Approved: March 13, 1996
Date

MINUTES OF THE HOUSE COMMITTEE ON FINANCIAL INSTITUTIONS AND INSURANCE.

The meeting was called to order by Chairperson Bill Bryant at 3:30 p.m. on March 7 , 1996 in Room 527S-of the Capitol.

All members were present except: Representative Tom Sawyer
Representative Phill Kline
Representative Don Smith
Representative Gwen Welshimer
Representative Clyde Graeber

Committee staff present: Bill Wolff, Legislative Research Department
Bruce Kinzie, Revisor of Statutes
Nikki Feuerborn, Committee Secretary

Conferees appearing before the committee: Senator Robert Vancrum
Tom Wilder, Kansas Insurance Department
Bea Bacon, Advocate for Aging, Olathe
Jake Reisinger, Kansas Department of Aging
Teresa Sittenauer, HAIA
David Hanson, Kansas Life Insurance Co.
Senator Sandy Praeger
Kathleen Sebelius, Insurance Commissioner
Representative David Adkins
Elizabeth Miller, citizen
Gail Kiefer, citizen
Meg Henson, Kansas Medical Society

Others attending: See attached list

SB 529 Sub: Reinstatement of certain life and long-term care insurance policies

Senator Vancrum explained the bill as a mandatory reinstatement of long term care policies in case of the failure to pay a premium due to the mental incapacity of an insured (Attachment 1). At least one person designated by the insured would also receive any notice of lapse of policy or termination. The policy would include a provision whereby the insured would be reinstated up to five months after termination in case of lapse if the lapse was due to cognitive impairment or loss of functional capacity.

Tom Wilder, Kansas Insurance Department, told the Committee that the language is based on the Model Long Term Care Regulations drafted by the NAIC (Attachment 2). This type of policy would be of great assistance to individuals with Alzheimer Disease who forget to pay their premiums. Mr. Wilder suggested that an amendment to include group as well as independent policies has been adopted by some states. The inclusion of life policies has brought objection from the companies due to the expense of notification although that provision was in the original bill.

Bea Bacon, Advocate for Aging from Olathe, related a personal experience of a lapsed long term care policy which caused hardship on a friend (Attachment 3). Due to the high percentage of aged population in Kansas, this bill is needed for their protection. She asked for the expansion of **SB 529** to include life insurance with a one year reinstatement and notification of second party on all existing policies. This cost would still be a savings vs. what it would cost Kansas in medicaid for long term care lapsed policies.

John Reisinger, Director of the SHICK Program of the Kansas Department on Aging, provided testimony supporting the Agency's support of the bill which would be extremely beneficial to Older Kansans (Attachment 4).

Teresa Sittenauer, Legislative Counsel for Health Insurance Association of America, spoke in favor of the bill which would require that long-term care insurers obtain from the applicant for insurance, the name of another

person designated to receive notice of lapse or termination of the policy or certificate or obtain a waiver from the applicant (Attachment 5). Besides notices sent to the insured and the designee, long-term care policies or certificates must include a reinstatement provision in the event of lapse if the insurer is provided proof of cognitive impairment or lack of functional capacity. They agree with the Insurance Department amendments to include group policies.

David Hanson, Kansas Life Insurance Association, voiced strong support for the bill in its present form and will present written reasons to the Committee regarding the exclusion of life insurance policies in this bill.

Hearing on SB 573: Requiring minimum inpatient care coverage following birth of child

Senator Sandy Praeger explained that the legislation is an attempt to clarify that the decision to send a mother and her newborn child home earlier than 48 hours for a normal delivery and 96 hours for a caesarean section should be based on clinical judgment not economic judgement by the attending physician (Attachment 6). Home health care would also be included as an option for the new mother. She reported that the existing fiscal note of $750,000 prepared for the State Employees Health Plan is exaggerated and does not include the cost associated with readmissions. The first day of the hospital stay is the most expensive while the second day is a great deal less. The State Employees Health Care Plan Administrator is working on a revised fiscal note based on new information.

Kathleen Sebelius, Insurance Commissioner, informed the Committee of the similarity between this bill and that introduced in Congress by Senator Kassebaum (Attachment 7). Fifteen other states have had similar legislation introduced. She quoted post-delivery problems as described in the New England Journal of Medicine. Early discharge can contribute to problems in breast-feeding, the diagnosis of jaundice, sepsis, and other conditions in newborns. The new language in the bill involves the mother in the decision-making process. Included in her testimony were the results of a study regarding "drive-through deliveries" which was prepared by the Department of Insurance. This proposed legislation would not cover medicare (health card) patients but it would mandate such coverage in managed care companies who are involved with Medicare. ERISA plans are not included in the mandate. The mandate would impact approximately 40-50% of the childbearing population.

Representative Adkins reported that insurance companies and HMO's have been dictating shorter and shorter postpartum stays which have resulted in many insurers limiting the stay to 24 hours and others as short as 6 hours after delivery (Attachment 8). This bill is needed to protect mothers and infants from insurance company policies who attempt more cost-cutting for profit motivations rather than accepting medical guidelines.

Elizabeth Miller of Topeka related her personal trauma of agreeing to be dismissed eight hours after the birth of her daughter (Attachment 9). Her experience and training as an RN led her to recognize serious problems with the newborn which was readmitted to the hospital with Sepsis Neonatorum. This could have caused very serious problems or death if it had not been aggressively treated in a hospital-based setting. Had the child and mother remained in the hospital longer, the symptoms would have been recognized and the readmission and serious illness could have been avoided.

Gail Kiefer, citizen from Olathe, explained how her child nearly died from choking on amniotic fluid after being released less than 18 hours after hospital delivery (Attachment 10). She credits the First Response Team and the ambulance emergency personal for saving her child's life. The cost for this near death experience far exceeded what an extra day in the hospital would have cost the insurance company.

Meg Henson, Director of Government Affairs for the Kansas Medical Society, reminded the Committee that a good medical management system involving sound utilization review should be adequate to assure that only medically necessary care is provided (Attachment 11) She asked for the addition of an amendment on Page 1, Line 27 which adds the word "provided" to the attending physician's definition.

During Committee discussion, Commissioner Sebelius told the Committee that they were receiving complaints from attending physicians who have been dropped from the network probably due to their requiring longer hospital stays for deliveries than are currently recommended by the insurance companies. The Kansas Medical Society is concerned with this practice and are investigating such complaints.

Tom Bell of the Kansas Hospital Association presented written testimony regarding the average length of hospital stays in Kansas (Attachment 12).

Dr. Steven Potsic, KDHE, offered written testimony supporting the bill (Attachment 13).

Written supporting testimony was presented from the Perinatal Association of Kansas; Dr. Anne Wigglesworth, an obstetrician from Manhattan; Dr. James E. Delmore on behalf of the American College of Obstetricians and Gynecologists; and Karen B. Nelson, R.N., B.S.N., the Maternal/Child Clinical Manager of Shawnee Mission Medical Center (Attachment 14).

The meeting adjourned at 5:00 p.m. The next meeting is scheduled for March 11, 1996.

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: March 7, 1996

NAME	REPRESENTING
Callie Denton	KID
Aletia Vaughn	KID
Tom Wilder	KID
Dave Hanson	Ks Insur Assocs
Gail Kiefer	
Bea Bacon	Volunteer
Liz Miller	self
Bob Heintzelman	SRS
Hanna J. Kidd	Jayhawk AAA (Aging)
Linda Kearney	KDHE
Martha Minnow	Kansas Insurance Department
Sheila Kreutzer	KCDD
Carrie Ann Brown	KHA
Meg Henson	Ks. Medical Society
Kevin Davis	Am Family INS
Tom Bell	Ks. Hosp. Assn.
Rick Guthrie	Health Midwest
Dan Dana	~~KUMC~~ self
Susan Nelson	self

HOUSE FINANCIAL INSTITUTIONS AND INSURANCE COMMITTEE GUEST LIST

DATE: 3/7/96

NAME	REPRESENTING
Jake Rejcingan	KDOA
Theresa Kenney	HIAA
Melissa Wangemann	Hein Ebert & Weir
[illegible]	[illegible]
Carol Ridgway	Ks Ins Dept
Brad Smoot	BCBS

STATE OF KANSAS

BOB VANCRUM
SENATOR, ELEVENTH DISTRICT
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STANLEY, STILWELL, IN
JOHNSON COUNTY
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(913) 341-2609

TOPEKA

SENATE CHAMBER
STATE CAPITOL
TOPEKA, KANSAS 66612-1504
(913) 296-7361

COMMITTEE ASSIGNMENTS
VICE-CHAIRMAN: ENERGY AND NATURAL RESOURCES
MEMBER: WAYS AND MEANS
JUDICIARY
MEMBER: COMMERCE, LABOR AND REGULATIONS
COMMITTEE, NATIONAL CONFERENCE ON STATE LEGISLATURES
MEMBER: ENVIRONMENTAL TASK FORCE, COUNCIL ON STATE GOVERNMENTS

TESTIMONY FOR

HOUSE FINANCIAL INSTITUTION AND INSURANCE COMMITTEE ON SENATE BILL 529

FROM SENATOR BOB VANCRUM

This bill relates to mandatory reinstatement of long term care policies in case of the failure to pay a premium due to the mental incapacity of an insured. The goal is to prevent lapse of such policies in cases of alzheimer's and other diseases often afflicting the aging which cause memory loss.

The bill would permit an applicant for an individual long-term care insurance policy to designate at least one person who would receive any notice of lapse of policy or termination, in addition to the insured. Also, individual long-term care policies must include a provision which allows for reinstatement of coverage in the event of a lapse if the insurance company is provided proof that the lapse occurred as a result of the cognitive impairment or the loss of functional capacity of the insured party. The ability to reinstate a policy exists for a period of five months from the termination or lapse and is contingent upon payment of past due premiums. Proof of impairment may not be more stringent than set as the original eligibility criteria for coverage.

Other states have passed similar anti-lapse laws.

House FI&I
Attachment 1
March 7, 1996

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: House Financial Institutions
and Insurance Committee

From: Tom Wilder, Director of
Government and Public Affairs

Re: Sub for S.B. 529 (Reinstatement of Long
Term Care Insurance Policies)

Date: March 7, 1996

I am appearing today in support of Substitute for S.B. 529 which will assist long term care insurance policyholders whose insurance may lapse because of the non-payment of premiums. There are situations where an individual may forget to pay premiums because of a mental incapacity such as Alzheimer Disease. This bill will allow for the reinstatement of the long term care insurance if the past due premiums are paid.

The language in the Substitute Bill is based on a provision from the Model Long Term Care Regulations drafted by the National Association of Insurance Commissioners. The bill provides that when a long term care insurance policy is sold in Kansas the insurance must include a provision for the applicant to give the insurance company the name of an additional person who will receive notices. Before a company can cancel a policy they must notify the policyholder and the additional person who was designated by the policyholder. Policies must also provide for reinstatement of coverage if the insurance is provided proof that the policyholder was incapacitated and unable to pay premiums.

House FI&I
Attachment 2
March 7, 1996

420 SW 9th Street
Topeka, Kansas 66612-1678

913 296-3071
Fax 913 296-2283

Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

The Substitute Bill as originally drafted only applied to individual long term policies. The NAIC Model Regulations on the lapsing and reinstatement of long term care insurance clearly cover both individual and group policies. I have attached a proposed amendment to Sub for S.B. 529 which would make this change.

Substitute for S.B. will provide an important protection for Kansas consumers who purchase long term care insurance. The Department of Insurance requests your support for this legislation as amended.

SUBSTITUTE for SENATE BILL No. 529

By Committee on Financial Institutions and Insurance

2-22

AN ACT relating to insurance; concerning long-term care insurance policies; lapse notice; reinstatement.

Be it enacted by the Legislature of the State of Kansas:

Section 1. The provisions of this act shall apply to all individual long-term care policies that are ~~subject to lapsing~~ issued to residents of this state on and after the effective date of this act.

Sec. 2. (a) No ~~individual~~ long-term care policy or certificate shall be issued until the insurer has received from the applicant either a written designation of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy or certificate for nonpayment of premium, or a written waiver dated and signed by the applicant electing not to designate additional persons to receive such notice.

(b) The applicant has the right to designate at least one person who is to receive the notice of termination, in addition to the insured. Designation of an additional person to receive notice of lapse or termination shall not constitute acceptance of any liability by such person for services provided to the insured. The designation shall include the full name and home address of such additional person.

(c) The policy shall include a waiver stated in clear terms in the case of an applicant who elects not to designate an additional person. The waiver shall state that the applicant has the right to designate at least one person other than the applicant who will receive notice of any lapse or termination of the long-term care policy and that the applicant elects not to designate an additional person to receive such notice.

(d) The insurer shall notify the insured of the right to change this written designation, no less often than once every two years.

Sec. 3. When the policyholder or certificateholder pays premiums for a long-term care insurance policy or certificate through a payroll or pension deduction plan, the requirements contained in section 2 need not be met until 60 days after the policyholder or certificateholder is no longer on such a payment plan. The application or enrollment form for such policies or certificates shall clearly indicate the payment plan selected by the applicant.

Sec. 4. No ~~individual~~ long-term care policy or certificate shall lapse

and group

or certificates

or certificate

or certificate

or be terminated for nonpayment of premium unless the insurer, at least 30 days before the effective date of the lapse or termination, has given notice by first-class mail to the insured at the insured's last known address and to any person designated by the insured pursuant to section 2 to receive notice of lapse or termination. Notice shall not be given until 30 days after a premium is due and unpaid and will be deemed to have been given five days after the date of mailing.

Sec. 5. Long-term care insurance policies or certificates shall include a provision which provides for reinstatement of coverage, in the event of lapse if the insurer is provided proof of cognitive impairment or the loss of functional capacity. This option shall be available to the insured if requested within five months after termination and shall allow for the collection of past due premium, where appropriate. The standard of proof of cognitive impairment or loss of functional capacity shall not be more stringent than the benefit eligibility criteria for cognitive impairment or the loss of functional capacity contained in the policy or certificate.

Sec. 6. This act shall take effect and be in force from and after its publication in the statute book.

2-4

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Kansas House Financial Institutions & Insurance Committee
Hearing Room 527-S, 3:30 p/m, Thursday, March 7, 1996

Mr. Chairman, Members of the Committee, thank you for allowing me to come before you in support of Senate Bill 529 which mandates reinstatement of a lapsed insurance policy, due to mental or physical incapacity.

This deficiency in insurance coverage first came to my attention about 15 years ago when a friend in Kansas found it necessary to go to Wisconsin and put her mother in a nursing home due to failing health. In an effort to put her mother's affairs in order, my friend discovered a lapsed insurance policy for long term care which had been in force several years. Efforts to get the policy reinstated, with back payments, were unsuccessful. The mother's good intentions to provide for the debilitating condition she ultimately suffered was a cruel hoax when all her payments were able to be pocketed without responsibility by the insurance company.

Subsequently, Kansas Representative Edgar Moore attempted to put in a bill similar to the original version of SB 529 but was told the leadership did not support it and advised him to withdraw.

Kansas ranks higher in the percentage of people over age 85 (1.7%, ranking 5th) than Florida (1.6%, ranking 6th).

According to the University of Kansas Center on Aging: "Kansas ranks 11th in percentage of residents over 65 (13.8%). Many counties are as 'aged' now as the percentage of the United States population will be in the year 2030, when the youngest of the baby boomers reach 65."

SB 529 was taken from a bill passed in Texas. It improves on the Texas bill by adding the requirement to seek a second party to be notified when a premium is due; and by adding the category of long term care. It is not as good as the original version of SB 529 patterned after the Texas bill which included life insurance as a category and a reinstatement period of one year, here reduced to 5 months. If the insured forgets to pay his/her long term care policy, can we expect the insured to remember to pay the life insurance policy?

Please expand SB 529 to include the life insurance category, with a one year reinstatement policy; and notification of second party on all existing policies.

When you consider a retroactive second party notification, also consider how much it will cost the state of Kansas in medicaid for lapsed policies that make paupers of nursing home patients.

Bea Bacon
Aging Advocate

House FI&I
Attachment 3
March 7, 1996

KANSAS
DEPARTMENT ON AGING

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Phone (913) 296-4986
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Bill Graves
Governor

Thelma Hunter Gordon
Secretary of Aging

Testimony before the
House Financial Institutions and Insurance Committee
on Substitute for Senate Bill 529
Jake Reisinger, Director of SHICK Program
Kansas Department on Aging
March 7, 1996

I would like to thank the members of the Committee for the opportunity to appear before you today on behalf of the Kansas Department on Aging regarding the Substitute for Senate Bill 529. We support this legislation and believe it will be extremely beneficial to Older Kansans.

The Department on Aging is familiar with the undue hardships and financial burdens which can be brought on people by themselves when suffering from a cognitive impairment, such as that caused by Alzheimer's Disease. Many times the purchase of a long-term care insurance policy is to provide a means of support in the event of just such an impairment. However, the onset of the impairment, which may cause these individuals to forget family members and friends, may also cause them to forget to make payment of outstanding bills, or act irrationally in their decisions relating to continuing insurance policies. Illnesses such as these slowly erode a person's cognitive abilities. The symptoms of the illness may be spread over a sufficiently long enough period of time that family members may be unaware of any problems created until it is too late to correct them.

The Department on Aging supports this legislation and views it as being very considerate of the situations many Older Kansans face. The provisions of the Substitute for Senate Bill 529 establish a means of preventing individuals suffering from a cognitive impairment from unintentionally harming themselves. The designation of a person, other than the insured, who is to be notified prior to a termination of the policy for nonpayment of premium, in conjunction with the reinstatement of coverage in the event of a lapse, will be of great assistance to many Older Kansans and their families in avoiding a serious hardship.

Thank you for this opportunity to present this testimony and I will be happy to answer any questions.

House FI&I
Attachment 4
March 7, 1996

MEMORANDUM

TO: The Honorable Bill Bryant, Chairman
House Financial Institutions and Insurance Committee

FROM: Teresa L. Sittenauer, Legislative Counsel
Health Insurance Association of America

DATE: March 7, 1996

RE: Sub. S.B. 529

Mr. Chairman, Members of the Committee: My name is Teresa Sittenauer and I represent the Health Insurance Association of America (HIAA). HIAA is a group of approximately 300 companies which together sell 80% of the private health insurance in the United States today, including long-term care insurance. We appreciate the opportunity to present this testimony in favor of Sub. S.B. 529.

Sub. S.B. 529 provides that long-term care insurers must obtain from the applicant for insurance, the name of another person designated to receive notice of lapse or termination of the policy or certificate, or obtain a waiver from the applicant. Notice of lapse or termination must be sent to the insured and the designee. Further, long-term care policies or certificates must include a reinstatement provision in the event of lapse if the insurer is provided proof of cognitive impairment or lack of functional capacity.

Sub. S.B. 529 in its current form is the product of several discussions involving the sponsor of the bill, the insurance industry, and the Insurance Department. We have reviewed the Insurance Department's amendments which make it clear that the legislation applies to group as well as individual policies, and we concur in the amendments. We are satisfied that the bill will ensure continuation of long-term care coverage in the unfortunate event that the mental or physical condition of the policyholder causes him or her to allow the long-term care policy to lapse.

House FI&I
March 7, 1996 Attachment 5

Long-term care insurance is an important emerging issue in the insurance industry. We support Senator Vancrum's efforts to protect long-term care consumers and their families. We urge your favorable action on Sub. S.B. 529.

Thank you for the opportunity to present our testimony. Please feel free to contact me if you have any questions.

Respectfully submitted,

Teresa L. Sittenauer

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SENATOR, 2ND DISTRICT
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STATE OF KANSAS

TOPEKA

SENATE CHAMBER

COMMITTEE ASSIGNMENTS

CHAIR: PUBLIC HEALTH AND WELFARE
HEALTH CARE REFORM LEGISLATIVE OVERSIGHT COMMITTEE

MEMBER: FEDERAL AND STATE AFFAIRS
FINANCIAL INSTITUTIONS AND INSURANCE
CORPORATION FOR CHANGE
JOINT COMMITTEE ON CHILDREN AND FAMILIES

TESTIMONY ON SB 573
Senator Sandy Praeger
March 7, 1996

Thank you, Chairman Bryant, and members of the House Committee on Financial Institutions and Insurance, for the opportunity to testify this afternoon in support of SB 573. As you can see, in addition to Senator Bond and me, this bill has good bipartisan support in the Kansas Senate. This legislation is an attempt to clarify that we believe any decision to send a mother and her newborn child home earlier than 48 hours for a normal delivery and 96 hours for a caesarean section should be based on clinical judgment by the attending physician. Should the decision to leave the hospital before the 48 or 96 hour period (and the bill does not mandate a required length of stay), coverage for home health services needs to be provided if desired by the mother. Again, the bill just reaffirms that the decision to leave early is based on clinical and not economic criteria.

Studies to demonstrate the economic benefits are "sketchy at best" according to a recent report from the Council of State Governments. One reason for the lack of data is the fact that it is difficult to designate a control group of mothers and newborns to be released automatically after a short hospital stay of 24 hours or less, which would place mothers and newborns at risk unnecessarily just to have a viable study. The report goes on to state that "in the absence of empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgment of attending physicians and not by economic considerations." A Sept. 28, 1995 article published by the New England Journal of Medicine stated:

> *"...studies have attempted to determine "safe" timing for early discharge by evaluating readmission rates among newborns. In a retrospective study reported in 1989, Conrad et al. reviewed 2000 normal births in an indigent population in Denver and concluded that hospitalization for 24 to 36 hours after delivery was sufficient to ensure the safety of normal newborns in such population. A careful review of the data, however, reveals that the readmission rate for the infants*

House F&I
Attachment # 6
March 7, 1996

discharged within 36 hours was 2.5 times higher that the rate for the infants staying longer than 48 hours. Sixty percent of the readmissions were for neonatal jaundice and 16 percent for possible infection."

A final comment about cost. You have a fiscal note on this bill of $750,000. That note is incorrect. Even in a worst case scenario costs to the state would not approach that amount. Blue Cross/Blue Shield of Kansas is one of our largest insurers of state employees and they have no limits on maternity stay. Hospital stays are based on medical necessity. The fiscal note also fails to take into account the cost associated with readmissions. I understand that the State Employees Health Care Plan Administrator is working on a revised fiscal note based on new information.

I believe that this bill is carefully drafted so that the public, providers of health care and insurers will know what to expect from maternity coverage.

Kathleen Sebelius
Commissioner of Insurance
Kansas Insurance Department

MEMORANDUM

To: House Financial Institutions
and Insurance Committee

From: Kathleen Sebelius, Commissioner
of Insurance

Re: S.B. 573 (Hospital Stays After Delivery of Newborns)

Date: March 7, 1996

I would like to thank the Committee for the opportunity to testify in favor of S.B. 573 which would require health insurers and health maintenance organizations to provide coverage for minimum hospital stays for mothers and newly born infants after delivery. The legislation requires coverage for 48 hours of hospitalization after a vaginal delivery and 96 hours in the case of a cesarean section. The mother and child could go home early if authorized by the attending physician. The bill also allows insurers to have programs for early discharge if followed up by a home health visit.

The Kansas Insurance Department conducted a survey of the top 12 writers of health insurance in this state on the average reimbursement for hospitalization after delivery. The information gathered by the Department indicates that the average reimbursement rates by health insurance companies and health maintenance organizations is between 1.3 and 1.9 days of hospitalization after a normal delivery and between 3.1 days and 3.3 days after a cesarean section. Several of the health maintenance organizations and preferred provider organizations which responded to the survey reported 24 hour hospitalization plans.

House FID
Attachment 7
March 7, 1996

420 SW 9th Street
Topeka, Kansas 66612-1678

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Consumer Assistance Hotline
1 800 432-2484 (Toll Free)

The provisions of Senate Bill 573 are similar to legislation introduced in the Kansas House of Representatives as well as a bill sponsored on the federal level by Senator Nancy Landon Kassebaum of Kansas. In introducing her bill, Senator Kassebaum made the following statement which I believe puts this issue in the proper perspective:

> I have consistently advocated and supported reforms to control health care inflation and have generally resisted government micromanagement of the private health care market. We cannot, however, allow our zeal to control health spending outweigh the need to protect the most vulnerable and fragile in our society. . . . Shorter hospital stays for newborns and mothers may be appropriate in some circumstances. But, in the absence of strong medical evidence, I believe we must err on the side of caution and allow decisions about the length of stay to be made by patients, their families and their doctors.

I would also note that legislation of this type has been introduced or approved in at least 15 other states.

I want to emphasize that this bill addresses a health care issue and not just a matter of insurance laws. A recent article in the New England Journal of Medicine discussed the necessity for hospitalization of a mother and infant after delivery. The authors noted that studies show readmissions for post-delivery problems are related to the length of the hospital stay after birth. As stated by the Journal, "early discharge has particular implications for breast-feeding and for the diagnosis of jaundice, sepsis, and other conditions in newborns." The article also indicated that symptoms of neonatal disorders may not be evident in the first 24 hours of life. There are valid medical reasons for setting minimum standards for hospitalization of mothers and infants after birth.

These criteria are one of the reasons that the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics in their published Guidelines for Perinatal Care recommend a 48-hour stay after a vaginal delivery and a 96-hour stay after a cesarean section if there are no complications. The American Academy of Pediatrics also issued a policy statement that sets forth similar standards for discharge after delivery.

I believe Senate Bill 573 will provide important protections for mothers and newly born infants. The bill leaves the decision when patients should be discharged after delivery up to the attending physician--who is in a better position than the insurer to decide whether a mother and child should be sent home from the hospital early. I urge this Committee to favorably approve S.B. 573.

The Kansas Experience with Drive-Through Deliveries

Prepared by:

The Kansas Insurance Department

October 1995

Kathleen Sebelius

Insurance Commissioner

7-4

The Kansas Experience with Drive-Through Deliveries

The recent phenomenon of early discharge of mothers and newborns, prompted Insurance Commissioner Kathleen Sebelius to take action at the Kansas Insurance Department in June, 1995. It is the Commissioner's concern that cost-cutting efforts by insurance companies and managed health care organizations have become the deciding factor in determining how long a mother and her newborn are allowed to stay in the hospital after birth.

The Kansas Insurance Department surveyed 12 major insurance companies of fully insured plans in Kansas . We asked them to tell us their average length of stay for a normal birth or cesarean section, guidelines for determining the length of authorized hospital stay, tracking results, if any, for number of readmissions following an early discharge, and what provisions were being made after early dismissal for follow-up services to mother and baby.(Attached are the survey questions and the list of companies asked to respond.)

Our survey confirmed that mothers and babies in Kansas are being released to go home sooner than in the past. Nationally, hospital maternity stays in 1970 averaged 3.9 days after a normal delivery, and then dropped to 2.1 days by 1992, according to the U.S. Center for Disease Control and Prevention. Our survey shows a pattern in 1995 toward even shorter stays, 24 hours or less. While most of the insurers or HMO's revealed the average reimbursement for a normal delivery is 1.3 to 1.9 days (slightly over 24 hours) and 3.1 to 3.3 days for cesarean section, several HMO's and PPO networks reported 24 hour stay plans. Days in hospital have decreased even though the policies approved in Kansas do not specify a limit on the length of stay.

All surveyed companies report that no financial incentives have been offered to physicians to shorten stays. All companies state that the physician has the final say in how long the mother and baby will stay in hospital. However, the companies reserve the right to review claims for medical necessity and deny excess charges if they do not agree.

When companies have offered early dismissal packages as an alternative to regular benefits, the mother is offered post-natal visits at home and one carrier included limited housekeeping services. Physicians and nursing staff have advised that often home follow-up is forgotten unless the visit is scheduled before the mother leaves the hospital.

Statistics tracking returns to the hospital due to early discharge are available on a limited basis. Tracking usually is only done within the first 30 days and the results show less than 1% readmission for mother or baby. This low return rate statistically shows no significant problem in Kansas.

Our department is not convinced that this survey tells the whole story. Reports from doctors, parents, and family members indicate that more serious problems exist. The Kansas Medical Society and several other obstetric specialists in the state presented guidelines from the major medical organizations, the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, which indicate the appropriate postpartum stay for a uncomplicated normal delivery should range from 48 hours for vaginal delivery to 96 hours for cesarean birth, excluding the day of delivery. If shorter stays are implemented, the protocol indicates that families need more intensive prenatal education and immediate home health care . While days are being curtailed in Kansas, effective implementation of these additional services is not occurring.

So, if the practice guidelines have not recommended a decrease in days, why have doctors been releasing their patients sooner, especially if the insurance company allows doctors to make the final decision? Physicians report that they are feeling the squeeze from the insurance companies. Physician profiles detailing a doctor's average length of stay for pregnancy are studied by the companies. Physicians have then been asked by the companies to review their practices. If they are not able to conform to the company's average they will be dropped as a contracting provider. One physician reports that he recently entered the delivery room thinking about how soon his patient might have to be released instead of the more critical issue of performing a safe delivery. As mentioned earlier, while companies don't mandate release, they can and do refuse payment for

additional days not regarded as "medically necessary" in spite of the doctor's recommendation.

Our survey reveals that there are instances where medical problems arise with both mother and baby after discharge from the hospital. It is not clear as to what extent this may be attributed to an early discharge. However, we feel the anecdotal information is vital and needs to be considered We do know that a mother may hemorrhage if she reinjures tissue torn during labor . We also know that more often it is the newborn who bears the real risk. Difficulty sucking is not always apparent at 24 hours. If the mother is nursing, her milk may not even have started to flow within 24 hours creating the possibility of the baby dehydrating. Jaundice doesn't appear until 24 to 36 hours. The chairman of the American College of Obstetricians, Dr. Michael Mennuti, (reported to Newsweek magazine) that physicians hadn't been seeing severe jaundice for 20 years. "Now it's turned up again. That's a red flag."

The Kansas Insurance Department will be supporting legislation in 1996 similar to bills passed in 3 other states and introduced by Senator Nancy Kassebaum in Congress, which would require health insurers to provide 48 hours of hospital care to mothers and their babies immediately after a normal delivery and 96 hours after a Cesarean section. We should not put Kansas mothers and babies at risk in an effort to save money. We know that there have to be some reasonable safe solutions. If early discharge programs are going to be successful, development of an accepted protocol with safeguards in place needs to happen before shortened stays are implemented. We are eager to facilitate these discussions, but in the interim urge protections for this vulnerable population.

Companies Surveyed

Kansas Blue Cross and Blue Shield

Prudential Insurance Company of America

Principal Mutual Life Insurance Company

Blue Cross and Blue Shield of Kansas City

Bankers Life and Casualty Company

John Alden Life Insurance Company

Mutual of Omaha

Humana Kansas City, Inc.

Kaiser Foundation Health Plan

Preferred Plus of Kansas, Inc.

HMO

Blue Care, Inc.; Total Healthcare: Healthsource, Inc.

FISCAL IMPACT OF SB573

February 5, 1996

Narrative Summary:

The impact of mandating stays for delivery after the birth of a child is mixed.

For companies with health policies that make maternity available upon request, claims are currently being processed for stays based on the discretion of the physician. Therefore the length of stay for maternity is not restricted. Based on this practice the premiums for the optional maternity rider would not increase. If premiums increased, it would be based solely upon the increased costs associated with normal maternity claims.

Conversely true is Mutual of Omaha who offers a maternity rider for coverage also. They report that additional stays would increase the cost of the maternity rider by 35%. This the overall increase with cesarean and normal delivery expenses for the maternity rider would be 22%.

One company, Blue Cross and Blue Shield of Kansas City interpreted the bill to mandate coverage to policies of all individuals, thus increasing premiums $9-$10 per person per month. In their group market, most of their employees have maternity coverage so the premium impact would be $1-$1.50. Mutual of Omaha reported an increase of 2% spread across both male and female rates for c-sections are considered a complication of pregnancy.

The effect of mandating length of stays will have an effect for the PPO's and HMO's reporting. Premiums would increase. The Principal Financial Group approximates a $12.50 per member increase for the PPO's and a significant increase for their HMO insureds at 19% for normal deliveries and 36% for cesarean stays.

The follow-up visit seems to be the biggest area of concern for all companies surveyed except for Mutual of Omaha which already provides this benefit. If it is a provision they currently do not provide, companies reported an approximated increase in premium, while others stated that it would be too difficult to assess its effect at this time. As the survey illustrates for example, BlueCross BlueShield of Kansas predicts a $.05 increase per contract month.

In summary, indemnity companies report a mixed report that mandating stays would result in premium increases in regard to mandating stays of 48/96 hours. For many, the effect of the cost of the follow-up visit for these companies could not be assessed at this time. For HMO's and PPO's, there would be an overall increase in premiums for insureds when mandating the length of stays.

Summary of company responses:

Coverage for normal maternity benefits are excluded in American Family Insurance Group current health policies in Kansas. However, as required by Kansas law, benefits for normal maternity are made available by rider. The adjudication process for normal maternity claims under this optional rider is based on the discretion of the attending physician in conference with the mother, and therefore does not restrict length of stay. Based on this practice, the premiums would not increase due to the passage of this bill. Future premium increases would be based solely on the increased costs associated with normal maternity claims.

BlueCross and BlueShield of Kansas stated that generally across the board would not be effected by the mandated periods for stay, but would be effected if the follow-up visit was implemented at early dismissal. The premium increase would be $.05 per contract per month.

Kaiser Permanente included suggested changes to HB 2738 and did not directly respond to the impact of the bill unless language was modified in the bill that would directly effect coverage by their HMO.

Principal's cost would increase for mandated stays for HMO/PPO contracts by $12.50 per covered member. Indemnity contracts would not be effected by mandated length of stay. The costs estimate of the mandated follow-up visit after early dismissal is not available.

Prudential estimates the fiscal impact would be an increase of approximately 1-1.5% of premium. In terms of dollar amount per insured, this would be in the range of $1 to $2.50 per insured per month.

Blue Cross and Blue Shield of Kansas City reported without time to evaluate the full effect of the proposed legislation, felt there were two components they could report on. One is that a significant block of their business has selected plans without maternity coverage. HB 2738 would effectively mandate this coverage, increasing our premiums in the range of 10% or roughly $9-10 per person per month. The second component is the group market in which most of the employees have maternity coverage. The 48/96 hour requirement would add approximately 1% to the cost or $1-$1.50

Mutual of Omaha estimates a 22% overall increase in premiums. Mandated stays for cesarean would be an increase of both male and females due to C-sections considered a complication of pregnancy. Mandating stays would increase on the maternity rider by 35%.

FISCAL IMPACT OF SB573

COMPANY	Premium Impact/ Mandated Stays	Premium Impact/ Follow-up visit
American Family Insurance Group	none	premium increases would be solely based on the increased costs associated with normal maternity claims
BlueCross BlueShield of Kansas	none	mandated follow-up visit $160,000 per year or $.05 per contract per month, less than 0.1% of our current premium
Kaiser Permanente	did not assess the cost effect of the bill need amendments made to the language important to HMO's	already provided
The Principal Financial Group	HMO premium impact would be substantial, 19% for normal delivery stay; 36% for cesarean. $12.50yr per/member PPO No impact on indemnity policies	unable at this time to determine how this would effect premiums charged
The Prudential Insurance Company of America and Subsidiaries	would impact all policies 1%-1.5% of premium=$1 to $2.50 per insured per month	this is a broad based estimate but their Medical Plan expects to report a premium of $63 to $64 million for Kansas. The impact of the proposed bill would be $0.75 to $1.0 million.
Blue Cross and Blue Shield of Kansas	Individual policies $9-$10 per person per month: Group 1% or $1-$1.50	Did not address specifically the impact of the follow-up visit.
Mutual of Omaha Insurance Company	With C-section, 2% increase for males and females. For mandated stays, 35% increase=overall 22%.	No impact, already provided.

STATE OF KANSAS
HOUSE OF REPRESENTATIVES

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CHAIRMAN: KANSAS YOUTH AUTHORITY
MEMBER: KANSAS FILM COMMISSION

REPRESENTATIVE DAVID ADKINS
TWENTY-EIGHTH DISTRICT

Testimony before the House Committee on Financial Institutions and Insurance on SB 573

Mr. Chairman and Members of the Committee:

The decision of when to leave the hospital after having a baby has traditionally been the decision of the woman and her physician. Increasingly, however, insurance companies and HMOs have been dictating shorter and shorter postpartum hospital stays. Today, many insurers only provide coverage for a 24-hour postpartum stay, while some insurers are promoting unsafe early discharges and will cover only a 6-hour postpartum stay.

To assure that women and newborns receive appropriate health care, we should insist that insurers provide coverage for postpartum care that is consistent with professional medical guidelines. The guidelines of the major medical organizations, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), provide that "when no complications are present, the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean birth, excluding the day of delivery."

SB 573 is needed to protect moms and babies from insurance company policies that are dictated more and more by cost-cutting and profit motivations and less by accepted medical guidelines. Legislation is needed to assure appropriate coverage, choice, and care.

SB 573 is needed to assure that women and their newborns have access to postpartum hospital care recommended by their physician. Requiring insurers to cover postpartum stays in accordance with medical guidelines assures this access.

House FI&I
Attachment 8
March 7, 1996

Currently, insurers are dictating shorter and shorter stays for new mothers and their infants that are contrary to accepted medical guidelines. SB 573 is needed to assure that the decision on how long to stay in the hospital following delivery belongs to the woman, her family, and her physician, and not to insurance companies.

SB 573 is needed to assure that new mothers and their infants have access to medical and psycho-social care appropriate to their condition. Current medical guidelines -- devised by doctors, not insurance companies -- recognize the importance and cost-effectiveness of postpartum care ranging from a 48 to 96 hour stay in the hospital.

I urge your favorable consideration of SB 573.

Respectfully submitted,

David Adkins

David Adkins

The American College of Obstetricians and Gynecologists

May 23, 1995

STATEMENT ON DECREASING LENGTH OF HOSPITAL STAY
FOLLOWING DELIVERY

The American College of Obstetricians and Gynecologists (ACOG) is concerned about the decreasing length of time following delivery when mothers and newborns are discharged from the hospital. Although the trend to short hospital stays has been jokingly referred to as "drive through delivery," it is not a laughing matter.

As an organization dedicated to the primary health care of women and to insuring the optimal outcome of pregnancies, ACOG believes that changes in practice such as early discharge following obstetrical delivery should be based on sound scientific data that demonstrate good outcomes for mother and infant, as well as being cost effective. As yet, these data do not exist. Until they do, the burden of proof of safety of early discharge rests with those who are driving the change.

A recent analysis by the Centers for Disease Control and Prevention (CDC) found 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] Because the data included complicated deliveries, the median length of stay for uncomplicated vaginal deliveries or cesareans was probably considerably shorter.

Guidelines for Perinatal Care, a collaborative document between ACOG and the American Academy of Pediatrics (AAP), indicates that in otherwise uncomplicated deliveries the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean delivery, *exclusive of the day of delivery*.[2] Yet it has become common for insurers to limit length of stay to up to only 24 hours following vaginal delivery and up to 72 hours following cesarean delivery. ACOG's concern is heightened by reports of insurers proposing 12 hour stays following uncomplicated vaginal delivery and 48 hour stays following uncomplicated cesarean delivery, and by indications that some insurers are considering 6 hour stays for routine deliveries.

Although the move 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 -- the recent trend to even shorter length of stay following delivery appears to be driven primarily by financial motivations. At a time when obstetrical delivery is the most frequent cause of hospitalization in the United States, the shortening of a woman's hospital stay holds obvious appeal to insurers.

409 12th Street, SW, Washington, DC 20024-2188 (202)638-5577

8-3

Length of hospital stay may affect the recovery of the mother, and the newborn's stabilization and screening tests. Significant maternal physiologic changes and newborn adaptation occur during the first few days of life. Not all serious maternal or newborn problems or complications are evident within the first 12 or 24 hours following birth. ACOG is concerned about anecdotal reports of serious problems in newborns, such as dehydration and undetected jaundice, following early discharge.

ACOG is also concerned that opportunities for educating new mothers in the care of their newborns are lost when early discharge is inappropriate. For example, the initiation of breast-feeding and lactation is a very important process that occurs over the first few days following birth. Home care services should provide education regarding maternal recovery and newborn care. However, the availability, structure and content of home visits and services vary widely across the country. Moreover, such instruction may not always be an effective substitute for "on-demand" education provided in the hospital.

In other instances, a mother may be discharged to go home first, without her baby, or an inappropriate early discharge may result in separate readmission of either the mother or newborn. Such separation, while temporary, can come at a critical phase in the development of the mother-infant relationship.

ACOG acknowledges that selective, early discharge is safe and desirable for some mothers and babies. However, a decision for early discharge should be *individualized* and should be a mutual decision between the patient, her family, and the obstetrical provider -- taking into account medical risk factors, support systems for the family, and the readiness of the mother to care for herself and her newborn.

The routine imposition of a short and arbitrary time limit on hospital stay that does not take maternal and infant need into account could be equivalent to a large, uncontrolled, uninformed experiment that may potentially affect the health of American women and their babies. There is relatively little scientific data on the ideal length of hospital stay for delivery. A critical review of existing literature indicates that studies have not yet conclusively demonstrated the safety of early discharge.[3]

For this reason, ACOG believes that the American health care system should call for a moratorium, or a "time-out," 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.

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[1] CDC. Trends in length of stay for hospital deliveries - United States, 1970-1992. MMWR May 5, 1995; 44: 335-337.

[2] AAP and ACOG. Guidelines for Perinatal Care, 3rd ed. 1992 (4): 105-111.

[3] Braveman P, Egerter S, Pearl M, Marchi K, Miller C. Early discharge of newborns and mothers: a critical review of the literature. Pediatrics 1995 (in press).

Wednesday, October 11, 1995
The Kansas City Star A-3

Doctors call for longer stays after childbirth

The Associated Press

CHICAGO — Most mothers and babies need to stay in the hospital at least 48 hours after childbirth, the nation's largest group of pediatricians said Tuesday, bucking the trend toward money-saving "drive-through deliveries."

"The fact that a short hospital stay...can be accomplished does not mean it is appropriate for every mother and infant," the American Academy of Pediatrics said in a policy statement.

Increasingly, insurers are refusing payment for hospital stays beyond 24 hours after an uncomplicated delivery, said the 49,000-member academy, based in suburban Elk Grove Village.

Three states — Maryland, New Jersey and North Carolina — have enacted laws to ensure that mothers and newborns have at least 48 hours in the hospital under most circumstances, according to the American College of Obstetricians and Gynecologists. Similar bills are pending in Congress and in California, Delaware, Illinois, Kentucky, Massachusetts, Minnesota, New York, Ohio, Pennsylvania and Rhode Island, the organization said.

The obstetricians' group and the pediatricians have recommended in the past that hospital stays after childbirth range from at least 48 hours for vaginal deliveries to 96 hours for Caesarean sections.

The new guidelines refine the old ones, said William Oh, chairman of the pediatricians' Committee on Fetus and Newborn. The guidelines are published in the October issue of *Pediatrics*.

"Mothers are very upset because some of the hospitals are discharging mothers within 6, 12 and, at most, 24 hours," Oh said Tuesday. "Many of the mothers are still recovering from labor."

Pediatricians are concerned for medical reasons, said Oh, chairman of pediatrics at Brown University School of Medicine in Providence, R.I.

Discharging babies only hours after they are born does not allow time to spot developments such as jaundice and infections.

The timing of a discharge should be decided by the doctor and not by an arbitrary policy established by a third party, the guidelines say.

8-5

Family-friendly legislation

Kansas City Star Editorials

One good place to change the way the insurance companies run the health care business is with the in-one-day, out-the-next hospital stays for mothers and their newborn babies.

Insurance-dictated policies frequently require discharge of still-healing mothers and their fragile newborns from the hospital in 24 hours or less. Mothers who have had Caesarean deliveries get only two days. The companies refuse to provide coverage for any longer. Lawmakers in several states, including Missouri and Kansas, are reacting appropriately to change such policies.

Legislation is advancing in both Jefferson City and Topeka to require insurance companies to cover at least a 48-hour stay in the hospital for mothers who have delivered vaginally, and 96 hours for those who have had a Caesarean. On the federal level, Sen. Nancy Kassebaum of Kansas has been a leading advocate for these reforms as well.

This is an insurance reform issue that challenges the legislative rhetoric about protecting family values. This is an opportunity to replace the rhetoric with action.

There is nothing family-friendly about policies that send babies and mothers home right after birth even though doing so contradicts medical judgment.

The legislation has struck a responsive note with the public, particularly when there have been reports of day-old babies who have come down with life-threatening conditions in the hours after leaving the hospital, with no expert around to help frantic parents unsure of what is happening. Physician groups say early departure from the hospital can lead to health problems for newborns. Others supporting the legislation point out that new mothers are often not prepared to take care of their babies at home so soon.

Of course, many women and their babies sent home from the hospital do just fine. Some women even choose to be discharged early. They could continue to do that if their doctors agree.

But families — not the insurance companies — should be making that decision, with approval of their physician. Far too often the insurers' first consideration is only cost, not the patient.

Protecting newborns

The health insurance industry increasingly is making decisions on medical care which should be made by physicians in consultation with their patients. This is happening in many aspects of health care, as insurance companies and HMOs try to rein in costs as well as make more hefty profits.

Recently, Sen. Nancy Kassebaum of Kansas and other national legislators began to fight back on behalf of some of the most vulnerable of patients, newborn children and their mothers recovering in the first hours after childbirth.

Kassebaum's proposal would require insurance companies to cover at least a 48-hour stay in the hospital for mothers and babies following uncomplicated deliveries, and 96 hours after Caesarean births.

Pediatricians, obstetricians, consumer groups and others have complained about policies dictated by insurers which force mothers and their babies to go home within 24 hours — or sooner — following childbirth. For Caesarean deliveries, women often are sent home after two days in the hospital, even though they have only begun to recover from the surgery.

Doctors and other health professionals have argued that some newborn babies' illnesses don't show up within 24 hours. They say that women are being sent home without adequate training on how to care for their babies, particularly those newborns who develop health problems. Horror stories of day-old babies who have come down with life-threatening conditions at home, where there is no expert to assess what is happening, have prompted lawmakers to take a look at this early dismissal practice

Two states already have laws similar to Kassebaum's proposal on the books and others have them under consideration. Rep. David Adkins, a Leawood Republican, is sponsoring such a bill in the next session of the Kansas Legislature.

The American Academy of Pediatrics as well as the American College of Obstetricians and Gynecologists have indicated concerns about the early dismissals taking place because there are no data to show that it is safe to send babies home in 24 hours.

Kassebaum's legislation does permit physicians to release patients earlier than the 48-hour period, if follow-up home care is available. Nothing should require that a woman and her baby stay that long if physician and mother agree.

But doctors — not insurers — should be making the decision on each patient's needs. And physicians should not be forced into releasing patients earlier than they feel is right or risk being cut from the insurance company's list of preferred providers.

The insurance industry advocates home health care follow-up visits as a way to keep babies and mothers under medical care but without hospitalization. However, until the insurance industry is willing to pay in all cases for quality follow-up care, this is not a reasonable option.

If — as some of the political rhetoric promises — we are becoming a more family-friendly nation, changing this insensitive insurance-dictated policy is an appropriate place to start.

8-6

"DRIVE-THROUGH" DELIVERIES

Topeka Capital Journal Editorial

Giving mothers the boot

New mothers today face more uncertainty than ever. Nuclear families are under assault, public assistance is being scrutinized and the notion of an extended family — grandparents waiting at home to help care for newborns — is sadly a distant memory for most young parents.

Yet, doctors are saying they feel pressured by insurers to send young mothers home from the hospital after only a day of care.

In some cases, that's plenty of time — especially when there *is* help at home — but many times we are sending tired mothers home to perform, often alone, one of society's most difficult and important tasks: caring for a baby.

Shouldn't the level of care given to patients be determined primarily by the doctors trained to make such decisions? Of course it should.

That's why the movement to end "drive-through" deliveries is a welcome development. Mothers shouldn't be sent home, against the doctors' better judgment, simply because an insurance agent starts getting sharp pains in the area of the wallet.

Yes, we're too free with insurers' money. But kicking mothers and babies out prematurely won't help.

The Legislature is considering several bills that would mandate insurers to pay for 48 hours for natural births and 96 hours for Caesarean sections.

Mandates may not be the best approach — especially in the area of health care. But clearly something needs to be done to empower doctors to make reasonable decisions for their patients' care.

Health care costs have spiraled out of control because we're too free with insurers' money. But booting mothers and babies out of hospitals prematurely is no way to solve that problem.

8-7

V. Elizabeth Miller, RN, BSN
131 Fillmore
Topeka, Kansas, 66606

Dear Representative Bryant: 07Mar96

I am speaking to you from the heart as a professional nurse and mother to consider SB573. I pray that SB573 will be passed for the following reasons.

I have been a professional nurse for 15 years. I am advocating with full voice monitoring the interium period of mother and neonate in that the majority of cases is without complication. The first 24-48 hours post-partum is critical in a neonate's life. In utero, fetal circulation channel's blood flow to functioning organ's and largely avoids the lung fields. At the time of birth an opening between the 2 atria of the heart closes forcing blood to be routed into the right ventricular, a fetal vessel between the pulmonary artery and aorta collapses to send blood into the lungs. This in itself, is an anatomical miracle. Additional risks of the term neonate are infection, low bloodsugar, hypothermia, and jaundice which by itself left untreated can lead to brain damage. At best, the neonate is a collection of new immature and independent body systems trying to survive.

As a professional nurse, I made educated choices during my last delivery. I chose to be discharged at 8 hours as my pregnancy and delivery were without complication After returning home my daughter had a brief cyanotic episode at 10 hours of age. I discounted this at first as anxiety on my part but with 2 more episodes a pediatrician was involved and she was admitted at age 15 hours to a neonatal intensive care unit. Her initial symtomology was

House Fed
Attachment 9
March 7, 1996

very vague. My own nursing assessments did not reveal any other neonatal abmormalities. In other words she was perfectly normal in all ways. In NICU she was closely monnitored for heart and lung problems in which she had none. She was labeled a "Germ Baby" or medically known as Sepsis Neonatorum. The diagnostic tests and aggessive treatment available for her were hospital based and not home based. This incidence occurs in 1-10 cases per 1,000 live births. The mortality rates for neonatal sepsis range from 10 to 40 per cent and increase to to 15-50 per cent from meningeal involvement.

I quote from the late Dr. Ed Saylor, "Liz, If you had waited any longer Shannon's prognosis would have been grim, you did well by acting so quickly!" As a nurse and mother I strongly advocate SB573. Educated choices do not guarantee cost saving or life.

Sincerely,

V. Elizabeth Miller BSN, RN

V. Elizabeth Miller, BSN, RN

9-2

On July 2, 1995 my husband and I went to the hospital to have our first child. Baylie Kristine Kiefer was born at 11:08 p.m. It was considered a normal delivery and birth. Since Baylie was born before 12:00 p.m. July 2nd was considered our night in the hospital. We were released at 5:00 p.m. on July 3, 1995. A mere 18 hours after delivery.

My husband and I were very excited to bring home our new baby. We were a little nervous about caring for her, but had several family members available to help. We had reservations about leaving the hospital so early. We were concerned about my physical condition not the well being of the baby. We assumed that since everything was considered normal we would be fine. We did not think that we would be released if there was a possibility that something was going to happen to Baylie.

The first night at home went well. My husband and I thought that nothing could go wrong now. It was not until 10:00 a.m. on July 4, 1995 that our near death tragedy occurred. I had taken a shower and was getting ready for the day when I went to Baylie's bassinet to check on her. When I looked in the bassinet I found Baylie laying on her side with her back arched, her head thrown back, her eyes and mouth open, and her arms and legs stiff. I called for my husband and I picked her up. She was not breathing. I told my husband to call 911 and I started giving her back blows. She appeared to be choking. Her mouth then closed and I had to pry it open. The local First Response Team and the police arrived within minutes. By that time Baylie was trying to cough and was turning blue. They took her and continued the back blows. Amniotic fluid started to drain from her mouth. They used a nasal aspirator to suction the fluid and gave

Diane F. Dr. D
Attachment 10
March 7, 1996

her oxygen. By the time the ambulance arrived Baylie was getting her color back and was still trying to cough up the fluid.

We were transported back to the hospital by ambulance. Baylie tried to cough up more fluid in the emergency room, where they suctioned more fluid from her. She was admitted to the hospital for the night. She was put through several tests and monitored. All the tests and monitoring showed that she was a healthy baby that had choked on amniotic fluid that she was trying to cough up.

My husband and I feel fortunate that this happened while we were awake. It really scares us that this could have happened during the night. Had we been sleeping we would not have a happy healthy baby with us today. We are also grateful for the quick professional response of our local emergency personal. They saved the life of our most precious possession.

Had we stayed in the hospital 48 hours we would not have had our near death experience. Had we been in the hospital the nurses could have suctioned her immediately. Baylie's experience cost our insurance company more than if they would have allowed us to stay 48 hours. I feel that Senate Bill 573 would have prevented this from happening. Please vote for this bill and save the life of a newborn.

KANSAS MEDICAL SOCIETY
623 SW 10th Ave. • Topeka, Kansas 66612 • (913) 235-2383
WATS 800-332-0156 FAX 913-235-5114

March 7, 1996

To: House Financial Institutions and Insurance Committee

From: Meg Henson
Director of Government Affairs

Subject: SB 573: Minimum inpatient maternity benefits

The Kansas Medical Society appreciates the opportunity to appear today in support of SB 573. This legislation would mandate all indemnity and HMO health insurers to provide inpatient hospital benefits of at least 48 hours for vaginal deliveries and 96 hours for deliveries by caesarian section.

This legislation would be unnecessary if all health insurers provided coverage for services that were determined to be medically necessary in the professional judgment of the patient's physician. A good medical management system involving sound utilization review should be adequate to asure that only medically necessary care is provided. The reality of the marketplace, however, is that sometimes physicians are pressured to discharge patients quickly in an effort to diminish costs. This bill is intended to address that issue as it relates to maternity care by assuring that new mothers and their infants receive adequate inpatient care.

A minor technical amendment is necessary for clarity. On page 1, line 27, in the definition of "attending physician," the word "provided" should be included so that the definition reads: "'attending physician' means the person licensed...who is responsible for the care **provided** to the mother or newborn."

Thank you for giving our comments consideration.

House FI&I
Attachment 11
March 7, 1996

State of Kansas

Bill Graves Governor

Department of Health and Environment

James J. O'Connell, Secretary

Testimony presented to

House Financial Institutions and Insurance

by

The Kansas Department of Health and Environment

Senate Bill 573

The trend of shortening the length of hospital stays from three days (vaginal births) and 5-6 days (Caesarean section) in the mid-1980's to stays of 24 hours or less for vaginal births in 1996 has become a serious medical concern. It is recognized that the driving force behind this trend is the need to contain escalating health care costs. However, these shortened stays can have adverse effects on the well-being of the mother, newborn and their family. Shortened hospital stays may not allow sufficient time for necessary maternal and newborn observation and education.

Adequate time for medical observation is difficult at best with a brief hospital stay. Observations should include such issues as infant feeding, urination, development of jaundice, responsiveness to external stimuli, etc. In addition, social and health risk factors are often difficult to access especially when there are concerns for necessary parental follow-through and the family environment. It is important that the care for mothers and infants should be tailored to their health care needs. Given the need to observe and recognize important risk factors, the decision about when it is safe and appropriate for a mother and infant to leave the hospital is one that should consider multiple factors, including any requirements for further follow-up assessment and care. We need decisions based upon sound clinical judgment if we want all of our children to have a healthy start in live. Obviously, the outcomes we wish to achieve are healthy babies and mothers.

Integrating the newborn into the family unit is a complex process with unique implications for the mother, newborn and family members. This process involves recovery from childbirth and assuming responsibility for the newborn's care. The newborn also faces a critical period of adaption. Thus, discussion on length of stay also gives us the opportunity to highlight the need for proper discharge planning and education.

House FI&I
Attachment 12
March 7, 1996

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The Kansas Department of Health and Environment supports having insurance coverage available for in-patient hospital stays of 48 hours for a vaginal delivery and 96 hours for a Caesarian Section post delivery. KDHE supports removing the potential for incentives to encourage early (premature) discharge or disincentives for early discharge. KDHE also supports inclusion of coverage for one possible post-discharge home follow-up visit within 48 hours of discharge if discharge occurs prior to the above inpatient stays.

Written testimony presented by: Steven R. Potsic, M.D., M.P.H.
Director of Health
Kansas Dept. of Health and Environment
March 7, 1996

KA[illegible]OSPITAL ASSOCIATION

Donald A. Wilson
President

To: House Committee on Financial Institutions and Insurance
From: Kansas Hospital Association
Re: Senate Bill 573
Date: March 7, 1996

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of SB 573. This proposal requires any health plan which provides coverage for maternity services to allow for at least 48 hours of inpatient care following a vaginal delivery and at least 96 hours of inpatient care following a caesarean delivery. It also states that any decision to shorten that period of time can only be made by the attending physician after conferring with the mother.

In recent months, several states have taken action to discourage what is commonly called "drive through deliveries." This term refers to the practice of insurance companies putting pressure on health care providers to discharge a mother and newborn baby shortly after delivery, specifically within 24 hours of delivery. These states have generally enacted laws to require insurers to pay for at least 48 hours hospitalization following delivery.

Data released by the Centers for Disease Control and Prevention in May 1995 disclosed that the average length of stay for all hospital deliveries in 1970 was 4.1 days; by 1992 the average had decreased to 2.6 days. (These figures include births with complications.) The following chart depicts a similar trend in Kansas.

Trends in Average Length of Stay (Kansas)

	1990	1994
All Hospitalizations	6.0 Days	5.1 Days
Hospitalizations for Patients < 65 Yrs of Age	5.2 Days	4.2 Days
Normal Deliveries (DRG 373)	2.0 Days	1.6 Days

House F.I.I
Attachment 13
March 7, 1996

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Some attribute the decrease in obstetric and newborn length of stay to intensified efforts by insurers, particularly health maintenance organizations (HMOs) and managed care plans, to reduce health care costs by imposing strict limits on childbirth payment or by offering incentives to patients to leave early. Others credit the steady decline in maternity stays to improved hospital efficiency and appropriate outpatient management. Still others point to consumer demand for increased family participation in the birth process, increased involvement of fathers in caring for their newborns, and better prenatal education. Finally, as the previous chart indicates, a general overall trend has had at least some impact. Obviously the forces behind the trend toward early discharge are complex and various--economic, social, medical and psychological.

The point is not that all mothers should stay 48 or 72 hours in the hospital after giving birth. The point is, rather, that the tug-of-war between what is medically appropriate for each patient and what is financially feasible should be predicated upon sound clinical guidelines applied by a physician and informed patients who understand the conditions of both their body and their insurance policy. In other words, the discharge decision is one to be made between the informed patient and her physician; not by the insurer or, for that matter, the legislature.

We are supportive of SB 573 because it calls attention to the potential in some managed care arrangements for sacrificing quality to cost. It also recognizes, however, that this decision is best reached by the responsible physician utilizing appropriate medical standards.

Thank you for your consideration of our comments.

PERINATAL ASSOCIATION OF KANSAS

Representative Bill Bryant, Chairperson
House Committee on Financial Institutions and Insurance
Kansas Statehouse Room 527-S
Topeka, KS 66612

March 6, 1996

Dear Representative Bryant:

I am writing in support of Senate Bill No. 573. I currently serve as president of the Perinatal Association of Kansas which is a multidisciplinary organization of professionals interested in the health and well-being of pregnant women, newborns, and their families. My support of this bill is also based on over 15 years experience as a registered nurse in the hospital care of mothers and newborns. Currently I am involved in the provision of obstetric care with nursing students as an assistant professor in the Department of Nursing at Pittsburg State University.

I am very supportive of the content of this bill as it provides insurance coverage for 48 hours following a vaginal delivery and 96 hours following a cesarean delivery based on a cooperative decision between the mother and the health care provider. Research has shown that immediately post-delivery a mother is not always ready to learn and able to absorb the knowledge necessary to provide care for her newborn and herself. In addition to having adequate time for education, it is necessary for the caregivers to have sufficient time to assess for complications, such as infections, feeding problems, certain congenital heart defects, and hyperbilirubinemia. Some of these complications may not be significantly apparent at 24 hours post-delivery. If dismissed prior to 48 hours after delivery, the mother may not have absorbed or understood the information needed to provide optimal care of her newborn and to be able to recognize symptoms appropriately early to prevent development of more serious problems.

Although this bill addresses a very important issue in the well-being of new mothers and newborns, the bill could be strengthened if it included insurance coverage for home health follow-up by a professional licensed nurse in the cases of early discharge or as deemed necessary by the health care provider and parent. Another provision that would benefit the well-being of mothers and newborns would be to include insurance coverage for prenatal and parenting education. Education on pregnancy, infant care and development, and parenting may have significant impact on the pregnancy outcome, maternal health during and after the pregnancy, and infant health and well-being.

Thank-you for your time. I sincerely appreciate your efforts in improving the health and well-being of mothers and newborns.

Respectfully submitted,
Barbara McClaskey
Barbara McClaskey
President, Perinatal Association of Kansas
Assistant Professor, Department of Nursing
Pittsburg State University
Pittsburg, KS 66762

House Fin. Inst.
Attachment 14
March 7, 1996

Testimony to Senate Financial Institutions and Insurance Committee, Feb. 10, 1996.
Anne Wigglesworth, M.D., F.A.C.O.G., 1133 College Ave., Manhattan, KS 66502.

Ladies and gentlemen of the committee, my name is Anne Wigglesworth. I've been an obstetrician for 20 years, and now practice in Manhattan. I was offered an opportunity to testify today in support of S.B. 573, which would mandate that insurors pay for hospital care for new mothers for 48 hours after normal deliveries and for 96 hours after delivery by cesarean section. People with some political clout--mostly women, as a matter of fact--are calling the public's attention to the fact that more and more payors for health care decline to pay for hospitalization beyond 24 hours for vaginal births, or 48 hours for Cesarean sections. They justify this by insisting that there is no "medical necessity" for longer hospitalization, and by declining to reimburse the hosptals for the extra days. This permits situations such as the following:

--The16 year old single SRS client who came in at10 p.m. Monday, gave birth to her first child in the small hours of Tuesday morning, and had to go home Wednesday, to a marginal home about which no one really knew anything.

--The 34 year old married mother of breastfeeding twins whose insurance company refused to pay for more than 24 hours postbirth because she delivered vaginally. It took four months of letters and phone calls between her physicians and the insurance provider before an obstetrician reviewed the case and a second day was allowed.

--The Cesarean section mother who developed an incisional infection on third postbirth day. Because the causative organism was anaerobic, the infection did not show up sooner. Some women come from many miles away to Kansas hospitals; after discharge it is hard to monitor them over distance. It seems counterproductive to ask them to "drop by" thirty miles to the office to be checked if a problem, which could have been detected in the hospital on the third postop day, has developed at home.

So it is true that there is a problem, but S.B.573 addresses only part of it. This bill does not address the fact that growing numbers of women are giving birth without adequate preparation, household stability, or resources to manage their own care or that of a newborn. I'm talking not only about the unmarried teen, but also about the 22--year-old couple with minimum-wage jobs and no family nearby, and the 32-year old divorced woman with 2 children at home whose "fiance" has disappeared. Support systems and prebirth education for parenting, selfcare, nutrition, breastfeeding, and return to work are sparse; both in terms of examples women can see around them, and in terms of adequately funded programs.

The irrational parental leave and maternity policies of American employers are a joke everywhere else in the world. Women, having had to fight to stay in jobs such as school teaching after the pregnancy begins to show, now find that they are expected to work fulltime and even overtime until delivery, or risk loss of benefits. Businesses and institutions who employ women often don't have any flexibility in scheduling, or any place where an employee (pregnant or not) can rest at breaks.

It has always been true that there is minimal to no third-party health-care reimbursement for preventative measures or education. Only acute care is paid for. So there is no incentive for hospitals, doctors, or county agencies to provide more than a rudimentary prebirth evaluation or postbirth homevisiting program, or to add new services as hospital days are cut.

Testimony to Senate Financial Institutions and Insurance Committee, Feb. 10, 1996.
Anne Wigglesworth, M.D., F.A.C.O.G., 1133 College Ave., Manhattan, KS 66502.

Hospitals have only one level of postbirth care--acute. So women must be in the hospital or at home after childbirth; though hospitals staff for "acuity," there is still no rational acuity level for new mothers beyond the first 24 hours. Much of the care given to these women in the hospital may not address fever, shock, hemorrhage, or wound healing. But it does address the less quantifiable needs of fatigue, anxiety, maternal-infant bonding, and the culture shock experienced by parents from every social stratum when a two-person household suddenly grows to three. Yet what cannot be quantified should not have to be paid for, in the cost-conscious, no-frills, managed-care environment we now occupy.

By reducing this very complex series of social problems to a matter of mandating 48 hours in the hospital for every postbirth mother, I believe (on my more charitable days) that the well-intentioned sponsors of this bill are missing the point. On my less charitable days, I think that there is a nationwide bandwagon which politicians (of all shades) want to board, and which rolls over many of the underlying and more complex issues. I think that the wider problems should be addressed as well, but they are certainly not as amenable to easy solutions.

Are these really problems which health insurors can solve by paying for an extra day? Should it not rather be the business of the state's leaders to insist that we fund preventative and supportive health care, programs aimed at deglamorizing early sexual activity, and ways to give girls hope that there is a role for them in life outside that of concubine? Insisting that insurance companies pay for a certain minumum of days in hospital will not help this. But it will almost certainly result in raising of premiums for people who carry maternity coverage, whether they choose to stay an extra day or not. I've been dealing with health insurors for years, and I know they can adduce convincing numbers to support almost any position.

Let me ask each of you, ladies and gentlemen, how long was your mother in the hospital after you were born? And what did she think about that?

Now, having made my points, I must say that, on the whole, I support this bill and hope it will be passed. I think that acknowledging that new mothers and their infants have many "soft" but important needs may be a first step toward solving some of the problems I have mentioned. But I would ask that our state and national legislators who are truly interested in improving the care of mothers at childbirth, and of the infants born to them, should look at the wider, more difficult issues and not just at this one, which is currently so popular. This is too important to be the issue du jour today, and forgotten tomorrow as you congratulate yourselves on the bill's passage. Thank you for your attention.

The American College of Obstetricians and Gynecologists

DISTRICT VII

Office of the Chair
Kansas Section
James E. Delmore, MD
Dept. of Ob-Gyn
University of Kansas School of Medicine
3243 E. Murdock Street-Level G
Wichita, KS 67208
(316) 681-0251

February 8, 1996

Dear Senator Bond:

I regret being unable to address the Senate Financial Institutions and Insurance Committee in person, but appreciate the opportunity to provide comments regarding SB 573. I have the pleasure of representing the Kansas Section of the American College of Obstetricians and Gynecologists.

As we face increasing and appropriate demand for cost effective medical care, some long held traditions in medicine are being questioned. Among the most visible changes is the length of hospital stay for many procedures and treatments. SB 573 addresses the length of hospital stay following childbirth. A survey of 12 major insurance companies in Kansas conducted by the Kansas Insurance Department reports a decrease in average length of stay following childbirth from 3.9 days to 2.1 days between 1970 and 1992. More recently there is increasing pressure from third party payors to continue the reduction in postpartum length of stay. Enclosed I have provided an excerpt of the third edition of Guidelines for Perinatal Care which was jointly published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. In addition to recommending stays ranging from 48 hours for uncomplicated vaginal deliveries to 96 hours for cesarean deliveries, the guidelines further specify that early discharge is acceptable as long as certain criteria are met. Some of the criteria include determination that the course of pregnancy and delivery was uncomplicated, collection of all pertinent laboratory data for both mother and infant, demonstration of maternal readiness to assume independent responsibility for her newborn, and identification of a physician-directed source of continuing medical care for both mother and baby. This care should be arranged for within 48 hours of discharge.

The decision to dismiss a mother and newborn infant following delivery involves assessment of many factors which could not and should not be defined by legislation. SB 573 allows a minimal length of stay for mother and infant without penalty for patient or physician. Rather than having health care mandated by legislation or insurance companies, SB 573 allows the physician caring for mother and infant to exercise medical judgment regarding early or delayed dismissal on a case by case basis.

I wish to thank the sponsors of SB 573 for an effort to allow the infants and mothers of Kansas to continue to have the safest delivery and postpartum care. I hope your committee will look favorably on the bill and would appreciate the opportunity to provide any assistance.

Sincerely,

Jed Delmore, M.D.
Professor, Department of Ob-Gyn
Director, Division of Gynecologic Oncology
University of Kansas School of Medicine - Wichita

JED/kh

APPENDIX

GUIDELINES FOR

PERINATAL CARE

Third Edition

American Academy of Pediatrics

American College of Obstetricians and Gynecologists

Supported in part by

March of Dimes
BIRTH DEFECTS FOUNDATION

Cover and Text Design: Christine Draughn

Guidelines for Perinatal Care was developed through the cooperative efforts of the AAP Committee on Fetus and Newborn and the ACOG Committee on Obstetrics: Maternal and Fetal Medicine. The guidelines should not be viewed as a body of rigid rules. They are general and intended to be adapted to many different situations, taking into account the needs and resources particular to the locality, the institution, or type of practice. Variations and innovations that improve the quality of patient care are to be encouraged rather than restricted. The purpose of these guidelines will be well served if they provide a firm basis on which local norms may be built. The segments related to obstetric practice do not replace the ACOG *Standards for Obstetric–Gynecologic Services*, but rather expand on the principles suggested therein.

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Discharge

Prior to discharge a discussion should be held between the physician or another health care provider and the mother (and father, if possible) about any expected perinatal problems and ways to cope with them. Plans for future and immediate care, as well as instructions to follow in the event of an emergency or complication, should be discussed.

Maternal Considerations

Prior to discharge, the patient should be informed of normal postpartum events, including the changes in the lochial pattern that she should expect in the first few weeks; the range of activities that she may reasonably undertake; the care of the breasts, perineum, and bladder; dietary needs, particularly if she is breast-feeding; the recommended amount of exercise; emotional responses; and observations that she should report to the physician (eg, temperature elevation, chills, leg pains, or increased vaginal bleeding). The length of convalescence based on the type of delivery should be discussed, and patients should be counseled to avoid abdominal straining. Patients who have abnormal bleeding or signs of infection or, fever should not be discharged. It is helpful to reinforce oral discussion with written information.

Methods of contraception should be fully reviewed and implemented. A diaphragm cannot be fitted adequately during the immediate postpartum period. If there are no contraindications, however, oral contraceptive use may begin right after delivery. Breast-feeding mothers may start using oral contraceptives once their milk flow is established. Patients for whom the use of oral contraceptives is contraindicated or patients who prefer other methods of contraception, such as foam and condoms, should be instructed in the use of these other methods.

The time at which coitus may be resumed after delivery is controversial. If resumed too soon, coitus may cause vaginal laceration and pain. Risks of hemorrhage and infection are minimal after approximately 2 weeks postpartum; by this time, the uterus has involuted markedly, and the endometrium and cervix have begun to reepithelialize. Thereafter, coitus may be resumed based on the patient's desire and comfort, and after contraceptive issues have been resolved. Sexual difficulties are common in the early months after childbirth. Scarring at the episiotomy site may cause the woman some discomfort during intercourse for 1–3 months. In the lactating woman, the vagina is often atrophic, and lubrication during sexual excitement may be unsatisfactory. Furthermore, the demands of infant care alter the couple's ability to find the time previously allocated to physical intimacy.

At the time of discharge, arrangements should be made for postpartum follow-up examination, and specific instructions should be conveyed

to the mother. The following points should be reviewed with the mother or, preferably, with both parents:

- Condition of the neonate
- Immediate needs of the neonate (eg, feeding methods and environmental supports)
- Roles of the obstetrician, pediatrician, and other members of the health care team concerned with the continuous medical care of the mother and neonate
- Availability of support systems, including psychosocial support
- Instructions to follow in the event of a complication or emergency
- Feeding techniques; skin care, including cord care; temperature assessment and measurement with the thermometer; and assessment of neonatal well-being and recognition of illness
- Reasonable expectations for the future
- Importance of maintaining immunization begun with initial dose of hepatitis B vaccine

When no complications are present, the postpartum hospital stay ranges from 48 hours for vaginal delivery to 96 hours for cesarean birth, excluding the day of delivery. When the mother is discharged early, especially within 24 hours of delivery, certain criteria should be met:

- The mother should have had an uncomplicated vaginal delivery following a normal antepartum course and should have been observed after delivery for a sufficient time to ensure that her condition is stable. Pertinent laboratory data, including a postpartum determination of hemoglobin or hematocrit level and, if not previously obtained, ABO blood group and Rh typing, should have been obtained. If indicated, the appropriate amount of RhIg should have been administered.
- Family members or other support person(s) should be available to the mother for the first few days following discharge.
- The mother should be aware of possible complications and should have been instructed to notify the appropriate practitioner, as necessary.
- Procedures for readmission of obstetric patients should be consistent with hospital policy, as well as local and state regulations.

The medical and nursing staff need to be sensitive to potential problems associated with early discharge and to develop mechanisms to address patient questions that arise after discharge.

Early Infant Discharge and Follow-up

The nursery stay is planned to allow the identification of early problems and to reinforce instructions in preparation for the infant's care at home. Complications often are not predictable by prenatal and intrapartum events. Because many neonatal problems do not become apparent until several days after birth, there is an element of medical risk in early neonatal discharge. Although most problems are manifest during the first 6 hours, data suggest that readmissions may be more common when early (by 48 hours) or very early (by 24 hours) discharge programs are instituted. With these observations in mind, the following criteria for early infant discharge are recommended:

- The course of antepartum, intrapartum, and postpartum care, for both mother and fetus, should be without complications.
- Maternal readiness to assume independent responsibility for her newborn should be assured by demonstration of skills and abilities such as feeding techniques, skin and cord care, measurement of temperature with a thermometer, and ability to assess infant well-being and recognize common neonatal illnesses. Family members who will care for the child should attend prenatal childbirth education or infant care classes, in which problems of the first days after birth are discussed.
- The infant should be delivered at term, be of appropriate birth weight, and found normal by examination.
- The infant should be able to maintain thermal homeostasis as well as suck and swallow normally.
- A physician-directed source of continuing medical care for both mother and baby should be identified and arrangements made for the baby to be examined within 48 hours of discharge.
- Laboratory data should be reviewed to include:
  - —Maternal testing for syphilis and hepatitis B surface antigen
  - —Cord or infant blood type and direct Coombs test (if the mother is Rho(D) negative, or is type O, or if screening has not been performed for maternal antibodies)

—Hemoglobin or hematocrit and blood glucose determinations as clinically indicated

—Screening tests required by law

- Initial hepatitis B vaccine should be administered.

At the initial follow-up visit, within 48 hours of discharge, the following assessments of the infant should be made:

- Evaluation of condition by history and physical examination to include evidences of adequate nutrition and hydration, normal stool pattern, degree of jaundice, quality of mother–infant interaction, and details of infant behavior
- Review of laboratory data obtained before discharge
- Screening tests for PKU, hypothyroidism, and other metabolic disorders, as indicated by state law and clinical judgment
- Planning for health maintenance, to include arrangements for emergency services, preventive care and immunizations, periodic evaluations, and necessary screening

High-Risk Infants

Each hospital should develop guidelines for the discharge of high-risk infants that may include the following criteria:

- The infant should be physiologically stable and should be able to maintain body temperature without cold stress when the amount of clothing worn and the room temperature are appropriate.
- The infant should be able to tolerate oral feeding by breast or bottle. If the infant's clinical condition precludes normal nipple feeding, the parents or other care providers should be instructed in an alternative feeding program.
- The infant should be gaining weight steadily at the time of discharge.
- The infant should be free of apnea prior to discharge or be receiving appropriate treatment.
- The physician or discharge planner should have confirmed parental competence (eg, ability to administer medications).
- The home situation should be considered appropriate.

It is essential to have a well-coordinated plan for the discharge and follow-up care of high-risk infants:

- A complete physical examination should be performed prior to discharge in order to identify problems that require specialized monitoring (eg, heart murmur, apnea, seizures, atypical head growth pattern) and to provide data on which to base future assessments.
- Immunization against diphtheria, tetanus, and pertussis (DTP) can be initiated in medically and neurologically stable preterm infants who have attained a chronologic age of 2 months. The status of this immunization should be assessed before discharge. Although the response of premature infants to *Haemophilus influenzae* type B vaccine is currently unknown, the first immunization should be given at 2 months of chronologic age.
- All preterm infants should be screened for anemia prior to discharge. It may be necessary to provide supplemental vitamins, iron, or blood transfusions.
- Infants with history of deafness in the family, rubella exposure in the first trimester, maxillofacial anomalies, birth weight less than 1,000 g, meningitis, or hyperbilirubinemia treated with exchange transfusion may require referral for audiometric evaluation.
- Low-birth-weight infants (ie, those who were delivered at less than 35 weeks of gestation or weighed less than 1,800 g at birth) who receive oxygen supplementation are at an increased risk for retinopathy of prematurity and should undergo an ophthalmologic evaluation prior to discharge or at 5–7 weeks of age if still hospitalized. Infants who were born at less than 30 weeks of gestation or who weighed less than 1,300 g should also be examined regardless of oxygen exposure. The examination should be repeated according to the schedule appropriate to the original findings. Follow-up is recommended for those with significant active disease.
- Parents of infants with bronchopulmonary dysplasia require specific instruction in administering medications (eg, diuretics, bronchodilators) and feeding (eg, schedules, amount, technique, problem solving, and caloric supplements). They must be adequately trained to recognize signs of acute deterioration (eg, wheezing, congestion, distress) and to carry out cardiopulmonary resuscitation. Infants who continue to be oxygen dependent may be discharged if appropriate family and community resources are available and the infant is feeding adequately, growing, and able to maintain adequate oxygenation activity while receiving oxygen via nasal cannula at a

rate no more than 1 L/min. Initial follow-up contact every 1–2 weeks is indicated.

- Informed consent should be obtained from their parents before infants are discharged with home apnea monitors. Parents of these infants require anticipatory guidance, training in infant cardiopulmonary resuscitation, complete verbal and written explanation of the monitor, guidelines for home monitoring, and referral for follow-up services.

Legislation in most states mandates that infants and children from birth to age 4 years be restrained in appropriate car seats while in motor vehicles. A recent study has indicated, however, that infants with a current weight of less than 2,000 g are at an increased risk of oxygen desaturation and bradycardia when placed in a standard car seat. Parents should be alerted to this risk and should be counseled regarding alternatives, as described in the article by the American Academy of Pediatrics Committee on Injury and Poison Prevention, "Safe Transportation of Premature Infants."

Part of the discharge plan should include an assessment of the family's strengths and weaknesses. Appropriate referrals to any of the following ancillary services can then be initiated accordingly:

- Visiting nurse
- Social service
- Women, Infants, and Children (WIC) Program
- Mental health service
- Teen support services
- Parent support groups
- Early intervention services
- Respite care services

SHAWNEE MISSION MEDICAL CENTER

Shawnee Mission Home Care

February 12, 1996

To The Honorable Members of the Senate Financial Institutions and Insurance Committee,

I appreciate the opportunity to provide communication regarding maternity hospital stays and the Senate Bill No. 573.

I have been involved in maternal/child nursing for over seventeen years. During that time, I have seen the length of postdelivery hospitalization change several times. It is obviously difficult to determine just how long the postpartum mother/infant couple should remain in the hospital. If the main objective of the Bill is to assist health care providers in determining the optimal method of providing care to newly delivered mothers and infants, factors beyond the hospital stay must be considered.

At Shawnee Mission Medical Center (SMMC), a comprehensive maternity program was implemented approximately 2 years ago. Prenatal and postpartum components were added to the existing inpatient maternity service. Prenatally, the patient has contact with a prenatal coordinator which enables discussion of expectations, concerns, and prenatal class options. Following hospital discharge, the mother/infant couple receives postpartum follow up care in the comfort of their home by Shawnee Mission Home Care's (SMHC) maternal/child staff. The success of this program is demonstrated by the following summary of 1995 data:

- 0.3% neonatal readmission rate to SMMC (the national data suggest an acceptable readmission rate of 3% among similar populations).
- 86% of postpartum mother/infant couples are dismissed by their physicians within 48 hours after delivery.
- 87% of mother/infant couples dismissed within 48 hours after delivery receive follow up care at home by SMHC.
- 39% of mothers and infants seen by SMHC have a secondary diagnosis (diagnosis in addition to well mother or well baby).
- Average number of SMHC visits per mother/infant couple: 2
- SMHC services provided in a wide geographic area in Kansas and Missouri.
- Greater than 95% patient satisfaction rate with SMHC program.
- Greater than 98% of the patients seen by SMHC would recommend the program.
- Physician satisfaction with SMHC program.

7314 Antioch • Shawnee Mission, Kansas 66204 • (913) 676-2162

14-15

The maternal/child program at SMMC was developed as a collaborative effort between SMHC and the maternity staff and physicians of SMMC. The goal of the program is to provide quality clinical follow up to reduce the length of hospital stay for the well postpartum mother/infant couple. From its inception, high standards for quality of service and clinical outcomes were established. The maternal/child home care Registered Nurse (R.N.) staff was selected based on experience and skill in caring for postpartum mothers and infants. Each R.N. had expertise in preventing, detecting, and managing postpartum and neonatal complications. Through this highly skilled team, the program's goals have been attained and unnecessary hospital readmissions have been avoided.

In addition to meeting clinical outcomes, the program has demonstrated high patient satisfaction. The patients have provided supportive feedback through surveys and comments (enclosed) Patients frequently comment that they did not realize what to expect prior to the visit, but after the visit they realized just how much more beneficial it was to receive information and assistance related to infant care and safety at home as opposed to in the hospital.

The hospital environment may facilitate communication between patient and physician and provide a sense of security among patients and their families. However, hospital stays are costly. In addition, many postpartum complications will not be prevented or detected within a 48 hour hospital stay. Infant problems such as hyperbilirubenemia, dehydration, and some heart defects typically do not appear until after the infant is 3-5 days old. The home care nurse is in the position to recognize and effectively manage these and other problems by providing skilled nursing care during the first postpartum week and beyond that time if necessary.

To achieve the goal of providing higher quality maternity care to mothers and infants, the focus should be on developing additional competent home care services instead of on increasing the length of hospital stay. These services should be made available to all postpartum mothers and infants.

If health care resources are going to continue to be limited, we have a cost effective model incorporating both high quality and excellent patient satisfaction. This model can be duplicated for use in another health care delivery systems.

If I can provide additional information or be of assistance in developing standards for maternal/child home care please contact me at (913) 676-2163.

Respectfully Submitted,

Karen B. Nelson

Karen B. Nelson, R.N., B.S.N.
Maternal/Child Clinical Manager

14-16

Department of Pediatrics

Hospital readmissions of Neonates Related to Early Postdelivery Discharge

This is a review of all infants readmitted to Shawnee Mission Medical Center (SMMC) within the first seven (7) days of life that had experienced an early (less than 48 hour) hospital discharge after delivery from 1-1-95 to 8-15-95. Available national data suggest a 3% readmission rate is expected among comparable populations. (1.2)

Between 1-1-95 and 8-15-95 SMMC delivered 2083 neonates. 1791 (86%) of them experienced a hospital stay after delivery of two (2) days or less. Six (6) of them were readmitted to SMMC within the first seven (7) days of life. Their diagnosis were: PSAH (one neonate), Group B Sepsis/Meningitis (one neonate), Hyperbilirubenemia (two neonates), Apnea secondary to Reflux (one neonate), and fever (one neonate).

This represents a readmission rate of 0.3%.

Each readmission was reviewed by a neonatalogist and by the Pediatric CQI Committee. They concluded that there was no morbidity associated with early discharge.

ADDITIONAL INFORMATION REGARDING FOLLOW UP:

From 1-1-95 to 8-15-95, Shawnee Mission Home Care provided postdelivery follow up to 1563 or 87% of the 1791 neonates discharged within 48 hours after birth at SMMC. Four (4) infants were readmitted within the first seven (7) days of life (four of the six infants previously mentioned).

This represents a readmission rate of 0.2%.

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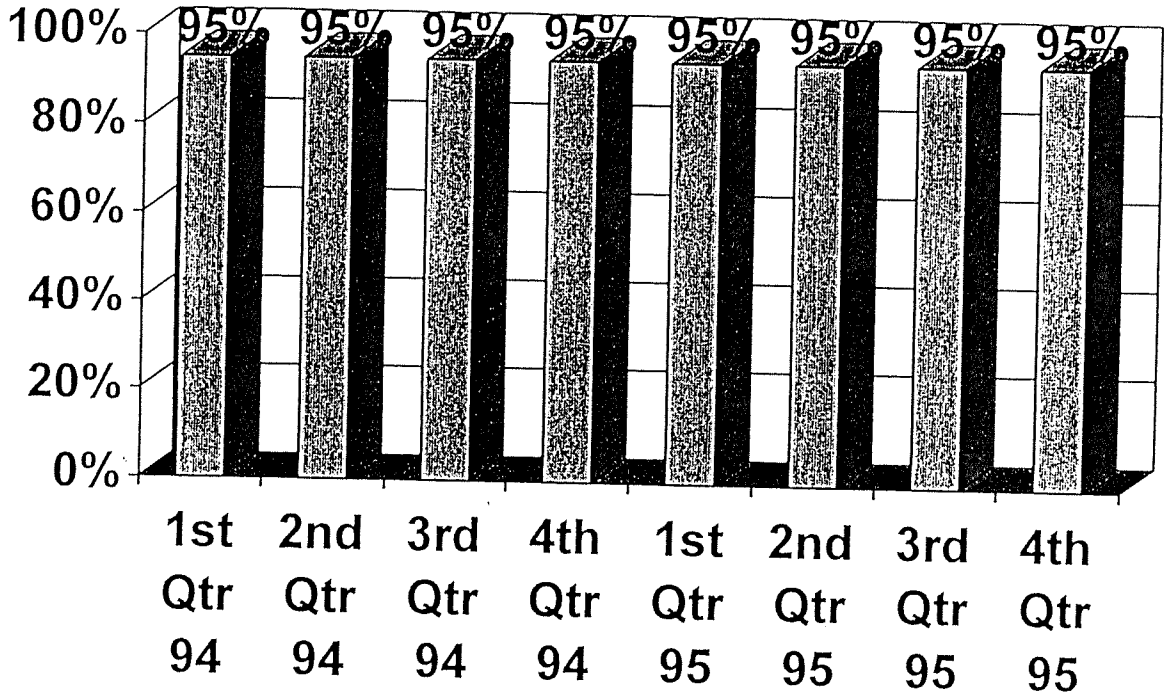
1. Hurt, H.; Early Discharge for Newborns - When is it safe?, Contemporary Pediatrics, p. 68-88, Aug 1994; Vol. 11
2. Williams, L. and Cooper, M.; Nurse Managed Postpartum Home Care, JOGNN, p. 25-31, Jan/Feb 1993; Vol 22: No.1

SHAWNEE MISSION HOME CARE MATERNAL/CHILD PATIENT SATISFACTION SURVEY RESULTS



Over 98% of the patients would recommend the program.

81-14

MATERNAL/CHILD HOME CARE SURVEY

WRITTEN COMMENTS
FIRST SIX MONTHS 1995

TEAM E COMMENTS

I don't have any family members such as sisters or mother here to ask questions or reassure me I'm doing the right thing. So it was great to have a caring nurse to help me and she even gave me a hugh I so much needed. Thank you.

Jennifer was wonderful. I really enjoyed her helpfulness. Keep up the good work.

Kim Mason was great. Very helpful, courteous and knowledgeable. I looked forward to her visits.

Marilyn was an absolute angel. Besides being very knowledgeable and professional she had a heart of gold. Her empathy, understanding and concern for us as a family gives her an A+ in our opinion.

Paula and Kim were both excellent. Kim was able to reassure me and advise me regarding some small feeding problems. Paula did a great job getting my IV started!

I really enjoyed having the nurse come visit me and appreciated her helpfulness and kindness (not too mention how far of a drive it was for her.) She was great! What a sweetie. Thank you.

Very friendly and helpful.

TEAM D COMMENTS

I didn't feel comfortable with the nurse coming to our home at first. I had been told that she would come in and start telling you everything you were doing was wrong. But that wasn't the case. I found her to be very courteous and profession. But since it was my home it seemed more relaxed and casual.

It was really a blessing to have the home care nurse come out. Questions I wouldn't have even thought to ask in the hospital came up quickly after I got home and was caring for the baby by myself. She helped give me confidence and a sense of peace because it was in my home and not in an outside location where I wouldn't be as comfortable and where I'd be afraid I couldn't transfer the info to my home specifically. She gave me great pointers, some specific to my home and feeding my baby, and really knew her stuff. It was nice to hear that we were both on the right track, healthwise, a big relief.

I really appreciated this service. My questions were answered and the nurse was very thorough. Thanks for the service.

Great program. I loved the way the nurse took care of me and the baby.

Paula Aaron was great and very personable. It was nice not having to take our baby out in the cold to a doctor's office at such an early age. It was also very reassuring to have access to someone on call after hours with my questions. Thanks again.

At first I was not comfortable about a stranger coming into my home and telling me what to do with my child, but I was very satisfied by the helpfulness and the wonderful knowledge that my home health care nurse provided. She only "advised" me of things to do to help me and my baby. And had great ideas. Thank you Paula!

It's a great program!

Home care was a great help. A must for a first time mom.

Great program.

Wonderful program. I was very happily surprised! Thanks!

Ginger was my home care nurse and I thought she was great! She let me know what to be concerned about and didn't make me feel stupid about things that weren't important. She is terrific.

I was very pleased with the service provided especially the assistance with breastfeeding.

I very much appreciated my home care nurse. She was a lot of help! Very good program.

I enjoyed the visit just to make sure myself and the baby were doing well since my stay at the hospital was less than 24 hours.

Lori was wonderful! The program was a tremendous help!

Kathy was wonderful! She really make me comfortable during my first efforts in nursing. I also appreciate her realization to the fact that nursing just wasn't for me. Thanks to her again! I feel that with the extremely limited time allowed in the hospitalization today this program is a must for all mothers!

I was extremely please and impressed with the home care program. After being discharged from the hospital 24 hours after having my first child and having problems breastfeeding, it was extremely reassuring to have the nurse visit the next day, check us and answer our questions. Keep up the good work. I think this is a very important part of the SMMC maternity care.

I was so pleased with the care provided to me by Ann Miller! She was so caring and knowledgeable, providing just what I needed at the transition point in my life of having a new baby. Thank you!

Jennifer did a good job and helped us to ease tensions about caring for the baby. It's nice knowing we can contact her if we have questions.

My home care nurse was excellent and a great help with breastfeeding.

I don't know what I would have done without the home visits! It reassured me I was doing everything alright and that my baby was gaining enough weight (which she was not at the first visit). So problems were avoided! It was nice to call her also for problems that arose after her visits.

The nurse helped my baby and me with breastfeeding. It was because of her that we can breast feed. I was very pleased with the nurse and all her help.

Without the home care nurses I probably would have abandoned breastfeeding my son. Thank you.

I feel this is an excellent program and will be sure to pass the word on. I felt so uneasy about going home so soon after my daughter was born, but having the home care nurse come over made me feel so much more at ease and more confident! Please continue this program and the wonderful help with breastfeeding!

I felt the home care nurse program was an excellent resource for me and my family. The were always willing to answer any question no matter how small. Paula was very helpful to me, especially on breastfeeding problems. Thank you for everything! We appreciate all you did for us!

The home care program is an excellent addition to the maternity care service. It can be difficult for new moms, particularly c-section, to get in to the doctor's office for those early checks.

The home care program is very helpful to even a third time mom like myself. There are questions that come up after you're at home a few days with the baby and it's very reassuring to have the nurse to be able to help.

Ginger was very knowledgeable and expressed genuine concern about my newborn and myself. This is an excellent program.

Marilyn was great! I called for information after her visits and she was most helpful. The program is very helpful and it is reassuring to know that resource is available. This was my second child and the program was very helpful. I'd think for first time moms it be essential!

I was skeptical about a 24 hour hospital stay and then having a nurse come into my home. But after experiencing it I am very satisfied with your program and learned more from the home care visit than in the hospital. Your nurses are very professional and knowledgeable. I felt like I could call your main number and get help quickly or ask a question. Above my expectations.

Paula Aaron was exceptional! She was kind, caring and patient. She was able to address my questions as a first time mom with respect. Paula spent lot of quality time with myself and Hannah, even though we only had 2 home visits.

I was very impressed with the care I received. The nurses were very concerned about the baby and how I was doing.

I know if I had not been visited and assisted on the phone I would not be nursing my baby. I also know he would have more than likely become dehydrated and been readmitted without her timely visit and availability. I had a 48 hour stay two years ago and no visits. Although leaving the hospital in 24 hours is not easy, the visits gave me a better start than the extra hospital stay.

Our home care nurse was very pleasant and caring. We were very pleased and comfortable with her.

Would have liked to have the option to have her come a couple more times in the first few weeks.

I honestly believe I wouldn't have continued breastfeeding my daughter. She gave me several tips.

The home care nurse we had was great!

Jennifer Allen is the best nurse I have had since my baby was born. What ever you are paying her isn't enough.

Kim Mason was great. She gave me confidence and the support a new mom needs.

Lori Hardman was my home care nurse and she was very nice. She is definitely an asset to Shawnee Mission Home Care Nursing.

This is an excellent program. I was thoroughly impressed with it. Thank you for providing such a service.

It was extremely helpful because I am a first time mother and all of my relatives live out of town. My nurse was genuinely interested in my health and my baby's health!

The nurse that came to our home was excellent! I had a little trouble breastfeeding at first, and the baby was dehydrated, but she helped us through that and my baby has gained 4 pounds since she was born and is still breastfeeding!

Kim was very kind and patient with me. She answered every question I had. I felt lucky to have such a terrific nurse.

Excellent home care, but also answered my phone calls in a timely manner for additional help on several occasions. I definitely would not have succeeded in breastfeeding without the encouragement and advice. Thank you! Keep up the good work!

I was very satisfied and extremely happy with both the care my daughter and I were given at the hospital and afterwards. The home care nurse was especially appreciated.

Our home care nurse was prompt, informative and shared in my joy when our baby finally took to nursing. Than you so much!

Kim Mason was a very informative nurse.

I think this is a very good program to have. I only wish it had been in use back in '92 when I had my first child.

My husband and I feel that Marilyn was one of the health care professionals responsible for saving our son's life. Furthermore, this program is vital, considering how short hospital stays have become.

I remained in the hospital less than one day and I appreciated the one-on-one follow up. Especially at the time of my delivery there were 15 other births that day and things were pretty hectic at the hospital.

I was impressed by the fact that after the two visits the nurse left her card with me and encouraged me to call with any questions, which I did in fact do.

Jennifer was very helpful with breastfeeding and all of the other concerns that my husband and I had. We came home from the hospital when Alex was only 19 hours old and so it was very helpful to have Jennifer come to our home.

My home nurse was very helpful. Even after she was finished with my visits she continued to answer my questions over the phone. It was a very beneficial program for me and my child.

The 24 hour help line was very beneficial! I used the line more than twice and they were very responsive. Please don't change anything.

This was our first child and though I wanted to breastfeed, I was concerned that the baby was not getting enough to eat, he kept falling asleep. The lady that came to the house showed me how to feed him, how to keep him interested, and most of all assured me that we were doing a good job. She was really wonderful and thanks to her I am still breastfeeding. Thank you so much.

Particularly for the first time parents such as us, this is a very worthy program.

I was very pleased with Marilyn. She was everything I needed. I was a first time mother, having trouble with breastfeeding. She was the best. I wish everyone could have this care when you leave the hospital!

I liked the home care nurse but it was really hard to come home from the hospital with only a 24 hour stay. I had a lot more trouble with fatigue leading to anxiety than I did with my first child. My home care nurse was wonderful. She took a lot of time with me and helped me especially with concerns that I had about breastfeeding.

Kelly was an exceptional person and nurse. She was very caring and quite knowledgeable. I really liked her a lot and felt her help was very beneficial. Thanks for sending her!

I think the Mother/Baby home health program is wonderful!

The nurse you sent out to me was very helpful, I think this is a good idea, since they only keep you in the hospital less than 24 hours. Thanks!

My first baby and I stayed in the hospital longer but had no home nurse. This hospital stay was shorter but it was very nice to have someone come to my home to answer my questions and concerns after being on my own for one night. Since hospital stays are now only for 24 hours, this program seems very important.

My home care nurse was extremely pleasant and answered any question I had about my baby. She made the whole experience very pleasant.

How convenient to have the medical care come to me instead of me to them - particularly in those first tired days after delivery. Thank you very much.

I didn't know what to expect from the nurse at the first visit. But once she was at my home I felt lucky. She provided me with much advise and help regarding breastfeeding. She made those first weeks more tolerable. Her help and concern got me through that tough time and I feel much more reassured and confident. It's a great program. Thank you!

Being an RN myself I thought it might not be necessary for the visits, but it was great. With being in and out of the hospital so fast now days this just gave me the encouragement and added teaching that was needed in that first week. Thank you!

I really appreciated the home care service. The nurse was friendly, knowledgeable and very helpful. It made me feel at ease to be able to ask her all the questions I had without having to call the doctor about things that weren't extremely important.

I was very, very pleased with all the care I received from Shawnee Mission Medical Center. I am very glad that a change in insurance necessitated our switching from KU med to SMMC. I felt the quality of care and overall concern of the staff far exceeded what I've experienced at KU. The entire experience was very satisfying. The home care people met my needs to a T. I had twins so they set me up with a home care nurse that had also had twins. This made the care and information I received that much more relevant and helpful to me. I really missed the home care nurse and the LDRP staff. They were exceptional clinically and in the human caring factor. I am a difficult patient and they met the challenge of caring for me exceptionally. I felt very good about my delivery and care all the way around. Thank you,

I was very pleased. I would use home care nurse again and would suggest it to others.

Excellent program. I would have been lost without the excellent help of my nurse, Kim.

Kim is perfectly suited for this job. She is calm, caring and very realistic.

The home care nurse, Lori, alerted me to the possibility of my daughter having a broken collar bone, and she did, something no one else had mentioned to us. Her suggestions on how to dress and lay our daughter to sleep made us all much happier and the baby more comfortable.

I want to thank Marilyn for doing such an excellent job taking care of my child and I. She was wonderful. He is growing well now, thanks for her help.

The home care visits were very helpful and reassuring. One suggestion: Perhaps the patient could meet with the home care nurse or a representative from home care before the patient leaves the hospital.

Positive experience for me and my baby. Thanks

I'd never had any kind of home health care before and was a little skeptical. It turned out to be wonderful. The convenience of not having to go to a doctor's office was so nice after having a baby. It was a good opportunity to ask questions and get help feeding the baby. We liked Ginger too. Thank you!

Wonderful program! The nurse was very caring and very naturally concerned with the baby as well as myself. She put 100% into our care and well being!

Thank you so much for all of your help. I really appreciate your encouragement and support on my decision to not continue breast feeding. I really needed to hear that it is not as easy as it looks. Guilt and failure is a major deal with me, but you really made me feel confident with my decision. Thanks again

SHAWNEE MISSION HOME CARE
MATERNAL/CHILD SURVEY COMMENTS
1995 LAST SIX MONTHS

Marilyn Suellentrop was a wonderful home care nurse and provided excellent care, instruction and support. Thank you for this wonderful service.

It was nice to have someone come and check on the baby! It put our minds at ease for someone to evaluate how the baby was doing from just 24 hours in the hospital!

I was very pleased by the home care provided. It is a nice addition as most insurance companies, including my own, have you out of the hospital in 24 hours.

The home care nurse was excellent! We spoke about some of my concerns and she felt that Jessica may have reflux problems. She contacted my pediatrician (Dr. Olson) and together they developed a treatment plan. This allowed me to continue to breastfeed, and also made Jessica more comfortable. She gave me a phone number to contact her anytime and came back the following day to help us. I feel that if this service had been available with my first baby I would have continued with breastfeeding my first daughter. The nurse was very knowledgeable about any problems that may arise from reflux, and also offered to put me in touch with other moms whose children have this problem. Please share my comments with my nurse and/or supervisor to let her know what a wonderful job she did. Thank you.

Kim was great. She helped me alot those first few days! Please tell her how satisfied I was with her. Hopefully I'll get her with my next child! I am glad this service was available. Thank you!

Marilyn Suellentrop was our home care nurse. We were delighted to have her in our home. She was very sweet and took her time with us. I would highly recommend her to others.

Very dependable. Arrived at time specified, which I appreciated.

The nurse was very nice and friendly as well as being able to answer all my questions.

Kathy Cook was a tremendous help during my difficult first week with my baby. I would have given up on breastfeeding without her assistance. She called often and came out for an extra visit to make sure we were okay. I was grateful for her visits.

I very much enjoyed coming home and having a nurse come to me. She was very good at helping me with breastfeeding and answered all my questions. She observed my baby feeding to make sure we were doing well together. I would highly recommend the program.

My home nurse really answered a lot of questions I had that did not get addressed while I was in the hospital. My nurse was very friendly and understanding. She also helped my husband with some concerns he had about the baby.

Many friends who have delivered at other hospitals are jealous of this service. I felt very comfortable and relieved to have this service. It really helped me since the hospital stay is so short now! It was nice that the nurse could take out my stitches (c-section) so I didn't have to go back to the hospital or doctor's office for that!

I thought the home care was excellent, as was my nurse Kim. I am glad she could come twice. That is much more reassuring when you are in the hospital only 24 hours.

I was very satisfied with the program.

My home care nurse was Marilyn Suellentrop and she was so helpful and nice. She always made it clear that if I needed any help or had any questions or concerns to not hesitate in calling her. If I have another child I would request her for my home care nurse.

Since I was expected to leave the hospital by 24 hours after my son's birth I was relieved to find out about the home care nurse and was thrilled after each visit.

I want to thank you for helping out with formula and information on pumping when I couldn't breastfeed because of all the medication I was on at the time. It helped out a lot and we are successfully breastfeeding now.

The home health care nurse was very helpful in answering questions and making me feel at ease about caring for my child and for myself after having a c-section. I was very pleased with the program and our nurse. Her name was Marilyn.

Paula's style was so informal, it was like getting advice from a more experienced girlfriend. You can't improve on something so great!

I was very satisfied with this program. It is necessary when being released so quickly from the hospital.

Very pleased with the visits of my nurse and the outcome of her visits. She seemed truly concerned about my needs and desires.

Having a nurse come to my home was a comfort. Knowing that if anything was wrong with the baby the nurse would catch it. It is a great program.

This was a good program, however, I would have felt much more comfortable and less stressed if I had been able to stay in the hospital another day or so. My baby had jaundice and I didn't feel good taking him home from the hospital so soon.

Everything was wonderful. The nurse was thorough in checking me and the baby. I can't think of any improvements.

My home care nurse was excellent. Very kind, patient, concerned, knowledgeable, and courteous. The home care nurse exceeded my expectations. She was great. Give her a raise.

Lori Hardman was so helpful! Lori's visits were great. It was so reassuring to see that Katie had put on weight and was ok. It is scary bringing home a baby after only 24 hours. Lori's concern and care made a difference. Thanks!

You couldn't make any improvements. Everything was wonderful. Paula was open and informative. She was great! She answered all my questions. This program was better than staying in the hospital. I received much more help from Paula then from anyone in the hospital. I appreciate being able to contact you and your staff for questions after the end of the visits. Thanks again.

The nurse set up a second visit just to make sure our infant was doing well as we had not had as many wet diapers as expected by her first visit. It enabled us to be at peace.

I thought our home care nurse was excellent as did my husband. It was a good experience for my whole family. She was very friendly and very informative. Thank you so much.

Home health and Ginger Ward were extremely helpful, and I recommend it continue. Especially for new mothers like me, questions arise after being released from the hospital. She put me at ease and offered assistance where needed. Very good program.

What a great idea!

Thank you for changing my mind about your program. I've called a few time since.

The nurse was really appreciated by my husband and me. I felt comfortable going home after 24 hours knowing a nurse would be in my home the next day and as much as I needed her in that first week by telephone or in person.

Thank you for providing this much needed service. With insurance companies making patients leave so early, this is a great service. Especially for first time mothers. Keep up the good work. My nurse was great!

Jennifer is an exceptional nurse. Throughout my pregnancy and afterward I had Jennifer with SMHC. She is an exceptionally knowledgeable and caring nurse. I was so thankful to have her. Thanks, again.

After being discharged less than 24 hours after delivery, this service was very helpful.

I think the 24 hour stay with two home health visits worked out perfect. Even better than a 48 hour stay with no visits. I think it is excellent having the home health visits. When you are in your own environment (it seems for me) I am more relaxed and have new questions and concerns that were not apparent during the hospital stay. Paula was excellent! She covered everything thoroughly and addressed concerns with issues in a professional manner, even though she knew I was a labor and delivery nurse with my third child. I respect this when health professionals do not assume you have knowledge due to your experiences and background. I am impressed how Paula took note of the home environment by pointing out safety concerns, tips, etc. I think home care is doing a great job fulfilling the needs of the community. Keep up the good work!

I support the Home Care philosophy - providing one on one support and information at home. I feel that I am much better educated about my baby's condition due to home care nurses visits and I know who to call when I need questions answered about G. E. reflux.

Kim was my home care nurse. She was wonderful! I had just had a c-section with twins, which was more than a little overwhelming. She made me feel more comfortable with everything and was especially helpful with information on feedings.

I appreciated the sensitivity and professionalism shown by Kathie. She did an excellent job since I was very sick with mastitis after giving birth. I found her patient and very diplomatic as well as caring. Thanks for all you do.

My nurse was Lori Hardman. She was very kind and concerned when I was having trouble nursing my son. Her encouragement inspired me to continue trying with him and now at 2 months he has doubled his birth weight on breast milk. She went over and beyond the call of duty to help me. She was wonderful!

Kelli was wonderful! She had to come three different times because my daughter would not eat. She was very helpful. My daughter, now 16 weeks old is a chunk! Thanks!

I believe this is a very worthwhile program because of how soon after delivery mothers are sent home due to insurances these days.

I thought Debbie was great!

Other hospital home care nurses do the 48 hour PKU test, saving me a trip to the hospital and the cost of a sitter for my other 2 kids. This would have been a wonderful addition to your home care product.

My nurse was great! Very nice lady!

My home care nurse was very friendly, helpful and prompt. She gave me good ideas for infant feeding and answered my questions about self care. I really liked her. Overall, a great experience!

Jennifer was really very helpful to us and we appreciated her concern when we had a couple problems.

My home care nurse was Kim. She was very helpful and friendly. I would recommend the program especially if all of the other nurses are like Kim.

Although I had a fairly problem-free pregnancy, delivery and first week, the home care nurse's visit gave me peace of mind. And every new mom loves to weigh her baby!

I must admit that I was very dismayed at having to be discharged from the hospital after my labor/delivery/recovery only 24 hours later because of insurance policy. I didn't think the home visits would be worth any good as what I really needed was another nights stay to rest. I was mistaken, though. The follow-up visits by my home care nurse, Debbie, were very helpful. Her sincere concern and friendly personality were an added benefit to the quality medical attention we received. Thank you

Kathie was a lifesaver!

I feel since the moms and babies go home so soon it should be a must to have home nurses come into the home of every new mom and child for proper care and concerns of both.

I liked having a nurse come to my home. With a brand new baby it was a lot easier than having to go to the hospital or doctor's office for an appointment.

I was very encouraged by the nurse home visits. I found out my son was gaining weight and how much he drank in a feeding. She also helped me with breastfeeding technique and encouragement. Coming home 24 hours after birthing is too soon. The home nurse care is a vital part of the birthing experience.

I learned a great deal from my home nurse about the correct way to breastfeed.