator Robert W. Singer, a Republican of Ocean County and one of the bill's sponsors. "This is a response to where we felt we were going as a state as to future jobs," Senator Singer said.

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The New York Times
NEW JERSEY WEEKLY
SUNDAY, MARCH 5, 1995
Section 13

Physicians Protest Maternity Insurance

By JACQUELINE SHAHEEN

As more and more insurance plans in the state limit coverage for uncomplicated deliveries to 24 hours, new mothers and their babies are spending less and less time in the hospital — and protests are mounting from women's groups and physicians.

The New Jersey chapter of the American Academy of Pediatrics, opposing the so-called 24-hours-and-out policy, recently issued guidelines for the hospital care and discharge of newborns, emphasizing the variety of conditions that should be met before a newborn is allowed to leave.

The Medical Society of New Jersey, the New Jersey Obstetrics and Gynecology Society and the New Jersey Pediatric Society have also criticized the insurers' policy. In December, representatives of some of these groups met with officials of the State Department of Health to air their concerns.

And members of the Assembly Insurance Committee are studying a bill, introduced last fall by the Assembly minority leader, Joseph V. Doria Jr., Democrat of Bayonne, and the Assembly Speaker, Chuck Haytaian, Republican of Hackensack, that would require a 48-hour stay for a normal delivery.

Critics say a 24-hour hospital policy can be unsafe.

Critics of the 24-hour policy say women need more than 24 hours to recuperate from giving birth and to learn how to breast-feed and care for their babies under the supervision of the nursing staff. They say that because of the shortened stay, babies may not receive the nourishment they need or may not have their health problems diagnosed at an early stage.

Critics also point to side effects of the policy. In some cases, for example, the mother may be ill enough to receive coverage beyond 24 hours, but her healthy baby is not eligible, so mother and baby are separated.

Insurance companies and health maintenance organizations contend that reducing the stay for healthy mothers and babies to 24 hours from 48 hours or longer is safe and appropriate for routine deliveries. Individual hospitals and the State Department of Health say they have not seen a significant rise in complaints as a result of early discharge. Both the insurance companies and the hospitals have introduced or expanded programs to help new mothers after they leave the hospital.

But Myra Terry, the president of the National Organization for Women of New Jersey, said the organization had received a flood of calls from women and

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Physicians Protes : Materr i :y Insurance

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physicians upset about the 24-hours-and-out practice. Women's health concerns, she said, "seem to be the ones that are very often the first ones to be compromised."

At a Feb. 23 meeting with obstetricians and pediatricians, the organization decided to turn up the heat on legislators to pass the 48-hour bill. "We can mobilize women who feel isolated and don't know where to complain," Ms. Terry said. As part of that effort, NOW plans to publish a pamphlet about 24-hour discharge to be distributed by obstetricians and other health providers.

The guidelines issued by the state chapter of the Pediatrics Academy say that "the length of stay is unique for each infant and is dependent on the health of the mother and infant, the ability and the comfort of the mother in caring for the infant, the adequacy of support at home, the access to follow-up care and the competency of the infant."

Dr. Michael A. Graff, the chairman of the chapter's Committee on Fetus and Newborn, said: "What I'm hoping is that the physicians abide by the chapter's policy and therefore convince the insurance companies not to put financial restraints on them to discharge the infants earlier. My biggest concern about early discharge is that the newborns have not had sufficient time to be properly evaluated and to go through the transition of being in the womb and out of the womb."

Dr. Anthony P. Caggiano, president of the New Jersey Obstetrics and Gynecology Society and president-elect of the Medical Society of New Jersey, said first-time mothers, in particular, were often not ready to go home in 24 hours. After a long, grueling labor, they are tired, dehydrated and sore and may not have had a bowel movement or be urinating well, he said.

"A lot of them, their breast milk isn't in, they haven't been instructed in how to feed the baby, they haven't even related with the baby," Dr. Caggiano said. "We think it's very important that in those first 48 hours that the nursery nurses and the floor nurses work with the new mothers and help them acclimate and bond to their new child."

In general, physicians complain that their ability to property treat their patients is limited by the 24-hour policy. Insurance companies and H.M.O.'s point out that they will pay for a longer stay if there is a valid medical reason, but doctors say the process of convincing insurance companies can be frustrating and time-consuming. And in the end, Dr. Caggiano said, the decision is very likely to be made by a nurse or a physician with no experience in obstetrics.

Some women are eager to be discharged, and that's fine, said Dr. Ruth J. Schulze, an obstetrician-gynecologist in Ridgewood. "If they feel comfortable and they choose to go home, I say terrific," she said. "What I'm saying is they should have the option to stay. I've had women standing at the nursing desk, crying that they don't know what to do, do they have to go."

Doctors say babies are more likely than their mothers to suffer problems as a result of early dischange. If the mother does not know how to breast-feed properly, the baby may not get enough to eat and may become dehydrated. Severe degydration can cause a stroke.

Moreover, first-time mothers especially may not pick up the early signs of jaundice, a symptom of a condition called hyperbilirubinemia. The condition, which affects a relatively small number of newborns, can cause impaired hearing and brain damage.

"What's happening is that the jaundice appears after the child is out of the hospital, and the inexperienced mother may not recognize it immediately," said Dr. Seymour Charles, a pediatrician in Maplewood who is the chairman of the New Jersey Pediatric Society's insurance committee. One such mother delayed bringing her baby to his office for a week. By then, Dr. Charles said, "it was a heroic thing to save the baby's life."

Doctors are also concerned about the impact of early discharge on state-mandated tests for disorders like phenylketonuria, or PKU as it is known, which can cause mental retardation. The tests, which are done before dishcarge, are most accurate more than 24 hours after the baby's first feeding. By then, many babies have gone home, necessitating a second test.

Cathleen Coleman, a spokeswoman for Blue Cross/Blue Shield of New Jersey, declined to comment on the physicians' concerns about 24-hour discharge. "I can say that the patients' response has been very favorable, and we've had few complaints," Ms. Coleman said.

But Susan Emanuele, the nurse manager of Lifestarts, a home care program for members of the New Brunswick-based H.I.P. Health Plan of New Jersey, said the physicians' concerns are "valid" if home health care is not provided after discharge.

H.I.P., like a growing number of plans, provides such care in lieu of an extra day or two in the hospital. It dispatches a registered nurse with experience in maternal-newborn care within 48 hours of discharge for a three-hour visit. The nurse examines the baby and the mother. Much of the nurse's time, Mrs. Emanuele said, is spent teaching the mother about breast-feeding and other aspects of infant care.

Women learn more in the relaxed atmosphere of home than they do amid the hubbub of the hospital, said Mrs. Emanuele, a former nursery nurse at the Medical Center at Princeton. It is also much easier to provide personalized instruction there than on the maternity floor, where the demands on a nurse's time are great, she said.

Mrs. Emanuele said that in 1994 the readmission rate for mothers and babies in the Lifestarts program was less than .01 percent.

All Blue/Cross Blue Shield of New Jersey policies are 24-hours-and-out, said Ms. Coleman, its spokeswoman. The company offers members of its managed care plans home visits through a program called Precious Additions. But three-quarters of its 1.8 million members have traditional indemnity policies, which allow free choice of physicians and hospitals, and they are not eligible for home visits.

Some hospitals are responding to shorter maternity stays by providing home visits, keeping in contact with mothers by telephone and expanding their prenatal classes. The Somerset Medical Center in Somerville has revamped its Lamaze program to include postnatal care. "It's kind of broadened the spectrum of a class that used to be really just sitting there and learning how to breathe

Continued on Following Page

Longer Stay Needed, a Mother Says

By JACQUELINE SHAHEEN

DIANE WEBER was lucky. Her pregnancy was uneventful, and labor and delivery on a Thursday night last fall were easy and swift. Her insurance plan covered only 24 hours in the hospital, but as she was preparing to leave Friday evening, her insurer said she could stay an additional night because she had not delivered until 10 P.M.

Even so, she and her son, Luke, went home less than 36 hours after his birth. Her insurance plan did not cover home health care.

Soon the first-time mother's luck began to turn. Luke's bilirubin — a pigment formed by the body in the normal breakdown of blood cells — was abnormally high, and before Mrs. Weber was discharged she was instructed to take him back to the hospital the next day to have it checked. She was then told that a third test would be necessary the following day.

Mrs. Weber, a resident of Howell, knew little about breast-feeding, she said. During her brief hospitalization, she did not have the opportunity to meet with a lactation specialist.

At home, Luke slept a lot. "I didn't know if I should wake him up to feed him," she said. Much of the time she didn't, and Luke gradually became dehydrated.

The third test revealed that Luke's bilirubin, possibly aggravated by his dehydration, had climbed to a dangerous level. He was admitted to the neonatal intensive care unit, hooked to an IV tube and given phototherapy, a treatment with special lights that helps the body to excrete excess bilirubin.

If the bilirubin goes too high, a baby can suffer brain damage; if he becomes severely dehydrated, he can have a stroke.

Dr. Michael A. Graff, the director of the division of neonatology at the Jersey Shore Medical Center in Neptune, where Luke was treated, said that if a baby stays in the hospital longer than 24 hours after birth, dehydration and a high bilirubin are spotted and treated before they become serious because of close observation by the medical staff and frequent testing.

Mrs. Weber said: "If I had stayed an extra day or two, somebody would have realized there was a problem, and they would have been able to correct it a lot sooner and not have it get so much worse."

Luke made a full recovery, but Mrs. Weber's troubles didn't end. She blamed herself for his illness, she said, and was hospitalized for postpartum depression. ■

The Record DATE MAY 14 1995

Mothers need time to recover

By ANN TWOMEY
and MYRA TERRY

TODAY, Mother's Day, instead of candy or flowers, many new mothers are asking for breakfast in bed — a hospital bed. After the birth of their newborn, mothers want enough time to recuperate and bond with their babies, unconcerned with the bottom line of some insurance company.

Instead of fancy greeting cards, a new mother needs nursing care, evaluation, and rest. She needs the attention of nurses trained to teach a new mother how to care for and identify the needs of her newborn. Her baby needs that same observation, evaluation, and nursing care.

But that's not what mothers and infants are getting in today's changing health care delivery system. Dictated by insurance companies, hospitals are required to discharge newborns and their mothers 24 hours after delivery. Mothers who deliver at 10 p.m. on Thursday, for example, are told they must leave the hospital by 10 p.m. Friday. In some cases, mothers and newborns are separated if one is not healthy enough to go home, but the other is.

Is the bottom line of an insurance company more important than the health of our newborn children, and the well-being of their mothers? You would believe so, if you watched exhausted mothers being told their 24 hours is up, it's time to go home.

If you listened to nurses and physicians, who feel powerless to change this policy, you would know the insurance companies are now dictating our health care policies.

Health care providers, as well as mothers, know that each delivery is unique, and an infant's needs cannot be adequately determined within that 24-hour period. Many infections, in both mother and child, will not manifest themselves until 36 or 48 hours. Some state mandated testing for infant disorders such as phenylketonuria (PKU) are most accurate after 24-hours. Babies may become dehydrated, develop jaundice, or other infections not immediately noticed by a mother.

> "Twenty-four hours is a cruel deadline for women who have a difficult labor."

Twenty-four hours may be adequate time for some, but it is a cruel deadline for women who have undergone long and difficult labor, who show signs of exhaustion, are in pain, or have no prior experience in caring for a newborn. Nurses, the primary care and teaching providers, will testify that mothers need more time to learn the basics of infant care, such as nutrition, breast or bottle feeding, bathing, and the warning signs of infection or health problems.

Increasingly, nurses and physicians are telling of babies being readmitted with infections detected after the 24-hour stay, or of mothers being re-admitted due to excessive bleeding. Some managed care companies do provide limited home care follow-up, but it does not take the place of in-hospital nursing care.

The length of hospital stay for mothers and infants should not be a cookbook approach designed by corporate insurance executives. The insurance company policy is based not on medical guidelines, which recommend a stay from 48 hours for vaginal delivery to 96 hours for Caesarean birth, but on cost-containment. They are less concerned with potential dangers to mothers and babies and more concerned with profit-making. The high cost of health care is not due to newborn deliveries, and cost savings should not be achieved at the expense of our mothers and infants.

If the needs of a 1-day old infant are not enough to make us say "Stop" to dangerous and arbitrary insurance company dictates, what is? On Mother's Day, it would be the best gift the state Legislature could give.

Ann Twomey is president of Hospital Professionals and Allied Employees of New Jersey. Myra Terry is president of National Organization for Women of New Jersey.

The Record DATE MAY 14 1995

The debate over shortened maternity stays

Reason, not emotion, should guide policy

By DALE J. FLORIO

THE CURRENT debate on when it is appropriate to discharge newborns and their mothers from hospital care is an important one. Unfortunately, a number of recent statements on the subject, and the newspaper articles reporting them, have drawn unsubstantiated conclusions regarding shortened maternity stays.

Phrases like "drive-through deliveries" and assertions that babies are receiving a "medically inadequate start in life" leave the public with an incomplete and largely inaccurate impression that mothers clutching babies in their arms are being heartlessly shoved out hospital doors by cruel and greedy insurance executives.

Recently this inaccurate impression has been leading commentators to another equally inaccurate idea — that health maintenance organizations (HMOs) are the driving force behind the "denial" of adequate maternity care because of a single-minded desire to cut costs. This belief is simply untrue.

By their very nature HMOs take an active role in maintaining the health of their members. In the case of maternity patients, this means assuring that mother and baby receive all the medical care needed in the setting that is the most medically appropriate, as well as the most cost-effective. HMOs oppose legislation that would arbitrarily mandate a minimum 48-hour hospital stay without concern for the medical necessity of the mother and child. We believe that all care should be individualized, and that by following nationally accepted criteria developed by specialists, our members receive high quality health care.

While there is no question that cost considerations have played a role in the move toward 24-hour discharge of newborns, in an HMO setting the decision is still made by the attending physician, and is based on what is deemed best for the mother and child.

Many doctors find that women who deliver a normal, healthy child, at term and without complications, can leave the hospital within 24 hours. There are many reasons for this, and most have nothing to do with cost.

"Many doctors find that women who deliver a normal, healthy child at term and without complications can leave the hospital within 24 hours."

First, it must be kept in mind that the hospital is not a risk-free environment. Five out of 100 people entering a hospital suffer a "nosocomial," or hospital-acquired, infection. Birth is not an illness and healthy mothers and newborns can thrive in the comfort of their own home.

Next, evidence from medical studies indicates that mothers discharged after 24 hours report a higher rate of satisfaction with their care than those who remained in the hospital longer. Other positive factors identified in those studies include improved maternal post-partum adjustment, enhanced breast-feeding activity, and enhanced interaction between infant and father.

Third, HMOs generally require physicians to apply criteria established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics in deciding whether to discharge a new mother and child within 24 hours.

Those criteria require that:

- The course of care has been without complications.
- The mother is ready to assume the responsibility for her newborn, including feeding, skin and cord care, and the ability to assess infant well-being.
- The infant delivered at term and was of appropriate birth weight and normal upon examination.
- The infant can maintain body temperature and is able to feed.
- Laboratory data are within normal limits.
- The initial hepatitis B vaccine has been administered.
- A physician-directed source of continuing medical care is established and arrangements are made to examine the baby within 48 hours.

To meet this last criterion HMOs generally favor home visits by qualified nurses and other medical personnel to follow up on the infant's adjustment at home and to administer any necessary additional tests.

To be sure, possible risks of early discharge remain of concern to many physicians. On the other hand, the superiority of a longer hospital stay in facilitating improved outcomes has not been established. Indeed, the rates of hospital readmission for infants who were discharged in 24 hours and infants who were hospitalized longer are virtually identical.

An article in the journal Pediatrics last September reviewed all existing medical studies on early discharge and found no evidence of danger to the mother or newborn resulting from the practice.

Finally, this debate is not without economic significance.

For most populations under 65 years of age, maternity is the No. 1 reason for hospitalization: In most managed care networks, 20 percent of hospital admissions are for maternity.

In New Jersey, where hospital costs average $1,800 per day, reducing maternity stays from the traditional three days to one day would have significant consequences. Indeed, assuming a commercially insured population of 6 million people under age 65, and our current statewide Caesarean-section rate of 24 percent, such a reduction translates to savings of more than $250 million per year.

The evidence seems to indicate this savings can be achieved with no harm to patients if early discharge is appropriately handled. That being so, it is certainly a factor that legislators should consider when deciding this issue.

Dale J. Florio is legislative counsel to the New Jersey HMO Association.

The Record DATE MAY 14 1995

IN and OUT of the HOSPITAL

Examining 1-day stay for moms, newborns

By MARY JO LAYTON

AS MANAGED care becomes more prevalent and hospital costs rise, statewide medical organizations say they're hearing more and more complaints about mothers and their newborns being required to leave the hospital 24 hours after normal childbirth.

Fearful that maternal and infant health is being shortchanged, Assemblyman Joseph Doria, D-Bayonne, and Assembly Speaker Chuck Haytaian, R-Warren, have proposed legislation requiring 48 hours of hospitalization following routine deliveries. The measure was released from an Assembly committee in March.

Assemblywoman Rose Heck, R-Hasbrouck Heights, chairwoman of the Assembly Advisory Council on Women, has scheduled a hearing tomorrow at Holy Name Hospital in Teaneck to address the 24-hour discharge practice. Heck said she plans to co-sponsor the bill requiring longer hospitalization.

"This should not be an issue determined by the insurance companies," Heck said. "This is not a tooth extraction. This is a major happening in a woman's life."

Nationally, women are spending 37 percent less time in the hospital for childbirth than they did in 1970, the federal Centers for Disease Control reported earlier this month.

The average length of stay for deliveries — Caesarean and vaginal — dropped from 4.1 days to 2.6 days in 1992 and the decline hasn't stopped, the CDC said.

Insurers and health maintenance organizations (HMOs) in New Jersey say that shorter hospital stays do not compromise care as long as home health care is provided after leaving the hospital, which many insurers and hospitals are already providing.

Many patients, in fact, prefer recovering in the comfort of their own home and are more receptive to education on newborn care and breast-feeding away from the hospital setting, they say. Often, the mother's milk — the optimal nutrition for infants — does not come in until after she is discharged.

"The issue is combining hospital and home setting to provide the mother and the newborn with continuity of care," said Dale Florio, legislative counsel to the New Jersey HMO Association.

In western states, where managed care is more common, three out of four women were discharged 24 hours or less after a normal vaginal delivery in 1993, according to the Health Care Investment Analysts Inc. (HCIA). In the Northeast, 16 percent of routine deliveries had one-day stays in 1993, up from 12 percent in 1991.

Florio disputes claims that most patients covered by HMOs are discharged 24 hours after birth, even though most HMOs strive for one-day hospital stays.

"In a situation where the HMO has an after-care program, discharge 24 hours after delivery is the goal," Florio said.

In a recent internal survey of its membership, the average stay for a normal vaginal delivery was about two days, Florio said. Patients are hospitalized longer than 24 hours if it is medically necessary, Florio said.

But Myra Terry, president of the National Organization for Women of New Jersey, takes a different view: "We don't want anyone forced out of the hospital 24 hours after routine deliveries," she said. "We don't want insurance companies making crucial decisions about women's health care."

The Medical Society of New Jersey, the New Jersey Obstetrics and Gynecology Society, the state's chapter of the American Academy of Pediatrics, and the Hospital Professionals and Allied Employees of New Jersey (HPAE), which represents 6,500 nurses statewide, are gearing up to fight for longer hospital stays.

While the legislation is debated, the state Department of Health is beginning to track the effects of the earlier discharge. Some preliminary data show a problem with 24-hour discharges.

A growing number of state-mandated blood tests for disorders like phenylketonuria, or PKU, which can cause mental retardation, must be repeated because the blood was taken too soon after birth to be valid, said Leah Ziskin, deputy health commissioner.

The tests are most accurate 24 hours after the baby's first feeding, but many babies are home by then. Sixteen percent of the tests statewide had to be repeated in 1994, compared to 12 percent the prior year, which Ziskin attributed in part to the earlier discharges.

Even if dire health consequences aren't a byproduct of the 24-hour discharge policy, the quality of care has suffered, many doctors say.

Dr. Ruth J. Schulze, a Ridgewood obstetrician who reported complaints on the earlier discharges by the vast majority of her patients, says: "We're trying to establish good maternal bonding, not parenting out of frustration and exhaustion."

An Oakland woman, discharged from the hospital 24 hours after

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Mary Jo Layton is a staff writer.

The Record DATE MAY 14 1995

giving birth to her second son, was in pain and exhausted. "It was the most horrible night. I did not sleep," recalled Sonia Adamo-Voss, whose insurance company required her to leave the hospital.

Even the prescription pain medication didn't help.

"I was more concerned about taking care of myself than handling this new addition to our family," she said.

Another North Jersey family fared even worse.

Mary Ann Milligan, treasurer of the HPAE, the Emerson-based nurses' union, recalled the story of a newborn who was recently discharged with breathing difficulties. Nurses racing to meet a 24-hour deadline gave the anxious parents a crash course on how to handle the problem. The baby suffered from apnea, in which its breathing stopped briefly.

"Why couldn't they have stayed an extra day? They were exhausted and discharged at 10:45 p.m. because it was 24 hours after she delivered," Milligan said. "The nurses had to tell the parents that if the baby should turn blue, give it a little tap on the cheek."

HMOs and insurance companies say they routinely pay for additional hospitalization if it is needed, but many doctors describe a tedious and difficult process in getting that approval.

Dr. Tova Yellin, a Fair Lawn pediatrician, believes the early discharges may be increasing post-partum depression. "I'm personally seeing more of it. Instead of a warm feeling, you have a parent frightened to be home with the baby. We're very concerned about the mothers having the right support," she said.

Breast-feeding has also become a casualty of the 24-hour discharges in many cases, Yellin and other pediatricians said. Many women are discharged before their milk is in and before the baby has adjusted to the breast.

"There's a lot of factors that work into successful breast-feeding, and stress and tension do not help at all," she said.

"I hear a lot of verbiage from the insurance industry on preventative health care. This is the absolute beginning of preventative care," she said.

While the legislation is debated, the state Department of Health is beginning to track the effects of the earlier discharge.

Critics of the 24-hour policy also note that mother and newborn can be separated if an insurance policy covers one but not the other.

Paula Feick, a 37-year-old Midland Park mother, who had complications following delivery in September, remained in the hospital while her newborn son was sent home with her husband and 3-year-old son.

"It was very difficult for my husband and hard on me," Feick said. "The mother and child should go home together."

"I didn't know at that time that I was going home the following day. It was very emotional for my older son," she said.

Feick's husband, Doug, asked if their newborn son could remain in the hospital with his wife. But the cost would have exceeded $600 a day, he said he was told.

Insurance companies and HMOs insist the home health care services they provide do not shortchange the quality of care.

HIP Health Plan of New Jersey, which has 175,000 members statewide, has provided the service — LifeStarts — for four years and reports much success.

In its fourth year, LifeStarts has serviced 4,450 mothers, none of whom has been readmitted to the hospital following 24-hour discharge, said Susan Emanuele, founder and director of the program.

A total of 15 infants have been readmitted over the four-year period, Emanuele said.

"New moms are not receptive to learning right after delivery. The learning level is higher at home," Emanuele said. RNs who must have a minimum two years' newborn nursery experience spend a minimum three hours in one visit in each home, Emanuele said.

But many physicians are fearful that quality in home health care varies significantly.

"There are some good ones," said Dr. Harris Lillienfeld, president of the New Jersey Chapter of the American College of Pediatrics. "But not all the companies suggesting early discharge have in place, in my view, quality health care follow-up," he said.

WHAT'S YOUR VIEW ?

AMONG the decisions many of us have to make in our choice of health-care plan is what kind of maternity coverage we want. Today we offer a package of stories examining the practice by some insurers and health maintenance organizations to limit mothers and their newborns to 24 hours in the hospital after normal deliveries.

A bill is likely to be acted on soon in the Assembly requiring longer hospitalization, namely 48 hours. The debate is focusing on a proposed exception to that requirement: when insurers provide in-home health care service, which involves up to three follow-up visits from a nurse to the new mother's home.

Weighing in with their views are Dale J. Florio, legislative counsel to the New Jersey HMO Association, and co-authors Ann Twomey, president of the Hospital Professionals and Allied Employees of New Jersey, and Myra Terry, president of National Organization for Women of New Jersey. Their viewpoints appear on Page RO-6.

In addition, we're interested in your views on the issue of providing home health care service in place of an additional 24-hour hospital stay?

A sampling of your responses will appear in the near future as part of our Instant Feedback feature. You can contact us:

- By e-mail on the Internet at newsroom@bergen-record.com
- By mail: Hospital Maternity Stay, Opinion Page, 150 River St. Hackensack, N.J. 07601.
- By fax at (201) 646-4135.
- Or, on the Instant Feedback Line: (201) 525-4600, Ext. 2210. The phone line will remain open until Tuesday at 5 p.m.

Please include your name, town, and daytime phone (for verification only).

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The New York Times DATE MAR 5 1995

Physicians Protest Maternity Insurance

By JACQUELINE SHAHEEN

As more and more insurance plans in the state limit coverage for uncomplicated deliveries to 24 hours, new mothers and their babies are spending less and less time in the hospital — and protests are mounting from women's groups and physicians.

The New Jersey chapter of the American Academy of Pediatrics, opposing the so-called 24-hours-and-out policy, recently issued guidelines for the hospital care and discharge of newborns, emphasizing the variety of conditions that should be met before a newborn is allowed to leave.

The Medical Society of New Jersey, the New Jersey Obstetrics and Gynecology Society and the New Jersey Pediatric Society have also criticized the insurers' policy. In December, representatives of some of these groups met with officials of the State Department of Health to air their concerns.

And members of the Assembly Insurance Committee are studying a bill, introduced last fall by the Assembly minority leader, Joseph V. Doria Jr., Democrat of Bayonne, and the Assembly Speaker, Chuck Haytaian, Republican of Hackensack, that would require a 48-hour stay for a normal delivery.

> Critics say a 24-hour hospital policy can be unsafe.

Critics of the 24-hour policy say women need more than 24 hours to recuperate from giving birth and to learn how to breast-feed and care for their babies under the supervision of the nursing staff. They say that because of the shortened stay, babies may not receive the nourishment they need or may not have their health problems diagnosed at an early stage.

Critics also point to side effects of the policy. In some cases, for example, the mother may be ill enough to receive coverage beyond 24 hours, but her healthy baby is not eligible, so mother and baby are separated.

Insurance companies and health maintenance organizations contend that reducing the stay for healthy mothers and babies to 24 hours from 48 hours or longer is safe and appropriate for routine deliveries. Individual hospitals and the State Department of Health say they have not seen a significant rise in complaints as a result of early discharge. Both the insurance companies and the hospitals have introduced or expanded programs to help new mothers after they leave the hospital.

But Myra Terry, the president of the National Organization for Women of New Jersey, said the organization had received a flood of calls from women and physicians upset about the 24-hours-and-out practice. Women's health concerns, she said, "seem to be the ones that are very often the first ones to be compromised."

At a Feb. 23 meeting with obstetricians and pediatricians, the organization decided to turn up the heat on legislators to pass the 48-hour bill. "We can mobilize women who feel isolated and don't know where to complain," Ms. Terry said. As part of that effort, NOW plans to publish a pamphlet about 24-hour discharge to be distributed by obstetricians and other health providers.

The guidelines issued by the state chapter of the Pediatrics Academy say that "the length of stay is unique for each infant and is dependent on the health of the mother and infant, the ability and the comfort of the mother in caring for the infant, the adequacy of support at home, the access to follow-up care and the competency of the infant."

Dr. Michael A. Graff, the chairman of the chapter's Committee on Fetus and Newborn, said: "What I'm hoping is that the physicians abide by the chapter's policy and therefore convince the insurance companies not to put financial restraints on them to discharge the infants earlier. My biggest concern about early discharge is that the newborns have not had sufficient time to be properly evaluated and to go through the transition of being in the womb and out of the womb."

Dr. Anthony P. Caggiano, president of the New Jersey Obstetrics and Gynecology Society and president-elect of the Medical Society of New Jersey, said first-time mothers, in particular, were often not ready to go home in 24 hours. After a long, grueling labor, they are tired, dehydrated and sore and may not have had a bowel movement or be urinating well, he said.

"A lot of them, their breast milk isn't in, they haven't been instructed in how to feed the baby, they haven't even related with the baby," Dr. Caggiano said. "We think it's very important that in those first 48 hours that the nursery nurses and the floor nurses work with the new mothers and help them acclimate and bond to their new child."

In general, physicians complain that their ability to property treat their patients is limited by the 24-hour policy. Insurance companies and H.M.O.'s point out that they will pay for a longer stay if there is a valid medical reason, but doctors say the process of convincing insurance companies can be frustrating and time-consuming. And in the end, Dr. Caggiano said, the decision is very likely to be made by a nurse or a physician with no experience in obstetrics.

Some women are eager to be discharged, and that's fine, said Dr. Ruth J. Schulze, an obstetrician-gynecologist in Ridgewood. "If they feel comfortable and they choose to go home, I say terrific," she said. "What I'm saying is they should have the option to stay. I've had women standing at the nursing desk, crying that they don't know what to do, do they have to go."

Doctors say babies are more likely than their mothers to suffer problems as a result of early dischange. If the mother does not know how to breast-feed properly, the baby may not get enough to eat and may become dehydrated. Severe degydration can cause a stroke.

Moreover, first-time mothers especially may not pick up the early signs of jaundice, a symptom of a condition called hyperbilirubinemia. The condition, which affects a relatively small number of newborns, can cause impaired hearing and brain damage.

"What's happening is that the jaundice appears after the child is out of the hospital, and the inexperienced mother may not recognize it immediately," said Dr. Seymour Charles, a pediatrician in Maplewood who is the chairman of the New Jersey Pediatric Society's insurance committee. One such mother delayed bringing her baby to his office for a week. By then, Dr. Charles said, "it was a heroic thing to save the baby's life."

Doctors are also concerned about the impact of early discharge on state-mandated tests for disorders like phenylketonuria, or PKU as it is known, which can cause mental retardation. The tests, which are done before dishcarge, are most accurate more than 24 hours after the baby's first feeding. By then, many babies have gone home, necessitating a second test.

Cathleen Coleman, a spokeswoman for Blue Cross/Blue Shield of New Jersey, declined to comment on the physicians' concerns about 24-hour discharge. "I can say that the patients' response has been very favorable, and we've had few complaints," Ms. Coleman said.

But Susan Emanuele, the nurse manager of Lifestarts, a home care program for members of the New Brunswick-based H.I.P. Health Plan of New Jersey, said the physicians' concerns are "valid" if home health care is not provided after discharge.

H.I.P., like a growing number of plans, provides such care in lieu of an

CONTINUED

The New York Times DATE MAR 5 1995

extra day or two in the hospital. It dispatches a registered nurse with experience in maternal-newborn care within 48 hours of discharge for a three-hour visit. The nurse examines the baby and the mother. Much of the nurse's time, Mrs. Emanuele said, is spent teaching the mother about breast-feeding and other aspects of infant care.

Women learn more in the relaxed atmosphere of home than they do amid the hubbub of the hospital, said Mrs. Emanuele, a former nursery nurse at the Medical Center at Princeton. It is also much easier to provide personalized instruction there than on the maternity floor, where the demands on a nurse's time are great, she said.

Mrs. Emanuele said that in 1994 the readmission rate for mothers and babies in the Lifestarts program was less than .01 percent.

All Blue/Cross Blue Shield of New Jersey policies are 24-hours-and-out, said Ms. Coleman, its spokeswoman. The company offers members of its managed care plans home visits through a program called Precious Additions. But three-quarters of its 1.8 million members have traditional indemnity policies, which allow free choice of physicians and hospitals, and they are not eligible for home visits.

Some hospitals are responding to shorter maternity stays by providing home visits, keeping in contact with mothers by telephone and expanding their prenatal classes. The Somerset Medical Center in Somerville has revamped its Lamaze program to include postnatal care. "It's kind of broadened the spectrum of a class that used to be really just sitting there and learning how to breathe and blow during a delivery," said Nancy J. Bohnarzyck, manager of maternal-child health services.

At the Jersey Shore Medical Center in Neptune, the class in infant care offered before delivery has been expanded to four hours from two. Through the hospital's closed-circuit television system, women can view videotapes 24 hours a day on postpartum and infant care.

Although hospitals say they have so far seen relatively few complications as a result of early discharge, many say they are monitoring readmissions of newborns closely to find those affected by the 24-hour-and-out policy.

Dee Campbell, director of the women and children's division at St. Peter's Medical Center in New Brunswick, believes that 24-hour discharge can work. "I think 24 hours is manageable for both the mom and for the baby," she said. "Shorter than that, I have concerns about our ability to really assess the mom and the baby and even just to assess them being together."

In fact, many doctors are worried that they may eventually have to cope with stays of less than 24 hours. The 24-hour discharge first caught on in California, where managed care is strong. Some insurance plans there now have a 12-hour limit. ■

Longer Stay Needed, a Mother Says

By JACQUELINE SHAHEEN

DIANE WEBER was lucky. Her pregnancy was uneventful, and labor and delivery on a Thursday night last fall were easy and swift. Her insurance plan covered only 24 hours in the hospital, but as she was preparing to leave Friday evening, her insurer said she could stay an additional night because she had not delivered until 10 P.M.

Even so, she and her son, Luke, went home less than 36 hours after his birth. Her insurance plan did not cover home health care.

Soon the first-time mother's luck began to turn. Luke's bilirubin — a pigment formed by the body in the normal breakdown of blood cells — was abnormally high, and before Mrs. Weber was discharged she was instructed to take him back to the hospital the next day to have it checked. She was then told that a third test would be necessary the following day.

Mrs. Weber, a resident of Howell, knew little about breast-feeding, she said. During her brief hospitalization, she did not have the opportunity to meet with a lactation specialist.

At home, Luke slept a lot. "I didn't know if I should wake him up to feed him," she said. Much of the time she didn't, and Luke gradually became dehydrated.

The third test revealed that Luke's bilirubin, possibly aggravated by his dehydration, had climbed to a dangerous level. He was admitted to the neonatal intensive care unit, hooked to an IV tube and given phototherapy, a treatment with special lights that helps the body to excrete excess bilirubin.

If the bilirubin goes too high, a baby can suffer brain damage; if he becomes severely dehydrated, he can have a stroke.

Dr. Michael A. Graff, the director of the division of neonatology at the Jersey Shore Medical Center in Neptune, where Luke was treated, said that if a baby stays in the hospital longer than 24 hours after birth, dehydration and a high bilirubin are spotted and treated before they become serious because of close observation by the medical staff and frequent testing.

Mrs. Weber said: "If I had stayed an extra day or two, somebody would have realized there was a problem, and they would have been able to correct it a lot sooner and not have it get so much worse."

Luke made a full recovery, but Mrs. Weber's troubles didn't end. She blamed herself for his illness, she said, and was hospitalized for postpartum depression. ■

The Star-Ledger DATE MAR 4 1995

Doctors warn insurers on short birth stays

By JOAN WHITLOW

Newborns sent home from the hospital 24 hours after birth are being readmitted with jaundice, a dangerous liver problem that was diagnosed and treated when insurance companies let the babies stay longer, Medical Society of New Jersey physicians have charged.

In letters to State Commissioner of Health Len Fishman, the physicians said insurance companies should "back off" from covering only 24 hours in the hospital after a routine vaginal delivery.

"Jaundice of the newborn has become the major cause of hospital readmission. A delayed diagnosis could put the newborn at higher risk: severe jaundice can lead to irreversible brain damage," the doctors said in a Feb. 22 letter to Fishman, which the medical society made public yesterday.

Deputy Health Commissioner Dr. Leah Ziskin said the department has seen no statistics to back up the claim about the high number of newborn readmissions but has been hearing anecdotes about babies sent home and readmitted.

Ziskin said the state is setting up a new tracking system to monitor newborn testing and may initiate surveillance of newborn readmissions.

The medical society also warned that new mothers may not get the help they need with breastfeeding, and early recognition of heart problems and other birth defects can be impaired when babies spend only 24 hours in the hospital.

Dr. Anthony P. Caggiano Jr., first vice president of the Medical Society of New Jersey, yesterday said maternity discharges are now "based on the bottom-line, not quality care." HMOs and other insurance companies claim the shorter maternity stays have proven safe in Europe and other states and help reduce costs so health insurance is affordable.

On Thursday, the New Jersey chapter of the National Organization of Women told an Assembly panel the "24-hours-and-you're- out" policies are dangerous and insurance plans have started 12-hour and even six-hour discharges in other states.

[FIFTH REPRINT]
ASSEMBLY, No. 2224

STATE OF NEW JERSEY

INTRODUCED SEPTEMBER 29, 1994

By Assemblymen DORIA, HAYTAIAN, Assemblywomen Turner, Weinberg, Assemblymen Romano, Garcia, R. Smith, Zisa, Felice, Bateman, Augustine, Corodemus, Hayden, Assemblywoman Heck, Assemblymen Roma and Warsh

AN ACT concerning certain health insurance benefits following the birth of a child and supplementing P.L.1938, c.366 (C.17:48-1 et seq.), P.L.1940, c.74 (C.17:48A-1 et seq.), P.L.1985, c.236 (C.17:48E-1 et seq.), Chapters 26, 27 and 27A of Title 17B of the New Jersey Statutes and P.L.1973, c.337 (C.26:2J-1 et seq.).

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

1. [1]a.[1] Every individual or group contract that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1938, c.366 (C.17:48-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide coverage for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to all contracts in which the hospital service corporation has reserved the right to change the premium.

[1]b. Notwithstanding the provisions of subsection a. of this section, a hospital service corporation contract that provides coverage for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours [4]and 96 hours, respectively,[4] of in-patient care unless such [4]in-patient[4] care is determined to be medically necessary by the attending physician [4]or is requested by the mother[4].[1]

[4]For the purposes of this section, attending physician shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.[4]

[4][[2]c. Post-delivery care shall consist of a minimum of three home visits, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with at least three years experience in community maternal and child health nursing. Services provided by the registered professional nurse shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits shall be conducted within 24 hours; within 25 to 48

EXPLANATION--Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.
Matter enclosed in superscript numerals has been adopted as follows:
1 Assembly AIN committee amendments adopted March 23, 1995.
2 Assembly floor amendments adopted May 1, 1995.
3 Assembly floor amendments adopted May 22, 1995.
4 Senate SHH committee amendments adopted June 1, 1995.
5 Assembly floor amendments adopted June 12, 1995.

hours; and within 96 to 120 hours following the discharge of the mother and her newly born child.

d. The Commissioner of Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]]4

[5]c. Every hospital service corporation shall provide notice to policyholders regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policyholder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.[5]

2. [1]a.[1] Every individual or group contract that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1940, c.74 (C.17:48A-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide coverage for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to all contracts in which the medical service corporation has reserved the right to change the premium.

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(C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]][4]

[5]c. Every medical service corporation shall provide notice to policyholders regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policyholder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.[5]

3. [1]a.[1] Every individual or group contract that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1985, c.236 (C.17:48E-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide coverage for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to all contracts in which the [4][medical] health[4] service corporation has reserved the right to change the premium.

[1]b. Notwithstanding the provisions of subsection a. of this section, a health service corporation contract that provides coverage for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours [4]and 96 hours, respectively,[4] of in-patient care unless such [4]in-patient[4] care is determined to be medically necessary by the attending physician [4]or is requested by the mother[4].[1]

[4]For the purposes of this section, attending physician shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.[4]

[4][[2]c. Post-delivery care shall consist of a minimum of three home visits, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with at least three years experience in community maternal and child health nursing. Services provided by the registered professional shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits shall be conducted within 24 hours; within 25 to 48 hours; and within 96 to 120 hours following the discharge of the mother and her newly born child.

d. The Commissioner of Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in

consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]]4

[5]c. Every health service corporation shall provide notice to policyholders regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policyholder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.[5]

4. [1]a.[1] Every policy that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to [1][N.J.S.C.17B:26-1 et seq.] N.J.S.17B:26-1 et seq.[1], or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide coverage for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

[1]b. Notwithstanding the provisions of subsection a. of this section, a policy that provides coverage for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours [4]and 96 hours, respectively,[4] of in-patient care unless such [4]in-patient[4] care is determined to be medically necessary by the attending physician [4]or is requested by the mother[4].[1] [4]For the purposes of this section, attending physician shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.[4]

[4][[2]c. Post-delivery care shall consist of a minimum of three home visits, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with at least three years experience in community maternal and child health nursing. Services provided by the registered professional shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits shall be conducted within 24 hours; within 25 to 48 hours; and within 96 to 120 hours following the discharge of the mother and her newly born child.

d. The Commissioner of Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]]4

[5]c. Every insurer shall provide notice to policyholders

regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policyholder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.[5]

5. [1]a.[1] Every policy that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.161 (C.17B:27A-2 et seq.) or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide benefits for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

[1]b. Notwithstanding the provisions of subsection a. of this section, a policy that provides coverage for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours [4]and 96 hours, respectively,[4] of in-patient care unless such [4]in-patient[4] care is determined to be medically necessary by the attending physician [4]or is requested by the mother[4].[1] [4]For the purposes of this section, attending physician shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.[4]

[4][[2]c. Post-delivery care shall consist of a minimum of three home visits, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with at least three years experience in community maternal and child health nursing. Services provided by the registered professional shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits shall be conducted within 24 hours; within 25 to 48 hours; and within 96 to 120 hours following the discharge of the mother and her newly born child.

d. The Commissioner of Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]]

[5]c. Every insurer shall provide notice to policyholders regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice

shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policyholder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.[5]

6. [1]a.[1] Every policy that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1992, c.162 (C.17B:27A-17 et seq.) or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide benefits for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

[1]b. Notwithstanding the provisions of subsection a. of this section, a policy that provides coverage for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours [4]and 96 hours, respectively,[4] of in-patient care unless such [4]in-patient[4] care is determined to be medically necessary by the attending physician [4]or is requested by the mother[4].[1] [4]For the purposes of this section, attending physician shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.[4]

[4][[2]c. Post-delivery care shall consist of a minimum of three home visits, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with at least three years experience in community maternal and child health nursing. Services provided by the registered professional shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits shall be conducted within 24 hours; within 25 to 48 hours; and within 96 to 120 hours following the discharge of the mother and her newly born child.

d. The Commissioner of Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]][4]

[5]c. Every insurer shall provide notice to policyholders regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policyholder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.[5]

7. [1]a.[1] Every policy that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to [1][N.J.S.C.17B:27-26 et seq.] N.J.S.17B:27-26 et seq.[1], or approved for issuance or renewal in this State by the Commissioner of Insurance on or after the effective date of this act shall provide benefits for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to all policies in which the insurer has reserved the right to change the premium.

[1]b. Notwithstanding the provisions of subsection a. of this section, a policy that provides coverage for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours [4]and 96 hours, respectively,[4] of in-patient care unless such [4]in-patient[4] care is determined to be medically necessary by the attending physician [4]or is requested by the mother[4].[1] [4]For the purposes of this section, attending physician shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.[4]

[4][[2]c. Post-delivery care shall consist of a minimum of three home visits, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with at least three years experience in community maternal and child health nursing. Services provided by the registered professional shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits shall be conducted within 24 hours; within 25 to 48 hours; and within 96 to 120 hours following the discharge of the mother and her newly born child.

d. The Commissioner of Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]][4]

[5]c. Every insurer shall provide notice to policyholders regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the policyholder; (2) the yearly informational packet sent to the policyholder; or (3) January 1, 1996.[5]

8. [1]a.[1] Every enrollee agreement that provides maternity benefits and is delivered, issued, executed or renewed in this State pursuant to P.L.1973, c.337 (C.26:2J-1 et seq.) or approved for issuance or renewal in this State by the Commissioner of

Insurance on or after the effective date of this act shall provide health care services for a minimum of 48 hours of in-patient care following [3]a vaginal[3] delivery [3]and a minimum of 96 hours of in-patient care following a cesarean section[3] for a mother and her newly born child in a health care facility licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.). The provisions of this section shall apply to enrollee agreements in which the health maintenance organization has reserved the right to change the schedule of charges.

[1]b. Notwithstanding the provisions of subsection a. of this section, an enrollee agreement that provides health care services for post-delivery care to a mother and her newly born child in the home shall not be required to provide for a minimum of 48 hours [4]and 96 hours, respectively,[4] of in-patient care unless such [4]in-patient[4] care is determined to be medically necessary by the attending physician [4]or is requested by the mother[4].[1] [4]For the purposes of this section, attending physician shall include the attending obstetrician, pediatrician or other physician attending the mother or newly born child.[4]

[4][[2]c. Post-delivery care shall consist of a minimum of three home visits, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with at least three years experience in community maternal and child health nursing. Services provided by the registered professional shall include, but not be limited to, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits shall be conducted within 24 hours; within 25 to 48 hours; and within 96 to 120 hours following the discharge of the mother and her newly born child.

d. The Commissioner of Insurance shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to implement the provisions of this section.[2]

[3]e. For the purposes of this section, the term "medically necessary" shall be defined by the Commissioner of Health in consultation with the Commissioner of Insurance pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.).[3]]4

[5]c. Every health maintenance organization shall provide notice to enrollees regarding the coverage required by this section in accordance with this subsection and regulations promulgated by the Commissioner of Health pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.). The notice shall be in writing and prominently positioned in any literature or correspondence and shall be transmitted at the earliest of: (1) the next mailing to the enrollee; (2) the yearly informational packet sent to the enrollee; or (3) January 1, 1996.[5]

[5]9. Within 18 months of the effective date of this act, the Commissioners of Health and Insurance shall report back to the Governor and the Legislature on the implementation of the requirements of this act.[5]

[5][9.] 10.[5] This act shall take effect immediately.

Requires health insurers to provide 48 hours in-patient care or 96 hours in case of cesarean section, following delivery for mother and newly born child under certain circumstances.

Helping Health Insurers Say No

Having a Caesarean? You Get 2 Days in the Hospital

By ALLEN R. MYERSON

A health plan asks a new mother to leave the hospital one day after her baby is born, instead of the usual two or three. Or it refuses to cover cataract removal in more than one eye unless the patient is fairly young and needs both eyes for work. Or it presses a generalist, not a neurologist, to treat epileptic seizures.

Who comes up with such rulings? The answer is often Milliman & Robertson Inc., a Seattle-based consulting firm that unknown to most doctors and their patients has quietly become the supreme court of medical insurance.

The firm's judgments on what to cover — and *not* to cover — are now used by the health plans of more than 50 million Americans, among them Prudential, Cigna, U.S. Healthcare, Kaiser Permanente and many Blue Crosses and Blue Shields.

Milliman & Robertson is the most influential among scores of firms that write standards and provide consultants who teach increasingly cost-conscious insurers to say no. By curbing practices they deem unnecessary and wasteful — like staying too long in a hospital, or seeing a costly specialist when a generalist would do — such firms have helped slow the growth of medical costs. Last year, for the first time in a decade, employers' total medical expenses fell, by more than 1 percent, even as health care prices rose nearly 5 percent.

"We believe," said Richard L. Doyle, the chief author of Milliman's guidelines, "that quality of care and efficiency of care are convergent."

But many doctors have revolted, arguing that the Milliman standards force them to sacrifice their patients' best interests and fail to recognize that each case is unique.

"Cookbook medicine," doctors call the guidelines. And worse. "Why don't we just set up a drive-through window where you deliver at one window and pick up your baby at the next?" J. Robert McGhee, one of the doctors who led a fight over the guidelines with Blue Cross and Blue Shield of Rhode Island, said in an American Medical Association magazine.

> "Cookbook medicine," many doctors derisively call the Milliman guidelines.

The doctors are fighting a losing battle. Annual sales of Milliman's guides, costing $300 a volume before quantity discounts, have risen from 602 since their introduction in 1990 to more than 6,000, not including electronic versions. Companies like General Electric, one of the nation's largest employers, use Milliman standards and consultants to size up their health plans.

The A.M.A. has fought the use of Milliman's guidelines at every turn. But, having failed for years to come up with its own guidelines, it is now considering buying Milliman's as a basis for further efforts. And the Harvard Community Health Plan has begun the first study of whether the Milliman standards can in fact improve health care while lowering costs. Should the answer be yes, the standards would shape treatment and training at one of Harvard's major teaching hospitals.

If Milliman & Robertson, a 48-year-old firm with $150 million in revenues, has become medicine's highest court, then Dr. Doyle is the chief justice. Now 57, he lists experience ranging from the practice of internal medicine to the medical direction of Travelers health insurance plans. Large and lumbering, he knows how to intimidate. When he

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Fred R. Conrad/The New York Times

Impact Visuals

Fred Conrad/The New York Times

Fred R. Conrad/The New York Times

Photodisc, Inc.

A sampling of Milliman & Robertson guidelines for patients under 65, without complications:

◄ **NO, YOU CAN'T** have a cataract removed in more than one eye unless you are fairly young and need both eyes for work.*

NO, YOU CAN'T be admitted to a hospital for a mastectomy.

◄ **NO, YOU CAN'T** stay in the hospital more than one day after a normal delivery, or two days after a Caesarean.

NO, YOU CAN'T see a neurologist for epileptic seizures unless anticonvulsant drugs fail, although the neurologist is allowed to read your brain-wave test.

◄ **NO, YOU CAN'T** have your stomach surgically reduced unless you are 100 pounds overweight.

NO, YOU CAN'T stay in the hospital more than three days for most strokes, even if you can't walk out.

NO, YOU CAN'T have a heart bypass unless you have chest pain, reduced heart pumping and a narrowing of all three major blood vessels, or a narrowing of two major vessels and recurrent chest pain after the strongest drugs have failed.

◄ **NO, YOU CAN'T** have a nose job unless the wall between your nostrils is crooked and you have had blocked breathing or chronic sinus infections despite treatments.

◄ **NO, YOU CAN'T** have a tonsillectomy unless you have suspected cancer, or six documented cases of tonsillitis in a year despite antibiotics, or breathing blockage during sleep.

**Revision due in May allows surgery on both eyes.*

Helping the Health Insurers Say No

Continued From First Business Page

sees an internist who refers most of his patients to costly specialists, Dr. Doyle calls him a witch doctor — someone who is always asking, "Which doctor?"

Dr. Doyle's fans, like Benjamin H. Robbins, medical director of a health maintenance organization based in Urbana, Ill., faithfully recite Doyleisms, especially about the urgency of cutting costs yet improving care in a cutthroat medical marketplace. "If there's a steamroller coming down the road," Dr. Doyle warned him, "you'd better be able to outrun it." Of Dr. Doyle's $395-an-hour consulting fees, Dr. Robbins said, "He's worth every penny of it."

Eighteen Milliman & Robertson consultants — nine doctors and nine nurses — spend much of their time writing new standards and updating older ones. Rather than hiring leading academic researchers, Milliman employs doctors and nurses who have plenty of clinical and administrative experience, especially at health maintenance organizations.

The standards are based on studying medical charts and scanning the academic literature to find the most effective and efficient practices, Dr. Doyle says. Proposed standards, which often include day-by-day hospital procedures, are then checked with doctors who work for Milliman & Robertson's client health plans.

But not with medical societies, whose recommendations are invariably more generous than Milliman's. The American College of Obstetricians and Gynecologists, for example, recommends two hospital recovery-days for simple deliveries and four for Caesareans — double the Milliman goals.

The Milliman guidelines generally apply to patients under 65, without complications. Some health plans that cover older patients under Medicare also use them. Dr. Doyle stresses that they are only guidelines or goals, not rules, but that the more rigorous the application, the greater the savings.

Few health plans or hospitals swallow them whole, instead modifying them and reducing hospital days gradually, year by year. Many health plans, like Prudential's H.M.O., combine the Milliman guidelines with some from its rivals, including Value Health Sciences of Santa Monica, Calif. But many regard Milliman's as the most comprehensive and the most likely to cut their costs, a conclusion the Harvard plan reached after surveying 20 other H.M.O.'s.

Milliman has issued four volumes of guidelines — for hospital admission and stays, doctor's office treatments, home health care and recovery times before returning to work. Two more, on medicines and dentistry, are on the way.

For proposed operations ranging from hip replacements to tonsillectomies to heart surgery, Milliman recommends refusal and delays unless a patient's state is serious and painful and other treatments have failed.

To save on specialists, generalists are told to handle most epileptic seizures, pneumonia, chronic bronchitis, sprains, tonsillitis, heart failure, herpes, diabetes, thyroid disorders, arthritis and hemorrhoids.

Dr. Doyle said he had heard of no readmissions or complications due to Milliman's guidelines. Neither has Milliman ever been sued. "I'm knocking on wood here," Dr. Doyle said, noting that the firm's lawyers wrote a warning that the guidelines are no substitute for professional medical judgment.

Milliman executives have mellowed somewhat, saying that revisions due in May will, for example, permit cataract removal in both eyes. But these guidelines will also chop many recommended hospital stays, sending bypass patients packing in just three days, down from four (the national average is eight), and heart-transplant patients in one week, down from two.

Alan Decker for The New York Times.

Richard L. Doyle, the chief author of the Milliman guidelines.

Dr. Doyle said his campaign to cut costs zeroes in on hospitals because of Sutton's Law — that's where the money is. Following its guidelines strictly, the firm says, health plans can cut hospital days by two-thirds without sacrificing well-being.

Denying coverage for surgery that doctors have recommended brings the loudest protests, he notes, but unnecessary admissions account for only 15 to 20 percent of wasted hospital days. Half the unnecessary days come from doctors' failure to send patients home promptly, he says, often due to outdated custom. Delays in tests, treatments and doctor visits account for 20 percent. A lack of home treatment arrangements and recovery centers for those who do not need full hospital care accounts for the other 10 or 15 percent.

Because hospital costs are so high, averaging $1,500 a day, cutting out unnecessary days and services can lower an insurer's total medical bill at least 15 percent, Milliman executives say.

The Urbana H.M.O., the Health Alliance Medical Plans Inc. of Illinois, reports that the Milliman guidelines and consultants reduced its count from 363 days a year per thousand members in 1991 to 227 in 1994. But when Dr. Robbins, the plan's medical director, recently boasted of his progress, Dr. Doyle curtly responded, "In California, they're down to 150."

Managed care and stiff guidelines are a tougher sell in the Northeast. Blue Cross and Blue Shield of New Jersey, with 1.9 million patients, began using the guidelines in the fall of 1993. The state's Blue Cross says guidelines have allowed it to reduce hospital days by more than 10 percent, saving more than $50 million a year with no harm to anyone's health.

The state medical society has tried to block their use, even offering to support legal challenges.

While Milliman says its hospital guidelines can apply to the 75 or 80 percent of all patients under 65 who do not have complicating ailments, doctors and insurers feud over defining these complications.

Gregory Sachs, president of the medical staff at Overlook Hospital in Summit, N.J., recounted his experience with a patient who required surgery on his leg after a skiing accident. Afterward, the patient became so short of breath that Dr. Sachs, a cardiologist, feared renewed circulation problems after a bypass nine years before. But a nurse from a commercial insurer threatened Dr. Sachs with a payment cutoff after the three days of hospitalization specified in the Milliman guidelines. "The trouble is that rather than becoming a guide, it becomes a crucifix, a cross of gold," Dr. Sachs said.

The insurance-company nurse backed off for two more days, Dr. Sachs said, after he threatened to call the state insurance commissioner. But Overlook now puts stickers on patients' charts to remind doctors of the Milliman standards.

In Rhode Island, Blue Cross planned to introduce Milliman hospital-stay guidelines last April 1. Members of the state medical society organized to do their own research and contest the rules. Blue Cross agreed to delay until committees in every specialty had given their views.

To Gary S. Dorfman, a medical society officer and the doctor overseeing quality and cost control at Rhode Island Hospital, the state's largest, the standards take an absurdly optimistic approach. "If all the stars are aligned in the heavens and everything turns out just right, what is the least we can do?" he said.

Rosario Noto, the state Blue Cross medical director, remains determined to give his nurse reviewers, assigned to every hospital, rules they can enforce. Take a patient who has had an uncomplicated hysterectomy, he said. If she is "walking around the halls and taking oral medicine for pain," and the only reason she is still in the hospital is that her doctor cannot get back that day to release her, he said darkly, "that leads to further discussion."

Even the A.M.A. is now considering using Milliman's as a starting point.

The Inquirer
IT'S YOUR LIFE

DATE JUN 2 8 1995

Bradley bill aims to halt 'OB Express'

Whitman is to sign a bill today shielding newborns from early release.

By Gwen Florio
INQUIRER STAFF WRITER

A bill to halt a nationwide trend in which hospitals are sending new mothers home within a day of giving birth was introduced yesterday by U.S. Sen. Bill Bradley (D., N.J.), on the eve of Gov. Whitman's signing of similar legislation in New Jersey.

The measure that Whitman is expected to sign this morning at Holy Name Hospital, in Teaneck, will make New Jersey the second state in the country, after Maryland, to try to derail what some call the "OB Express."

Bradley's bill would extend the protection across the country.

"Hopefully, this will save other parents the grief and pain that we, as a family, have experienced," said Dominick A. Ruggiero Jr., 62, of Turnersville, whose grandniece died in May, 48 hours after being born — and a day after being sent home from the hospital.

The baby's health rapidly deteriorated — pediatricians say many infants' systems take at least 48 hours to stabilize — and the baby died in her cradle.

Until the last five years or so, women typically stayed in the hospital for three days after having a baby or five days, if they delivered by cesarean section.

But insurers and health-care firms across the country increasingly have refused to pay for more than 24 hours' postpartum care for vaginal births, and three days for a cesarean section.

Both pediatricians and obstetricians say that the shorter stays don't give them enough time to evaluate patients' health and have complained vehemently that insurers prevent them from keeping patients longer, even when the doctors felt those stays were justified.

"We're just looking at too many instances of loss of life or health impairment," said Pennsylvania Rep. Lawrence H. Curry (D., Montgomery), who is cosponsoring a bill in the Pennsylvania House.

Although the American Medical Association has expressed concern about the shorter postpartum stays, it doesn't support a legislative solution.

"We believe that legislators should make laws, insurance companies should provide insurance, and that doctors should make clinical decisions," said John C. Nelson, an obstetrician and gynecologist who is an AMA trustee and deputy director of Utah's Health Department.

"While I think it (Bradley's bill) is quite laudable, I think he's a bit out of his element," Nelson said.

The measure, called "The Newborns' and Mothers' Health Protection Act of 1995," is cosponsored by U.S. Sen. Nancy Kassebaum (R., Kansas). U.S. Rep. Marge Roukema (R., N.J.), who has spoken in support of the state legislation, said she generally thought that state laws might be the most effective way to stop the practice. "But this is going to be a great impetus" for other states, she said of Bradley's bill.

As do both New Jersey's and Maryland's legislation, Bradley's proposal allows women to go home with their babies after a single day — as long as they and their doctors agree that they're ready.

Insurance firms say that's how it's usually done, anyway.

"Overall, for many people who give birth without complication, a shortened stay or a 24-hour stay may be appropriate," said Richard Coorsh, spokesman for the Washington-based Health Insurance Association of America.

But Ruggiero, a retired transit worker, said yesterday that his niece was one of those women who perfectly fitted the insurance companies' profile: "She had a very normal and uneventful pregnancy, the birth was normal, and the baby was born healthy — a nice, little, pink bundle of joy." Mother and baby, Michelina Alanna Bauman, went home the next day.

"I was really, really angry," Ruggiero said. "It was a seething anger."

He took out some of that anger testifying in hearings for New Jersey's bill; he said he hoped to do the same for Bradley's measure.

Speaking of the bill that Whitman is expected to sign today, Ruggiero said: "I will always remember this as the Michelina bill."

Senate recess could delay vote on Crown/Vista pact

The New Jersey Senate's summer recess will extend the layoff of construction workers hoping for the revival of the proposed coal-fired electrical power plant in West Deptford.

The legislation would permit owners of the Crown-Vista Energy Project to extend the May 1997 deadline to have the plant on line. But the prime customer, Jersey Central Power & Light, wants out of the contract if the 1997 deadline is not met, even if it kills the Crown Vista project. In May, a state court agreed that JCP&L could void the deal.

The Assembly passed an emergency bill sponsored by Gloucester County Republicans to overrule the court and save the project, but fitting it into the crowded Senate agenda has proven a problem. The bill must be approved by the Senate Commerce Committee, whose chairman, Gerald Cardinale (R., Bergen), has been preoccupied with lawsuit-reform bills. The committee and the full Senate have no scheduled sessions until after Election Day, but some sessions should be held this summer.

Whitman staff defends plan to close 2 mental hospitals

The Whitman administration remains firm on its plan to phase out Marlboro Psychiatric Hospital in Monmouth County and the North Princeton Developmental Center in Mercer County, spokeswoman Rita Manno said yesterday. "This is an administration policy that is well-planned," she said.

Manno's remarks followed a protest in Trenton on Monday by more than two dozen people whose relatives are housed in state institutions. The group, headed by Democratic Sens. James E. McGreevey and Richard J. Codey, opposed the proposed closure of the two facilities.

In a plan to revamp the state's mental health system, the Whitman administration plans to shut down both facilities and relocate 531 residents of North Princeton to community homes and 760 psychiatric patients from Marlboro to other state-run facilities around the state — including the transfer of 71 criminally insane patients to Ancora Psychiatric Hospital in Winslow Township.

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Not all moms get 2-day stay for childbirth

Some insurers not complying

By ART WEISSMAN
PRESS STATEHOUSE BUREAU

TRENTON — Thousands of New Jersey women are discovering that a new state law requiring insurers to cover mothers and their infants for 48 hours after birth does not yet apply to them — and will not apply to people who are insured by out-of-state firms.

The law, signed by Gov. Whitman on June 28, gives mothers the nation's strongest protection against health insurers that might want to stop paying for hospital care 24 hours after delivery. Bucking a national trend toward rapid discharges, the law gives mothers the option to stay in the hospital for 48 hours after normal deliveries and up to 96 hours for births by Caesarean section.

A loophole created by an overriding contract law allows insurers to avoid the new requirements until policies are renewed or a new policy is issued — most likely, within a year — state officials are learning. Companies that are self-insured can also delay providing the extra coverage until renewals, and insurers based in other states do not have to follow New Jersey regulations.

"A contract is a contract is a contract. . . . No matter how we do it, we cannot change the contract; it's contract law," said Assembly Minority Leader Joseph Doria, D-Hudson, the bill's chief sponsor.

"There really wasn't any way to avoid it," said Carl Golden, Gov. Whitman's chief spokesman. "We could not force the insurance companies to offer this coverage" for current policies. For most employees, health insurance policies are renewed annually.

Insurance Commissioner Drew Karpinski is negotiating with insurers, hoping to convince them to implement the law immediately. Several of the state's largest insurers — including Blue Cross/Blue Shield, Prudential, and large HMOs — are providing the new coverage regardless of a customer's policy date.

"It's the law," said Fred Hillmann, a Blue Cross vice president, stressing that the company's average length of stay for new mothers had been 1.8 days even prior to the new law's passage. "Once the law was passed and the governor signed it, there's no reason not to implement it immediately."

State officials concede they do not know how many women will be caught in the loophole. Major hospitals in Monmouth, Middlesex and Ocean counties report no problems in the law's first month, but the Insurance Department has been receiving calls from worried mothers-to-be.

"We would call the insurer and ask them what they are going to do and talk to them about the new law," said Kathleen Bird, an Insurance Department spokeswoman.

Most health care professionals strongly supported the law, noting that some medical problems, such as jaundice, cannot be diagnosed during the first 24 hours of life. Advocating quality health care over the profits of insurance companies was also politically safe for Whitman, legislators and medical organizations.

"The dollar is contributing to all of these decisions" by insurers to limit coverage, charged Dr. Louis L. Keeler, president of the Medical Society of New Jersey. He was among several state officials and health care leaders who did not know of the loophole until this week.

Insurance companies and HMOs, Keeler said, "certainly should be doing it voluntarily."

Assembly Speaker Garabed "Chuck" Haytaian, R-Warren, the bill's co-sponsor, plans to ask Whitman and her staff to persuade more insurers to overlook the loophole.

"The only thing we can do at this point is to . . . encourage compliance. It was our intent, the Legislature's intent, for this to take effect immediately," Haytaian said.

Haytaian also noted that a pending federal bill, based on the new state law, could provide the 48-hour coverage to New Jersey residents insured by an out-of-state company. Tens of thousands of New Jerseyans receive their health insurance through employers in New York or Pennsylvania that contract with out-of-state insurers.

The federal bill is sponsored by Sen. Bill Bradley and Rep. Frank J. Pallone Jr., both D-N.J.

"We can only pass laws that are relevant to the state of New Jersey. I think our best bet is to get a law nationwide," Haytaian said.

Consumers who are unsure about whether they are covered should contact their insurance company. The Insurance Department complaint division can be reached at (609) 292-5316.

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The Record DATE JUL 19 1995

Blue Cross C-section policy spurs an uproar

By LINDY WASHBURN
Staff Writer

Danette Forsyth panicked when she learned of efforts by Blue Cross and Blue Shield of New Jersey to reduce "unnecessary" Caesarean deliveries by cutting its pay to doctors to match that for normal births.

The last time she gave birth, the Fort Lee woman delivered twins and nearly bled to death, she says. Now seven months pregnant, she worries that a doctor will hesitate if a Caesarean section is needed. "This is a child-endangerment issue," she says.

Barrie Marlowe said she felt insulted.

"It's almost as if society doesn't respect women and what they're doing," she said. Her doctor promised her — after she labored in vain to deliver a 7-pound, 13-ounce baby and ultimately underwent a C-section — that he wouldn't put her through a similar experience. The Mahwah woman stands 4 feet 11 inches tall and weighs 93 pounds. A big baby just doesn't fit.

Assemblywoman Loretta Weinberg, D-Teaneck, on Tuesday called for an emergency meeting of the Assembly Health Committee to try to put the brakes on the policy. Lawmakers already have blocked the policy of many insurance companies that required mothers and newborns to leave the hospital one day after a normal birth. They can do the same with this, she said.

But Blue Cross, which announced the policy on Monday, is sticking by it. It will apply to an estimated 10,000 births a year.

The new fees will not vary for vaginal or Caesarean births. They will be set between $2,400, the state average for a vaginal birth, and $3,000 to $3,200, the state average for a C-section, and will include a $100 bonus for a vaginal birth after a Caesarean.

They are just part of a comprehensive approach — including computer analysis of doctor's practice patterns and physician education — to lower the company's 27.5 percent C-section rate, said Michael McGarvey, vice president for health-industry services.

The national average is 22 percent, he said. "I would love to see us get down to that after a couple of years," he added.

The average in New Jersey is 24.3 percent. One possible explanation for Blue Cross's higher C-section rate is that its patients are two years older, on average, than those insured by other companies.

Blue Cross has seen no significant progress in lowering C-section rates since the late 1980s, and felt "the time had come to step out in front on this," McGarvey said. Noting the furor among obstetricians, patients, and legislators, he said, "It worked."

Blue Cross is not the first company to apply such a policy in New Jersey. Its managed-care plans, covering 350,000 people, already use such a fee structure. Other insurance companies, including Oxford Health Plans, do the same.

Nationally, 40 of 67 Blue Cross plans pay equal fees for Caesarean section and vaginal births, said Pam Kelch, spokeswoman for the Blue Cross and Blue Shield Association. "Usually it's applauded," she said.

By neutralizing the financial incentive to do a C-section, she said, only the medically necessary ones — not those for pure convenience — are performed.

Deliveries are the most common reason for hospitalization, accounting for one in four admissions of Blue Cross members in New Jersey. Employers, seeking to curb health-insurance costs, are usually supportive of these measures, Kelch said.

But the national experience did not stop lawmakers from condemning the announcement as just one more way managed-care companies interfere in the relationship between doctors and patients.

"It invites a public outcry," said Charlotte Vandervalk, R-Montvale, chairwoman of the Assembly Health Committee. "They really have to stop meddling in in the doctor-patient relationship. The more they do that, the more people object. They don't belong in the business of deciding appropriate health care."

"I think it's outrageous that they would punish the doctors that perform these deliveries," said Assemblyman Charles "Ken" Zisa, D-Hackensack. The doctors "are making a decision that ultimately could result in saving a life." He joined Weinberg in calling for an Assembly Health Committee meeting.

The whole push to trim costs by compromising care, he added, is part of a pro-business, anti-consumer climate cultivated by Governor Whitman.

"Mothers don't ask to give birth by C-section" said state Sen. Richard J. Codey, D-Essex County. "Doctors perform these operations because they feel it's medically necessary." Blue Cross' cost-cutting strategy, he added, "could jeopardize mothers' health and safety in their rush to save money."

Staff Writer Mary Jo Layton contributed to this article.

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'Drive-through delivery' opponents lining up

The Associated Press

TRENTON — It's the '90s version of politicians kissing babies. They're lining up behind newborns and mothers in a battle against insurance companies over the trend critics dub "drive-through delivery."

Many insurers say there's no reason for most mothers to be hospitalized more than a day after a normal birth or two days after an uncomplicated Caesarean delivery. But doctors and nurses argue that's too soon: Some medical problems don't show up in the first day and brand-new moms haven't yet learned to feed, care for and spot health problems in their newborns.

When insurance companies' efforts to cut medical costs run up against mothers' pleas for more care, the choice is obvious to many politicians.

"It's outrageous for insurance companies to push women out of hospitals after a day, after 12 hours in some cases," says Sen. Bill Bradley, D-N.J.

Bradley and Sen. Nancy Kassebaum, R-Kan., are sponsoring a bill requiring insurers to pay for a two-day minimum hospital stay after vaginal childbirth. At least two such bills have been introduced in the House.

At the state level, Maryland's legislature passed the first such bill in April. Lawmakers quickly followed suit in New Jersey — where one newborn's death is being blamed on early discharge.

California, Massachusetts and New Hampshire have pending bills with broad support from lawmakers, the public and the medical community. An unsuccessful New York bill is expected to be reintroduced, and at least two other states, Rhode Island and New Mexico, are studying the issue.

Insurers are vigorously lobbying against the bills, which generally require they cover a 48-hour stay after uncomplicated vaginal deliveries and four days after Caesarean sections.

The American Medical Association, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists recommend adding those minimums to the day of delivery. ACOG recently urged a moratorium on early discharges until they're proved safe.

The bills let the woman and doctor opt for an earlier discharge, but the insurer would then have to cover follow-up care. For mothers delivering at home or birthing centers, most of the bills mandate home care for 48 hours.

Childbirth is the most common reason for hospitalization in the United States, and the legislation appears to collide with government efforts to cut health-care costs. Politicians insist the welfare of newborns and mothers is more important — and preventing emergency treatment of those sent home too soon will help offset costs of extending their stays.

"I think it's going to be an infinitesimal increase in costs," Bradley says.

There's little data available on exactly what the bills would cost insurers. But Rep. Robert Torricelli, D-N.J., notes that with about 4 million births a year and maternity beds averaging $1,000 a day, insurers save $4 billion annually for every day they slice off the average stay.

That average fell from 3.9 days in 1970 to 2.4 days in 1993 — figures that include births with complications. Now most insurance guidelines call for discharge in 12-24 hours after uncomplicated vaginal births, and one Los Angeles hospital, Kaiser Permanente, has let a handful of "the healthiest of moms and babies" leave after eight hours if they want, says spokeswoman Kathleen Barco.

Insurers and hospital officials say that pleases mothers who want to go home quickly, limits risk of hospital-acquired infections and lets the family start bonding sooner.

Torricelli and Rep. Frank Pallone Jr., D-N.J., are sponsoring House bills similar to Bradley's. At a news conference last Monday with doctors and new and expectant mothers, Pallone said earlier this year his wife and son were rushed out of the hospital much quicker than when their daughter was born 17 months earlier.

Medical experts say such practices can mean easily treated illnesses in newborns go unchecked, causing irreversible mental retardation, hearing loss, organ damage — even death.

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