

Lissa -

In my last hour here before leaving I was trying to finish up this column. Suddenly, the network "went down." I take it as a sign that it's time to leave. This is somewhere between an outline and a draft. It is also obviously only half done. I would continue by talking about the physical and emotional challenges of having children, the things to learn, the bonding process, and the supports women need. Actually, I guess you'd be better at that than I would! Anyway, sorry I didn't finish.

See you on Sept. 25th

;) Jen

P.S. You may also want to add something about other countries.

e.g. England has a 10 day stay, followed by 10 days of daily visits by a midwife, followed by home health visits as needed.

draft #2

FIRST LADY HILLARY RODHAM CLINTON
COLUMN # 11 -- SEPTEMBER 31, 1995
TALKING IT OVER/CREATORS SYNDICATE

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Before my daughter was born, I did everything I could think
of to prepare for the arrival of a new baby. →

I asked my doctor hundreds of questions. I read every book I
could get my hands on. And my husband and I went together to
childbirth classes.

Even so, I was in for some surprises.

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when I was still learning to breastfeed. Suddenly I noticed foam
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holding the baby at an awkward angle, making it difficult for her
to swallow the milk she took in.

That wasn't the only time nurses came to my rescue during
the four days I was in the hospital. They taught me to bathe and

When you turn over to ins. companies
here is what happens

- ⑥ Mother + children - she
- ⑦ meningitis > this

debate that touches all of us - -
not just "them"



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see how much \$ these companies
are making

adm costs way higher for managed care

how do you stand in front of a tidal wave &
say it's gonna ruin our country -

Newborns, moms don't deserve the bums' rush

BOSTON—The phrase is just a little too cute: "Drive-thru deliveries." Not even the most parsimonious health insurer has actually told a mother to keep her car running outside the delivery room for a postpartum getaway.

But you get the idea. Suddenly, we are confronted with a fast-food approach to birthing. Mothers don't dally at the hospital anymore. They don't even have time to digest. They're supposed to get what they came for—a baby—and get out.

Remember all those years when women tried to

Ellen Goodman

get the medical establishment to stop treating childbirth like an illness? Remember the pressure to make delivery less institutional and more homey? Well, be careful what you wish for.

In the 1990s, the postpartum world isn't just like home, it is home. Mothers and babies are routinely discharged in a day. Sometimes they're ejected 12 or even six hours after delivery.

This is not because the insurers took a women's health movement seminar. It's because of financial pressures. The new managers of care may not yet have limited the number of contractions on your health plan, but they've determined how many hospital hours you're permitted.

The managed care of mothers is not all that different from the managed care of any other patients. In the new world of cost-cutting medicine, any treatment short of a triple-bypass is a candidate for an outpatient procedure. People are being discharged with—I use the term deliberately—abandon.

But with four million deliveries a year, birth is the most common reason for hospitalization and the most widely shared experience. With the growing testimony about dramatic and sometimes dangerous results of early discharge, this is the procedure that's finally rung the national alarm bell.

There is alarm about the small but serious number of problems in newborns discharged too early. Problems of jaundice, dehydration, even death. There's alarm as well about the mothers dismissed before they felt physically or emotionally ready to deal with their children at home. There's the loudest alarm at the sense that neither patients nor doctors—but rather HMOs and insurers—are making medical decisions.

For every story about a newborn who developed severe problems, for every mother without enough time to heal or learn how to breastfeed, there's a tale of a doctor under pressure to cut costs or be "de-selected" from some insurer's list of providers. One threatened obstetrician in New Jersey even called herself "an indentured servant."

For these reasons, "drive-thru" patients and stressed-out doctors have jointly turned to the legislature for help. Maryland and New Jersey have both passed bills that require insurers to pay for a hospital stay of at least 48 hours after a routine delivery. Similar bills have been introduced in California and Massachusetts.

On June 27, a bill was also introduced in the U.S. Senate that would make 48 hours the standard for a routine delivery and 96 hours for a Caesarean. Shorter stays would be permitted as long as the doctor and mother agreed and home health care was provided.

Generally, it's a bad idea to legislate medical treatment. We don't want politicians deciding that everyone's entitled to an X-ray or to a certain medication for a disease. Medicine changes too fast. Health problems are too diverse for mass prescription.

Even in childbirth, there are a lot of women who regard the hospital as unhealthy and want to get out as quickly as possible. There are some who prefer to give birth at home.

At \$1,000 or so a day, the hospital's a pretty expensive place to use for recuperating or for learning how to bring a newborn. The option of a home health visit is far less expensive.

But it's clear that we need some legislation to keep medical decisions in the hands of patients and doctors. That's not just true in the managed maternity ward but in the whole new health care world.

Robert Blendon of Harvard's School of Public Health says that we are witnessing the emergence of new medical consumer protection laws. There's an alliance between the consumer—the patient—and the physician. Both want medicine to be practiced according to the highest professional standards, not according to the industry's bottom line.

In the end we don't just want to protect the number of hospital hours. We want to make sure that the quality and quantity of treatment is determined by medical judgment.

What better place to begin than at birth? On the highway to drive-thru deliveries, we're finally laying down some speed bumps.

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FIRST LADY HILLARY RODHAM CLINTON
COLUMN # 11 -- SEPTEMBER 31, 1995
TALKING IT OVER/CREATORS SYNDICATE

gld
a/ps

Before my daughter was born, I did everything I could think of to prepare for the arrival of my new baby.

I asked my doctor hundreds of questions. I read every book I could get my hands on. And my husband and I went together to childbirth classes.

Even so, I was in for some surprises.

I remember lying in bed a few days after Chelsea's birth, when I was still getting accustomed to breastfeeding. Suddenly I noticed foam in her nose. Afraid that she was convulsing, I pushed every call button within reach.

When the nurse arrived, she assured me that I was simply holding the baby at an awkward angle, making it difficult for her to swallow the milk she took in.

That wasn't the only time nurses came to my rescue during my stay in the hospital. They taught me to bathe and feed my daughter, and also gave me a chance to recover from the emotional

and physical toll of a Caesarean section.

Nowadays, experiences like mine are far more common in countries like Australia, Germany, Japan, Ireland, and France than here in the United States.

As insurance companies look for ways to cut costs, new mothers routinely are rushed out of the hospital 24 hours after an uncomplicated birth and three days after a caesarean.

I have one friend who was pregnant with twins and began hemorrhaging during labor. She had to undergo an emergency caesarean under full anesthesia. After the delivery, she was severely anemic and was placed in intensive care.

Even so, based on a "checklist" of medical factors, her insurance company said it would not pay for more than three days in the hospital . In the end, the company did cover a longer stay, but only because her doctor spent hours on the phone arguing that it was medically unsafe to send her home.

Unfortunately, many doctors won't take on such battles because they fear being dropped by the managed care companies with which they do business.

[NOTE: Creators thinks we should cut the next paragraph

because it is "inflammatory." Also, they think the second sentence in it undermines the point we want to make because it suggests that private companies do better than Medicare/Medicaid in most cases. I told them we will probably keep the paragraph in the column anyway.]

The irony is that, while pressuring doctors to limit hospital stays to save money, some of these companies are spending millions of dollars on bonuses for their top executives. And in some instances, their administrative costs run higher than those of publicly financed programs like Medicare and Medicaid.

Insurance companies insist that limiting a baby's time in the hospital is not only a money-saver, but it also reduces exposure to hospital germs. ^{Most health care experts agree that} ~~And~~ there is little health risk to

^{the majority of} ~~most~~ new mothers and babies who are discharged in the first 24 hours, ^{But they question insurance company claims that those who develop complications} ~~they say, because they~~ are usually provided with follow-up ^{after discharge --} visits by a nurse in the home. ^{like jaundice or dehydration --}

^{to look at} ~~It is true that~~ ^{some} ~~for most new mothers and infants, leaving the hospital after one day is perfectly safe.~~ But what happens if the baby develops an infection or other complication like jaundice that only becomes apparent on the second or third day after birth? What if the new mother has difficulty learning to breastfeed properly, which could result in dehydration or other serious problems for her baby?

Cut this?

The reality is that many insurance companies only cover one

home visit per patient; others simply provide for a phone consultation with a nurse in the days after childbirth. And cases have been reported in which the nurse or home visitor simply didn't have time to show up or didn't even know the baby had been born.

A retired transit worker in New Jersey, Dominick A. Ruggiero, Jr, told this story to the New Jersey legislature earlier this year:

His niece had an uneventful pregnancy and childbirth and was discharged after 28 hours. At home, however, her baby, Michelina, suddenly took a turn for the worse. A nurse was supposed to visit the home on the second day but never came. When the family called, they were told the visiting nurse wasn't aware the baby had been born.

The family also called the pediatrician several times, who said the baby had a mild case of jaundice and did not need to be examined.

The baby died from a treatable infection when she was two days old.

Thanks in part to Mr. Ruggiero's testimony, New Jersey now has a law that will make sure that insurance covers mothers for a

minimum of 48 hours in the hospital after uncomplicated deliveries and 96 hours following caesarean deliveries. Maryland passed similar legislation last spring, and Congress is now considering a bill.

Although a handful of critics has suggested that this is another example of government intrusion into the health care system, I think that protecting the health of new mothers and infants is a clear case of where government regulation is needed.

No government employee should ever decide whether an infant has jaundice or a new mother is anemic. But at the same time, no insurance company accountant should make the final judgement about what is medically best for newborns and their mothers.

That decision should be left to doctors, nurses, and women themselves.

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9/25/95

w/ Creators suggestions

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Unfortunately, many doctors won't take on such battles because they fear being dropped by the managed care companies with ^{which} ~~whom~~ they do business.

Creators think this is inflammatory (e.g. political?) and should be deleted.
They also think the sentence about administrative costs makes it sound like private companies are better because most have lower costs. I told them we probably use to keep this stuff in if we can.

★ The irony is that, while pressuring doctors to limit hospital stays to save money, some of these companies are spending millions of dollars on bonuses for their top executives. And in some instances, their administrative costs run higher than those of publicly financed programs like Medicare and Medicaid.

Insurance companies insist that limiting a baby's time in the hospital is not only a money-saver, but it also ~~limits~~ reduces exposure to hospital germs. And there is little health risk to most new mothers and babies who are discharged in the first 24 hours, they say, because they are usually provided with follow-up visits by a nurse in the home.

But what happens if the baby develops an infection or other complication like jaundice that only becomes apparent on the second or third day after birth? What if the new mother has difficulty learning to breastfeed properly, which could result in dehydration ^{or} ~~and~~ other serious problems for her baby?

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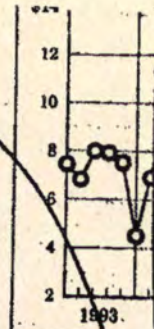
World-Wide

A HOUSE PANEL MOVED closer to a radical overhaul of farm policy.

The Agriculture Committee rejected a plan to cut \$13.4 billion from subsidies and other programs as it turned toward a radical Republican proposal to end 60 years of government controls on farm production. The GOP's so-called Freedom to Farm proposal would abolish most price-support and income-support programs while capping and gradually phasing down subsidy payments. If enacted, it would be a historic break from farm policies dating from the New Deal era. (Articles on Pages A2 and A4)

The House voted to eliminate federal highway speed-limit and motorcycle-helmet requirements, going beyond similar action already taken by the Senate.

The U.N. and NATO concluded that it is "currently not necessary" to resume air strikes over Bosnia. Bosnian Serb forces



THE U.S. Trade services rose 1.1% in July, justed \$11.5 billion in July, reports. (Article)

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Dole, Kansas Republican, said before the vote. "We are closing the book on a six-decade-long story of a system that may have been well-intentioned, but a system that failed the American taxpayer and that failed those it was designed to serve."

A 50-49 vote passed an amend-

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enate votes today n reform measure

by Steve Daley

WASHINGTON BUREAU

WASHINGTON—To the dismay of politicians on the ideological margins, President Clinton and Senate Majority Leader Bob Dole are expected to reap a political windfall on Tuesday with passage of a welfare-reform bill they can claim as their own.

The vote on a plan to end the

federal government's 60-year-old guarantee of cash assistance to the indigent and transform the nation's welfare system comes after weeks of furious negotiating.

The bill, which would shift the burden of welfare to the states through \$17 billion in block grants over five years, reflects the changing nature of the country's view of its poorest citizens.

The measure is backed by a majority of senators, especially moderate Democrats and Republicans. But it is opposed by the conservative Christian Co-

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A RUN OF 60 YEARS

87 to 12 Margin Backs
Bill Pushing Jobs and
Limiting Benefits

By ROBIN TONER

WASHINGTON, Sept. 19 — On an overwhelmingly bipartisan vote, the Senate today approved a bill that would fundamentally restructure Federal antipoverty policy and end the Government's longstanding guarantee of assistance to families who need it.

The vote, which the bill's supporters called a recognition that the current welfare system had utterly failed, was 87 to 12, with only 11 Democrats and 1 Republican in opposition.

Compromise blueprint ends 60-year aid to poor

By Leslie Phillips
USA TODAY

The Senate Tuesday voted to overhaul the nation's welfare system, ending its 60-year guarantee of aid to the poor.

The 87-12 vote virtually guarantees passage once the Senate version is reconciled

Ear infection
germ resists
penicillin



FAX TRANSMISSION

Date: 9/25/95Time: 4:40 pmPages (including this cover sheet): 4

To:

Name: Melanne VerueerAt: Office of the First LadyFax Number: 456-6244

From:

Name: Ron PollackDept/Activity Code: 80Project: 20**Comments:**

Here's memo — the hard copy
and enclosures are being
messengered.

MEMORANDUM

TO: Melanne Verveer
FROM: Bob Shrum
DATE: 9/25/95

Herewith, some suggestions...

1. Possible Refrain Lines -

- Those who believe in family values should value the health of our children (a family's savings, a child's hearing, the treatment of a child born with HIV, etc.)

- Children have no lobby and no vote -- so we must be their voice.

We must say ... [transition from issue to issue]

2. Possible lines -

- By this legislation, they have decided to leave the children home alone -- with no help when they are unhealthy, unsafe, or underfed.

- There is something fundamentally wrong with a federal budget that takes medicine from children in order to hand more money to the wealthy and the powerful.

- The Medicaid bill is the act of a schoolyard bully: Pick on children smaller than you.

- They say they are part of a Christian Coalition and that they adhere to a Christian agenda. Have they forgotten Christ's words about children: "Whatever you do unto these, the least of my brethren, you do unto me."



TO: Melanne Vermeer

FROM: Ron Pollack

A handwritten signature in black ink, appearing to read "Ronny".

RE: Materials for the First Lady's Speech

DATE: September 25, 1995

As you suggested in our telephone conversation on Saturday, the current policy debate in Washington offers a meaningful glimpse at the moral bearings of the country -- or, at least, whether the moral bearings of Congressional leaders are consistent with those of the American public. The debate on Medicaid cuts, perhaps, offers some of the clearest questions that shed light on some of those moral bearings. Without traipsing into policy-work-land, here is how I would try to pose the issues in human terms that are posed by the Medicaid debate:

- Will we continue to guarantee that low-income children, and children of low-wage working parents, have health coverage?
- Will we continue to guarantee that people who lose their jobs during economic downturns can get health coverage?
- Will we continue to encourage families to get a job by protecting those who move from welfare to work that they are guaranteed their (Medicaid) health coverage for a time after getting a job?
- Will we continue to guarantee that people who need long-term care can still get it after they have run through their life savings?
- For the spouses of loved ones who have been institutionalized in a nursing home, will we continue to protect such spouses against economic devastation by guaranteeing that they can keep enough income to live on?
- Will we continue to guarantee that the nation's nursing homes will not return to the shocking conditions that existed in many places around the country before Medicaid cracked down on them?
- Will we continue to guarantee that people with disabilities can get the specialized care that they need?

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- Will we continue to guarantee that lower-income families are given the health care services that they need at a price that they can afford?
- Will we continue to guarantee that lower-income senior citizens — who cannot afford the high and rapidly-increasing premiums, deductibles and copayments of the Medicare program — will get the help that they need so that they can continue receiving Medicare coverage?
- Will we continue to guarantee that low-income families receive protection from substandard health care?

Based on the House and Senate Medicaid proposals introduced last week, the Republican answers to each and every one of these questions is negative. Although some people would receive some of these protections for a period of time, these very basic nationwide guarantees would vanish under the pending bills. A nation that was on the brink of a bi-partisan consensus to provide affordable, high-quality health care to all Americans would — if these bills pass — take giant steps backwards for its most vulnerable citizens. More tangibly, the incremental and bi-partisan improvements that were made for vulnerable children and seniors during the past decade would be eliminated.

For example: Until 1989, a woman whose husband went into a nursing home was in danger of being left destitute, required to spend virtually all of her income and resources for her husband's care. As a result, spouses — already devastated by the incapacity of a loved one, and experiencing the heart-wrenching emotion of having him institutionalized — faced the ultimate humiliation of filing for divorce so that they would not be forced into destitution. Congress enacted the "Medicare Catastrophic Coverage Act of 1988" (signed by President Reagan) which provided this "spousal impoverishment protection" for the first time and, even though the overwhelming bulk of the "Catastrophic" legislation was repealed soon thereafter, this crucial protection was exempted from that repeal. The "spousal impoverishment" provision increased both the monthly income and overall assets the spouse remaining at home could retain. The House and Senate bills end the guarantee of protection against impoverishment for spouses of nursing home residents. States will have freedom to drop this protection; and, as Medicaid funds shrink, many states are certain to do so.

For another example: Until the mid-1980s, very few children from low-wage working families qualified for Medicaid. Up until that time, Medicaid assistance was largely reserved for people or families receiving welfare assistance, either AFDC or SSI. As a result, many millions of children with incomes below the poverty line (today, slightly more than \$1,000 of income per month for a three-person family) were without any health coverage. Indeed, as of 1984, a family of three could not have income above 14 percent of poverty and qualify for Medicaid in Mississippi, and the same family of three could not get Medicaid in Connecticut if their income

...the same family or three could not get Medicaid in Connecticut if their income exceeded 66 percent of poverty. As a result of various changes of law enacted in the 1980s,

Medicaid now requires that all children up to age six and pregnant women be covered by Medicaid if their family incomes are below 133 percent of the federal poverty standard. Coverage for children up to age 12, with incomes up to the poverty line, is guaranteed; coverage for older children is being phased in. The Medicaid expansions have made a difference in children's health: infant mortality rates declined by 21 percent from 1984 to 1992, and birthweights have improved. Unfortunately, at a time when employer-paid health coverage is dropping quite rapidly, the pending Medicaid proposals in the House and Senate would remove the guarantees that lower-income children receive coverage. Again, as federal Medicaid funding is limited, states will be forced to cut off millions of needy youngsters from health coverage.

And another example: Americans give encouragement to families that wish to work. At the same time, Americans like to extend a helping hand to people who temporarily lose a job through no fault of their own. Both of these values are incorporated in the existing Medicaid program. For lower-income families moving from welfare to work, transitional Medicaid benefits now allow beneficiaries to continue receiving Medicaid for up to one year while they are working, giving them a chance to get on their feet. This protection recognizes that low-wage jobs available to welfare recipients typically do not provide employer-paid health insurance. Similarly, the Medicaid program extends aid to children whose breadwinner-parent loses a job, and enables communities that are hard hit by economic downturns to continue providing this protection. Under the proposed Medicaid legislation pending in the House and Senate, neither of these protections would be guaranteed. Indeed, in states and communities hard hit by plant closings or a recession, they will not have the fiscal capability to protect families affected by layoffs.

Melanne — I would make sure that the First Lady's comments are not designed to critique America's values but are more designed to critique how Congressional leaders are making proposals that are contrary to America's values. I believe that — no matter the public's interests in reducing welfare dependency — there is little sympathy for ending the protections that are described above.

As further background for the speech, I am enclosing a copy of our publication "Hurting Real People -- The Human Impact of Medicaid Cuts" (which contains illustrative stories of real people) as well as last week's brief checklist/report on the pending House Republican Medicaid proposal. Let me know what else you need in preparation for the First Lady's speech.

Across the country, babies just hours old are being discharged from hospitals—simply to satisfy insurance companies. Tiny lives are at risk. Here's how you can help stop this shocking practice.

Pat Steenland, 40, a professor of English literature in Moraga, CA, gave birth to her first child, Miya, March 15 at 12:05 A.M. A mere fourteen hours later, at 2:00 P.M. on Thursday, the hospital discharged her. "I wasn't at all ready to go home," says Steenland. "I had been up two nights straight because I kept going into labor and then stopping. I was exhausted. I had also started hemorrhaging and was hooked up to an IV with Pitocin to stop the bleeding." The hospital really wanted to send her home at noon but, says Steenland, "a very nice nurse gave us two extra hours. I was hooked up to the IV until literally ten minutes before I walked out the door."

But that wasn't the worst of it. Once home, on Friday night, Miya started to wail. Her temperature was 102.7. Steenland and her husband, Glen Moriwaiki, an artist, called their pediatrician, who told them to unsaddle her. That brought her temperature down. On Saturday morning they took her to the doctor's office where a blood test was taken. On Monday morning they got a call that Steenland remembers as "just chilling." The blood test showed signs of a massive infection that could be streptococcus. The doctor told Steenland to take Miya immediately to Children's Hospital Oakland. "We were terrified," she says.

Miya was rushed to intensive care and started on intravenous antibiotics. When the culture from the blood test finally came back, it confirmed that she had alpha streptococcus, a rare but fortunately mild form.

When the hospital was ready to release her, Health Net, the family's HMO, wanted to have a home nurse come to their home once to teach Pat and Glen how to administer antibiotics to their infant daughter with an intravenous needle in her scalp. "I told them 'No,'" Pat says. "Fortu-

nately someone at the hospital was doing the negotiating for me so it was easier. I said either they pay for five days of home nurse visits or five more days of intensive care. Finally they agreed.

"But they didn't let up the pressure," Steenland says. "The home nurse tried to get us to learn to flush the IV line so she could come only two times a day instead of four. One night the line was jammed and the nurse had to replace it and draw blood from my daughter's scalp, and I said, 'You expected me to deal with this? It was hard enough to watch.'"

"It really was a terrible ordeal, a trauma," Steenland remembers. "Fortunately, Miya's perfectly fine now—for her, it's as though nothing happened. For us, it's going to be with us for the rest of our lives. I think the twenty-four hour release is a terrible policy. I keep saying, 'How many babies are going to die before they change it?'"

A potent coalition of doctors, mothers, and some of the nation's leading politicians are wondering the same thing, and have joined forces to lead an outcry against what have become known as "drive-through deliveries." This refers to a policy of releasing mothers and their newborns from the hospital too soon—anywhere from eight to 24 hours after birth. The result has been a growing number of infants who've developed life-threatening complications—and even died.

In May, the American College of Obstetricians and Gynecologists (ACOG) issued a statement calling for a moratorium on the practice and called upon insurance companies to prove that early discharge is safe. For many years, ACOG and the American Academy of Pediatrics have recommended that mothers and newborns spend 48 hours in the hospital unless, in select cases, doctors deem earlier release safe, according to strict criteria. (According to the National Center for Health Statis-

BY JEANIE RUSSELL KASINDORF



tics, the average length of stay for mothers and babies dropped from 4.1 days in 1970 to 2.4 days by 1993.) In its statement, ACOG cited reports of two serious problems that doctors were suddenly seeing: babies suffering brain damage from untreated jaundice that parents weren't trained to recognize, and breast-fed babies suffering from dehydration because mothers didn't realize they weren't getting enough milk. Soon after, the American Medical Association passed a resolution saying that discharges should be "determined by the clinical judgment of attending physicians and not by economic considerations."

Obstetricians also complained loudly about how difficult early discharge was on women. "The risks are greater to the newborn than the mother," says Anthony Caggiano, M.D., past president of the New Jersey Obstetrics and Gynecology Society and president-elect of the Medical Society of New Jersey. "But our concern is the abuse of mothers. They are exhausted, they're sore, yet they're also wired because of the new baby and all the people calling and visiting. They don't have time in twenty-four hours to take a deep breath and get a good night's sleep and learn how to take care of their newborn and themselves before they leave the hospital."

In May, Maryland passed a law requiring that infants who are discharged in 24 hours meet certain medical criteria and receive a home visit. In June, New Jersey legislators passed a stricter law mandating insurance companies and HMOs to cover a 48-hour stay in the hospital if the mother requests it. Alan Langsner, M.D., senior consultant of pediatric cardiology at St. Barnabas Medical Center in Livingston, NJ, told legislators that "it is only a matter of time before an infant with a correctable cardiac lesion dies in the name of early newborn discharge." Parents, doctors say, have no way of recognizing the subtle signs—bluish red or purplish blood or small changes in skin coloring—of that heart condition.

By summer, bills were introduced in New York, California, Pennsylvania, and Massachusetts. In June, Senator Bill Bradley (D-NJ) filed a bill to require health insurers to allow new mothers to remain in the hospital for a minimum of 48 hours (96 hours for a cesarean); Senator Nancy Kassebaum (R-KS) signed on as a cosponsor. In the House, Congressman George Miller (D-CA) proposed a similar bill. Even the leading ladies in both political parties—First Lady Hillary Rodham Clinton and New Jersey's Republican Governor Christine Todd Whitman—have

voiced support. Governor Whitman signed her state's bill at a New Jersey hospital and then, for the photo opportunity, stood bedside with a new, smiling mother. And Hillary Clinton said on *The Oprah Winfrey Show*, "I personally am appalled that we are now discharging mothers with babies as soon as we possibly can get them out the door."

Throughout the emotional debate, the insurance companies and HMOs have stood firmly opposed. Why? It costs from \$700 to \$1,110 for an additional day in the hospital for each of the four million babies born each year. In defense of the early-release policy, Susan Pisano, spokesperson for the Group Health Association of America, says, "These decisions need to be made on a patient by patient basis by the attending physician, not by legislators in some cookie cutter approach."

It was in 1993 that insurance companies—especially HMOs—began asking their doctors to make sure mothers and newborns were discharged in 24 hours (two to three days for cesarean sections). State Senator John J. Matheussen (R-NJ), who sponsored his state's 48-hour bill, says that HMOs force their doctors to comply. Holly H. Roberts, D.O., an obstetrician-gynecologist in Red Bank, NJ, says that an HMO she works with, which she declines to name, "came into my office and showed me a chart of how soon their doctors got their patients out and threatened to drop me from their system if I didn't get my patients out sooner. They also told me there would be a financial incentive if I decreased my patients' length of stay."

In some states it has dropped even lower. In 1994, 16.6 percent of the babies discharged from California hospitals—90,000 babies—went home in under 12 hours. And in March 1995, the Southern California Permanente Medical Group, a division of Kaiser Permanente, the nation's largest HMO, issued a memo to its doctors asking them to "encourage" mothers to leave the hospital "as early as eight hours after delivery." They were also warned that, even with such breathtakingly speedy discharges, home health visits were "not to be used routinely." The memo—which was made public by a Los Angeles-based watchdog group called Consumers for Quality Care (CQC)—gave the doctors a checklist of things to tell new mothers about why they should go home early, including the fact that "hospital food is not tasty." Elaine Burn-Pyrez, spokesperson for CQC, says, "It's outrageous because it's totally profit driven. It's clearly not giving any concern to the mother or the newborn."

Indeed, some feel conditions have deteriorated to sheer recklessness once hospitals got into the early discharge habit. "Initially HMOs intended only full-term, healthy babies to be released within twenty-four hours," says Susan Panny, M.D., a pediatrician in the Maryland Department of Health and Mental Hygiene. However, when her department did a study of Maryland births they found that in 1992, 22.2 percent of all newborns who were not considered healthy were discharged before 24 hours. "It's very scary," Dr. Panny says.

One of those scary things that pediatricians are seeing—which they almost never saw before—is permanent brain damage caused by untreated jaundice. Jaundice is very common among newborns and causes no problems when babies are treated soon after detection. When left untreated, however, jaundice can lead

to mental retardation or impairment, motor problems, and hearing loss.

"When I went to medical school," says Augusto Sola, M.D., the director of neonatal clinical services at the University of California San Francisco Medical Center, "I remember a professor showing me pictures of babies with untreated jaundice. He said, 'Your generation is very lucky. You will never see this problem again.'" So when Dr. Sola began seeing babies with untreated jaundice, he looked at his hospital's records. He discovered that from June 1992 to October 1994, five babies had been admitted for the late stages of the condition. All five had been discharged from other area hospitals between eight and 28 hours after birth, and four of the five had no home nurse visit within two days of release. In the 20 years prior, there hadn't been a single admission for the condition at UCSF Medical Center. "A mother cannot be expected to diagnose jaundice that needs to be treated," Dr. Sola says. "Even doctors cannot always agree on it."

Yvette Joseph, 29, a New Jersey mother who is a mathematics editor at a school publishing company, sadly learned that all too well. She gave birth to a son, Nigel, at 7:32 P.M. on September 12, 1994. Since her insurance company would not pay for a second day, mother and son were released from the hospital the next evening around 10:30. "Before we were released, the baby was shivering very badly," Joseph says. "The nurses didn't know what was wrong. They said, 'Maybe he just hasn't adjusted well.' They released us anyway. The next day, a Wednesday, a visiting home nurse came and told us he was jaundiced, but we should expect that and to just expose him to sunlight. He was still shivering and she said his immune system just hadn't adjusted as well as other children's."

Nigel's yellow color continued to worsen. On Friday they talked to Seymour Charles, M.D., their pediatrician, and made an appointment to see him first thing Monday morning. As soon as he examined the baby, he rushed him to the nearest hospital. "It was a shattering experience," Dr. Charles says. "I'll never forget it. That baby was as yellow as can be and very lethargic. His temperature was down to ninety-three, his heart beat was down to eighty-three. I was afraid the baby was going to die."

Nigel spent two weeks in the hospital. When he was five months old, he started having six or seven seizures a day. "His eyes would roll back in his head," Joseph says, "and he would go limp." Now he has a seizure only about every fourth day, but no one is sure whether he will ever completely recover. "This baby is not out of the woods," Dr. Charles says. "This baby could grow up to have a seizure disorder."

What's so sick about this," says Dr. Charles, the chairman of the Insurance Committee of the New Jersey Pediatric Society, "is that we have systems in place in every major medical center to monitor and screen newborn infants. HMOs are saying all this is superfluous. They are taking all the technology that we built up for newborns in the hospital and casting it aside. We have one baby dead from streptococcus because the poor, unsuspecting mother can't possibly recognize it. And yet there is no way it would go unrecognized in a newborn nursery."

The case Dr. Charles is talking about is the one that prompted ACOG to issue its call for a moratorium on early discharges. Michelina Alanna Bauman was born at 12:12 A.M. on May 16, an apparently healthy full-term baby. "She came out pink as a flower," her mother, Michelle Bauman, says. "She was beautiful." The next afternoon Michelle, 28,

a housekeeper, and her husband, Steve, 30, a cement truck driver, took Michelina home to their house in Williamstown, NJ. The family's HMO, U.S. Health Care, paid for mothers and full-term newborns to spend only 24 hours in the hospital.

Around 10:30 that night, Michelina started moaning and refused to eat. Her parents stayed up all night trying to comfort her. Although they had no way of knowing it, their 2-day-old baby was dying of a massive beta streptococcus infection that her tiny body was unable to fight.

At 6:00 A.M. the next morning, they called the pediatrician. During the following day, the Baumans made four calls to their pediatrician, who told them the baby probably just had gas. As the day went on, Michelle remembers, Michelina's moans got "louder and louder." Michelle tried to comfort her by putting her in her baby swing for short periods of time. At three that afternoon, purple spots began to appear on her skin, a sign a neonatal nurse or doctor would have recognized as a "terminal event." The pediatrician's office said it was probably "just newborn rash."

At six that night Michelina died in her baby swing. Michael Grossman, D.O., the vice-president of medical affairs at Kennedy Memorial Hospitals-University Medical Center of New Jersey, where she was born, says that had Michelina "spent one more day in the hospital, the infection would have been detected and treated and she would have had a fifty-fifty chance of recovery."

"The system didn't even give our baby a chance," says a distraught Michelle Bauman. "Even if they had tried all they could and she hadn't made it, it would be easier to accept. My husband and I don't even know what to say to each other. He carries the little hat she wore home from the hospital with him all the time. We have pictures of her all over the house. I walk around and talk to the pictures and tell her I'm sorry. Some days I feel like grabbing her through the picture and just holding her, but I can't do that." ★

JOIN THE GOOD HOUSEKEEPING LOBBY!

If you want to help prevent the deaths and illnesses of any more newborns due to drive-through deliveries, fill in this petition and mail it to:

Senator Bill Bradley, Washington, DC 20510.

Dear Senator Bradley:

1995

Please add my name to the list of supporters of the Newborns' and Mothers' Health Protection Act of 1995, cosponsored by Senator Bill Bradley (D-NJ) and Senator Nancy Kassebaum (R-KS), which will require insurance companies to allow mothers and their infants to spend a minimum of 48 hours in the hospital after a baby's birth.

Sincerely,

name

address

FOCUS

THE BOSTON SUNDAY GLOBE • JULY 2, 1995

HEALTH CARE

Braking the OB Express

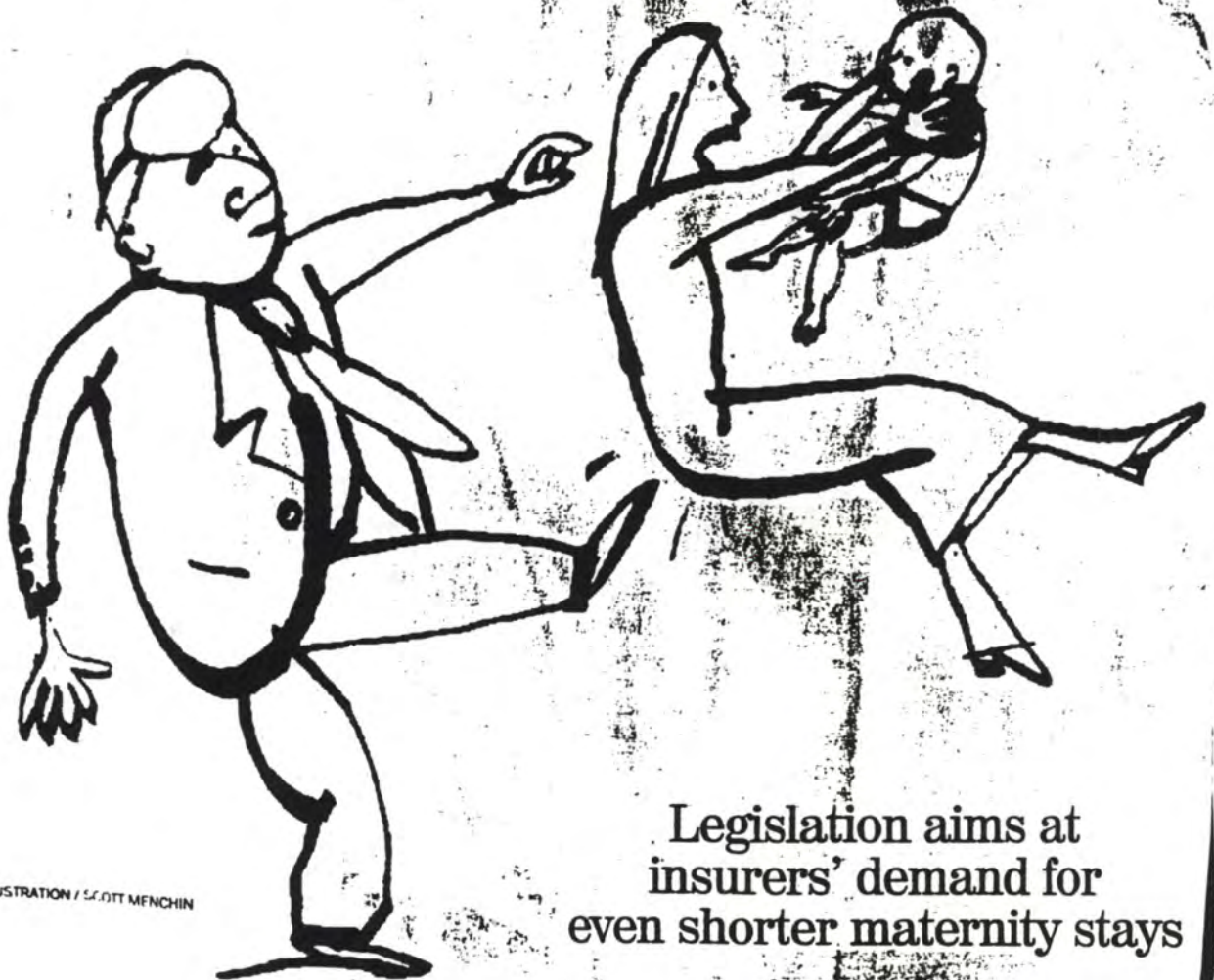


ILLUSTRATION / SCOTT MENCHIN

Legislation aims at
insurers' demand for
even shorter maternity stays

BY SUZANNE GORDON

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

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

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

New Jersey Gov. Christine Todd Whitman signed into law Wednesday a bill allowing new

mothers to stay in the hospital for 48 hours after a normal delivery, double the previously allowed time. And, in this era of managed care, a nearly revolutionary provision allows women and their doctors to determine when a longer than 24-hour stay in the hospital is medically necessary.

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

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

And two weeks ago, the American Medical

Association's annual policy-making body endorsed this growing consumer revolt in a strongly worded attack on insurance policies that place "economic considerations" above medical ones.

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

Critics say a better route to cost-cutting would

CHILDBIRTH, Page 5

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

Putting the brakes on the OB Express

■ CHILDBIRTH

Continued from Page 57

be a more fundamental overhaul of the health care system.

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

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

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

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

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

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

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

the health care system."

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

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

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

THE BOSTON SUNDAY GLOBE • JULY 2, 1995

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

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

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

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

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

MEMORANDUM

To: Lissa
Fr: Sabrina
Re: More OB Express stuff
Da: September 22, 1995

- Congressman Torricelli recently calculated that with about 4 million births per year, and maternity beds averaging \$1,000 per day, insurers save \$4 billion a year for every day they slice off the average stay.
- A recent study by the Dartmouth-Hitchcock Medical Center found that within an infant's first two weeks of life, there is a 50% increased risk of readmission and a 70% increased risk of emergency room visits if the infant is discharge at less than two days of age. According to the AMA, other studies have shown that early release of infants can result in jaundice, feeding problems, respiratory difficulties, and infections of the cord, ears, and eyes. [NOTE: At the same hearing, a representative of ACOG said that data regarding early discharge are inconclusive. If we decide to use the Dartmouth numbers, I am going to have to double and triple check them on Monday, so let me know.]

MEMORANDUM

To: Lissa
Fr: Sabrina
Re: Newborn jaundice
Da: September 21, 1995

According to Dr. Barry Kirkpatrick of the American Academy of Pediatricians' Committee on the Fetus and Newborns, there are two main kinds of jaundice that develop in newborns. The first, the "good" -- and most common -- kind, develops in the first 3-5 days, and usually does not require medical attention. The second, pathological jaundice, does require medical care, and can develop anytime in the first week, and even after.

The issue is not really whether the infant stays in the hospital 24 hours or 2-3 days, because jaundice can still develop after mother and child leave the hospital. The most important thing is that the hospital/insurance company provide adequate information and follow-up care.

In addition, about three years ago, Dr. Kirkpatrick heard rumors that insurance companies were offering women in the Richmond area up to \$200 to leave the hospital within a day of delivery. He has no concrete evidence, and hasn't heard anything about it recently.

MEMORANDUM

To: Lissa
Fr: Sabrina
Re: OB express
Da: September 19, 1995

- According to the American Academy of Pediatrics, each year approximately 60% of the 4 million newborns in the United States become clinically jaundiced. [NOTE: not all of these newborns are readmitted to the hospital. Their condition mostly depends on the kind of follow-up care they receive]
- Infant mortality in the Philippines is relatively low by developing country standards. Fabella Hospital in Manila serves as one example why. It focuses on delivery services, "well baby" care and breast feeding programs. A hospital for the poor, it is considered better than many private hospitals because of its innovative "rooming-in" policies.
 - Rooming-in involves immediate and continual contact between the mother and her newborn. If there are no problems, mothers stay for a day or two and continuously feed their babies: the baby feeds on demand, and takes as much as it can. Infant formula is forbidden in the hospital.
 - The newborn is never put into a nursery, even if the mother is sick. If she has an infectious disease, she and her baby are placed in an isolation room and she continues to breast feed.
 - The Journal of Paediatrics in 1982 did a study of the difference in mortality and morbidity before and after rooming-in. In the two years prior to the rooming-in policy, 64 babies died with signs of infection. In the two years after rooming-in, only three babies died.
- U.S. News and World Report, in Dec. 1994, lists typical maternity stays in the following countries:
 - Australia: 4-6 days
 - Canada: 2 1/2 days
 - France: Up to two weeks, five day minimum
 - Germany: 7 days
 - Great Britain: 3 days
 - Ireland: 5-6 days
 - Japan: 5-7 days
 - Netherlands: Mostly home births, with all-day nurse for a week

- Sweden: 1-3 days, with midwife home visit
- On June 27, 1995, Senator Bill Bradley introduced the "New Borns' and Mothers' Health Protection Act of 1995." Currently, there are 10 Democrats and 3 Republicans co-sponsoring this bill, including Sen. Nancy Kassebaum. The bill was referred to the Labor and Human Resources Committee, but as of 9/18/95, there was no committee action scheduled on this bill. There are four counterparts or companion bills, all in the House. The bill is known to have widespread, bipartisan support.
- The bill itself "Requires a health plan to provide maternity benefits for a minimum hospital stay for a mother and her newborn following the birth of the child."
- Carol Vargo from ACOG has heard anecdotal evidence of the cash payments to mothers in Oregon and Utah for early hospital departures, but she has seen no documentation on it.

NOTE: According to the women's health LA in Cong. DeFazio's office, about four years ago, Select Care, an HMO in Oregon, was offering women \$100 or \$150 to leave the hospital 8 hours after a normal vaginal delivery. An Oregon judge, who was expecting, received a letter from Select Care (her HMO) making this offer. She informed them she would have them in court if they did not immediately stop the offer, which they did. DeFazio's office said they had been trying to get documentation but had been unsuccessful.

TESTIMONY OF MICHELLE AND STEVE BAUMAN
SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES
SEPTEMBER 12, 1995

Charles Krauthammer

The Inevitability Of Rationed Care

And the dilemmas of living with it.

Sens. Nancy Kassebaum and Bill Bradley held hearings last week in which tearful young women told stories of being discharged from the hospital only one day after childbirth with tragic results, including even the death of the newborn. The hearings were meant to dramatize the need for legislation Bradley and Kassebaum are sponsoring. It would force health insurance companies to allow mothers and their newborns to spend two postpartum days in the hospital (four after C-section), unless mother and doctor agree to a shorter stay.

Talk about a motherhood issue. Who could fail to be moved by the stories? Who will fail to vote for the legislation? Yet few issues illustrate better the dilemmas of legislating good intentions.

This legislation is as arbitrary as it is appealing. We know that there is a cost crunch in medicine. Insurance companies are under financial and political pressure to cut costs. They in turn put pressure on doctors and hospitals. One form of pressure—and one excellent way to save serious money—is to keep hospital stays, with their staggering daily costs, to the barest minimum.

So patients are being shown the door much earlier than ever. But this is true of *all* patients. We all know someone sent home in no condition to go home because he had exceeded the customary stay covered by insurance. Why not legislation mandating the length of hospitalization for an appendectomy? Why not mandate from Washington the number of days needed to recover from open-heart surgery? These are all good causes. Why just childbirth?

The cynical answer is that young mothers and their babies are far more telegenic and sympathetic than beef-eating fat guys who've just traded up for a new set of coronary arteries. Yet one could argue that of all places to cut hospital costs, sending home early a population of generally healthy postpartum moms and babies incurs less aggregate risk than discharging early a population of generally sick postoperative seniors.

It is, moreover, ironic that longer hospital care for childbirth is now the fashionable cause. Twenty years ago, progressive thinkers were decrying how doctors and hospitals with their drugs and devices had mechanized and bureaucratized the childbirth ex-

perience. Natural childbirth, indeed home birth, was the vogue. The vogue has apparently changed.

When I was 22, I broke my neck and was hospitalized for the next 14 months. Today, when I counsel a young person with a similar injury, I often discover he has been sent home after a month. A month! After one month, I could not yet drive a car or wheel a chair or even sign my name. Many of these kids are in similar straits. Why is there no legislation to mandate that they be fully rehabilitated before being turned out into the cold?

Answer: This country is going broke on medical costs, and full rehabilitation costs money. At a time when we are desperate to cut costs, federally mandating longer hospital stays would send health care costs through the roof. These are the cruel facts. And if they apply to these kids, why not to all patients? Why do newborns and moms get a pass?

One question to ask about the Kassebaum-Bradley "Newborns' and Mothers' Health Protection Act" is whether the heavy hand of government should be involved in determining who stays in the hospital for how long. But the larger question is whether we are prepared to face the real costs of the welfare state.

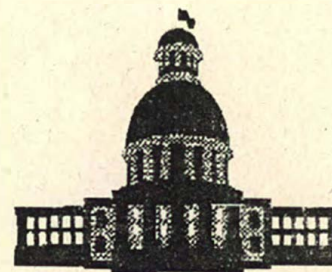
We know that with high-tech medicine people live longer and thus have far more opportunity for disease and disability. Disease and disability are expensive. The inevitable result is that costs will rise catastrophically—unless we do something. And that something, however we wish to disguise it, will be a form of rationing: not giving everyone optimal care, for the sake of spreading care around as much as possible.

The shift from hospital to outpatient and home care is generally, and rightly, praised as a serious way to help reduce the nation's huge medical bill. We don't like to admit it, but this is a form of rationing. And like any form of medical rationing, this rationing will have its casualties. In the abstract, we can accept that. Face-to-face with an actual casualty we cannot.

Instead, we continue our 30-year practice of granting a hodgepodge of special protections to whatever victim-of-the-month catches the ear and tugs at the heart of Congress. It is not particularly fair, and it is ultimately bankrupting.

SEP 10 03 WED 14:10 HMOG GOVT RELATIONS FAX NO. 202 488 3985 P. 01

**The
American
College of
Obstetricians and
Gynecologists**



DEPARTMENT OF GOVERNMENT RELATIONS

DEPARTMENT FAX NUMBER: (202) 488-3985

DATE: Wednesday, September 13, 1995

TO: Liz Bowyer

FROM: Carol Vargo, Federal Government Relations Representative

RE: Length of Stay

NUMBER OF PAGES (including this page): 12

RECIPIENT'S FAX NUMBER: 202-456-6244

COMMENTS:

Attached is an ACOG statement and an AMA report. Both reference studies on this issues. I will send you more
background via courier in the next few hours.

*IF THERE IS A TRANSMISSION PROBLEM, OR IF YOU WOULD LIKE TO SPEAK WITH SOMEONE AT
ACOG, PLEASE CALL (202) 863-2500*

2510
409 12th Street, SW, Washington, DC 20024-2188

(202) 638-5577

SEP-13-95 WED 14:10 ACOG GOVT RELATIONS FAX NO. 202 488 3985 P.02

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.

2.

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. *M&R* May 5, 1995; 44: 335-337.

² AAP and ACOG. Guidelines for Perinatal Care, 3rd ed. 1992 (+): 165-111.

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ADOPTED
6/21/95

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 5 - A-95

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

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

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

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

11
12 Background

13
14 A variety of sociological and economic factors have converged to shorten dramatically
15 postpartum stays for most American women and infants. Typical hospital stays used to be
16 four or five days for normal vaginal births and one to two weeks for cesarean births. Over the
17 past decade this decreased, and in the last three or four years typical hospital stays have
18 dwindled to 24 hours or less for uncomplicated vaginal deliveries and two to three days for
19 Cesarean deliveries. The driving force behind these changes has been largely socioeconomic.
20 However, some evidence exists that mothers may prefer shorter stays, and some researchers
21 have concluded that complication rates for abbreviated postpartum stays are no higher than for
22 traditional stays.

23
24 The first 72 hours of life are a time of significant transition and stabilization for newborn
25 infants. It is during this period that a variety of important tasks must take place. The mother
26 goes through a period of rest and recuperation and is further educated about infants,
27 breastfeeding, and parenting. The child is observed for ductal and cardiac abnormalities,
28 respiratory difficulties, infections, jaundice, adequacy of feeding, and gastrointestinal
29 anomalies. Newborn screening occurs, and the mother-child dyad is assessed for evidence of
30 biological and environmental risk factors. If any of these preventive measures do not occur,
31 potential risk to mother or child increases.

32
33 The first issue in examining the question of "early discharge" is attempting to define it. The
34 Guidelines for Perinatal Care, jointly published by the American Academy of Pediatrics
35 (AAP) and the American College of Obstetricians and Gynecologists (ACOG), define early

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

3
4 Empirical studies have varied in their definition of early discharge. Most research examines
5 the impact of discharge within 48 hours of vaginal delivery. Most expressions of concern
6 have targeted discharges occurring in substantially less than 24 hours. Consequently, the
7 available literature is limited and often does not focus on the populations of specific concern.
8 Further complicating the analysis is the fact that most studies have had rigorous inclusion and
9 exclusion criteria and have been conducted on mothers requesting early discharge. There is
10 therefore only limited ability to evaluate scientifically the effects of shortening postpartum
11 stays.

12
13 When evaluating the clinical effects of shorter stays, the following considerations are
14 appropriate:

- 15
- 16 • health effects on and complication rates in the infant
- 17 • health effects (both physical and psychological) on the mother
- 18 • extent of opportunity for maternal and infant-care education
- 19 • physical and psychological effects on other family members
- 20 • extent of opportunity for maternal and child psychosocial assessment
- 21

22 Available Research

23
24 Studies examining the issue of early discharge have tended to examine model programs that
25 included a pre-screening process to identify low-risk mothers and infants, some degree of
26 prenatal instruction or education, and some degree of follow-up care. The exact nature of
27 these interventions, however, varied from program to program. Follow-up care, for instance,
28 ranged from one home visit and a phone call to three home visits in the first three days home
29 and telephone consultation available 24 hours a day for two weeks.²

30
31 Methods of participant selection also varied from program to program. In almost all cases,
32 however, the women chose whether they wanted early discharge or traditional hospital stay
33 and the option was only available to a selected population. One study did use a randomized
34 method of participant selection, but the authors acknowledge that "sample sizes were too small
35 to detect significant differences in the outcomes."³

36
37 There are several factors that make interpretation of the available research tentative at best:

- 38
- 39 • discrepant definitions of "early discharge"
- 40
- 41 • exclusion of women and infants likely to have birth-related complications
- 42
- 43 • absence of random assignment
- 44
- 45 • no or flawed control groups
- 46
- 47 • provision of compensatory services in early discharge groups that may mask or
- 48 alter the effects of more rapid discharge.

Type I vs. Type II Error

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

In a review commissioned by the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration, Paula Braveman concludes that insufficient statistical power is a methodological flaw common to all published studies of early discharge programs— "None of the studies in the literature had adequate power to detect even a doubling of the neonatal readmission rate."¹

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

What is a Good Outcome?

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

Health of the Infant

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

Clearly, early discharge minimizes the risk of nosocomial infection (for both infant and mother).¹ However, it may not provide adequate time for routine medical and social assessment of the dyad.⁶ Most researchers have concluded that early discharge (discharge within 48 hours of delivery) is generally safe for low-risk infants, based on a lack of "significant differences in the levels or types of mortality or readmissions for the early discharge and control groups."²

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

1 results.¹

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

14
15 There are many anecdotal reports about other serious problems such as failure to thrive,
16 missed diagnoses of metabolic disorders such as phenylketonuria, and serious bleeding from
17 circumcision wounds, but these have not as yet been documented empirically.

18 19 Perinatal Screening

20
21 Mandated neonatal screening varies from state to state, but all screening programs are designed
22 to prevent morbidity and mortality through early diagnosis of medical problems and congenital
23 disorders that can have serious sequelae. Adequate screening programs require universal
24 participation, prompt diagnosis, and mechanisms for parental notification and education.
25 Common screening tests include those for persistent hyperphenylalaninemia, including
26 phenylketonuria, galactosemia, maple syrup urine disease, congenital adrenal hyperplasia, and
27 congenital hypothyroidism. Some states also mandate screening for sickle cell disease and
28 various sexually transmissible infections.

29
30 Historically, these screening samples have been taken on the second or third day after delivery.
31 This time period was established to optimize the sensitivity of the tests. PKU screening, for
32 example, has a false negative rate that is quite high (about 33%) during the first 12 hours of
33 life and drops to less than 1% after 48 hours. In contrast, early screening for congenital
34 hypothyroidism, especially using thyrotropin (TSH) as the primary screen, may have a high
35 false positive rate because of the normal TSH surge that accompanies parturition. Some
36 experts argue that screening samples taken in the first 24 hours of life serve merely to notify
37 the system of the existence of the infant. Follow-up screening for PKU or congenital
38 hypothyroidism, for example, must then be completed in a timely fashion, no later than two
39 weeks after birth.¹ Loss of infants to follow-up screening is a serious concern, but data
40 regarding the rates of missed rescreening are not yet available.

41 42 Health of the Mother

43
44 Methodological flaws also plague the few studies examining the impact of early discharge on
45 the physical health of the mother. Research has shown that very few mothers (less than two
46 percent) require rehospitalization after discharge.^{2,7} When they do, the problems are often
47 fairly serious, including significant infection and hemorrhaging. The majority of mothers who
48 did require readmission in one review suffered from endometritis.³ In that review, six of the
49 ten readmissions reported in four studies were for endometritis. (Two of the other four

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1 women were readmitted for postpartum hemorrhages, one for severe postpartum depression,
2 and one for a severely abcessed episiotomy.² Again, however, these findings are not
3 necessarily conclusive.

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

13
14 The impact of early discharge on the emotional health of the mother is a similarly important
15 area of concern. Emotional health includes such things as postpartum depression, mother-child
16 separation, the mother's confidence in her ability to be a good parent, stress management, and
17 the need for external support. In the randomized, controlled study that compared discharge at
18 12-24 hours, 25-48 hours, and four days, the mothers discharged 12-24 hours after giving birth
19 reported themselves to be significantly less depressed at one month postpartum than the two
20 later groups. In addition, the earliest group reported higher levels of confidence at one week
21 postpartum than the other two groups. At one month postpartum, however, the three groups
22 did not differ significantly with respect to levels of confidence. This suggests that women
23 who assume total responsibility for their baby sooner after delivery may feel more confident
24 initially than those who do not, but the direction of causality is unclear.³

25
26 Another study, which compared women who had domiciliary care after early discharge to
27 women who had hospital care until discharge, found that the difference between the emotional
28 health of mothers in both groups was not statistically significant.⁸

29
30 Although many of the studies mention other aspects of emotional health such as mother-baby
31 bonding and the mother's support system, they do not provide data. A second document
32 commissioned by MCHB reports on an October 1994 consensus meeting in Boston. There, a
33 group of experts with "intimate knowledge of both hospital and community based care for
34 mothers and newborns" found that "women who are from high risk social environments and
35 with limited social support structures may not be best served by a one-day stay." In addition,
36 "separation due to the need to observe either the mother or the newborn was deemed
37 unacceptable Policies that would result in increased rates of separation were viewed by
38 the group as detrimental to mother infant bonding, infant and maternal health, and threatening
39 to breastfeeding. Clinicians recognized a distinction between 24 hours and 72 hours because
40 mother/infant bonding occurs during this early and critical time period."⁹

41 42 Education

43
44 Many experts express concern that early discharge will reduce the degree to which health care
45 providers can offer parental education and instruction. The decreased length of hospital stay
46 associated with early discharge significantly increases the importance of comprehensive and
47 continuous prenatal and postpartum care.¹⁰ Such care includes breastfeeding instruction, early
48 discharge planning, and educating the mother about immunizations, well-baby care, and bodily
49 changes.

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

4 Impact on Other Family Members

5
6 The impact of early discharge on the rest of the family is not as well documented as the
7 impact on the mother and the infant. The studies do cite family togetherness and the
8 involvement of the father in caring for the new baby as sources of parent satisfaction.^{11,12,13}
9 These studies, however, focus on the effect of early discharge on the mother and not on the
10 rest of the family. The existing research does not sufficiently examine the impact of early
11 discharge on other family members.
12

13 Cost-Effectiveness

14
15 The cost-effectiveness of early discharge programs is the final consideration examined in the
16 literature. The literature only investigates the cost-effectiveness for the hospital. It does not
17 address the impact on the patient's costs. Some studies conclude that reduced lengths of stay
18 and the resulting increase in the number of beds available for other patients render early
19 discharge programs cost-effective.^{13,14} Other authors claim that no one has thoroughly
20 analyzed whether early discharge programs truly provide a way to contain costs.¹² Again, the
21 existing data are sketchy and inconclusive.
22

23 Conclusions

24
25 We still do not know how much and what kind of follow-up is needed for maternal and infant
26 safety.¹² In the MCHB review, Braveman "categorized studies of early discharge according to
27 the type of compensatory service provided in the early post-discharge days . . . [b]ecause
28 conclusions from studies about early discharge in the presence of a given compensatory service
29 cannot be generalized to early discharge in the absence of that service."¹⁴ The reviewed studies
30 that included post-discharge services did indicate that most women were generally satisfied
31 with the care they received for both early discharge and traditional stay. At least two studies
32 (both with postpartum home visiting) report that mothers who were discharged early were
33 more satisfied than mothers who had traditional hospital stay.¹³ Satisfaction, however,
34 depends upon expectations, and studies show that the expectations of women who choose early
35 discharge often differ from those of women who choose a traditional hospital stay. This
36 suggests that women should be allowed to choose the maternity care which best suits their
37 individual needs.³
38

39
40 While we can therefore conclude that some women prefer to be discharged sooner than later,
41 definitive studies regarding the safety of doing so are not available at this time. The
42 limitations of the existing research are significant. Inadequate statistical power, absence of
43 random assignment, careful participant selection, and unstable definitions of "early" and "good
44 outcome" render scientific conclusions highly unreliable. One of the major limitations of the
45 studies is that most of the early discharge programs were voluntary. Norr and Nacion
46 acknowledge that "it is likely that families who choose early discharge not only have favorable
47 attitudes about coming home early, but also the resources and social support needed to make
48 the discharge go smoothly."¹¹ Second, very few researchers have studied the effects of early
49 discharge on disadvantaged populations - most participants are either middle-class or upper

middle-class, healthy, well-educated, and living in a stable home environment.²³ The outcomes of the studies, therefore, cannot be generalized to high-risk populations. Further, there is no national consensus on what constitutes "low-risk" versus "high-risk." The October 1994 consensus meeting concluded that "neither the AAP/ACOG Guidelines for Perinatal Care regarding eligibility for 24 hour discharge nor the specifications concerning follow-up seemed adequate from the perspective of clinicians."

Some physicians worry that the current trend toward reduced hospital stays will have dire results. Arthur Eidelman, MD, for example, notes that "it is assumed [that] the mother will be discharged into a supportive family unit where another responsible adult is present and where there exists an accessible medical care system for follow-up and ongoing care." Fully aware that many women do not enjoy such inquiries, Eidelman warns that allowing high-risk mothers such as "an adolescent primipara, or a single mother subsisting on welfare . . . into a system that does not have any backup visiting nurse program or community health clinics is simply committing medical and social suicide."²⁴ Eidelman's concerns reinforce the necessity of limiting early discharge to low-risk mothers or providing comprehensive care that would ensure a safe and healthy discharge for high-risk patients.

The commissioned MCHB review concludes, "Although many studies have examined early discharge, when standard scientific criteria are applied it becomes clear that the currently available literature provides little scientific knowledge to guide discharge planning for apparently well newborns and their mothers. . . . Rigorously designed studies are needed to examine the impact of early discharge and a range of post-discharge practices not only on newborns but on mothers and families. . . . [I]nformation from sound research is needed to inform policy addressing third party reimbursement as well as clinical care standards."²⁵

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

- Discussions of an acceptable vs. unacceptable number of postpartum hours are unproductive and should be replaced by work to identify the essential prerequisites for timely and appropriate perinatal discharge of mother and infant
- Discharge policies that result in separations between mothers and infants due to staggered hospital releases are undesirable
- There needs to be concentrated work on developing national standards for adequate and sufficient care during the early neonatal period

Recommendations

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

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1. The AMA is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe.
2. It is the policy of the AMA that in the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate pre-discharge education, need for neonatal screening, and determination that adequate feeding is occurring. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.
3. The AMA urges all state neonatal screening programs to institute procedures that provide for timely follow-up screening for infants whose initial samples are obtained in the first 24 hours of life.
4. The AMA should encourage well-designed experimental studies are needed to identify safe neonatal practices with regard to the hospital discharge of mothers and infants.
5. The AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other concerned national organizations to examine more thoroughly the issue of appropriate medical care during the perinatal period.

and with consideration of the mother's social and emotional needs & preferences.

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By MICHAEL LIM TAN, MD

LIKE other government hospitals, the wards at the Jose Fabella Memorial Hospital are actually large halls, each with about a hundred beds dormitory-style.

At Fabella's wards, the patients aren't patients in the medical sense of the word: they are new mothers, and their newborn. Picture a hundred mothers, with a hundred babies, in one ward. Then imagine an extraordinary silence, despite those one hundred babies. There are few crying babies. Most of the babies are either sleeping contentedly, or breast-feeding.

The serenity is symbolic of a quiet revolution going on at Fabella, one of creating a "baby-friendly" hospital. Until a few years ago, when Fabella was still known as that hospital starting out as the administration building for Bilibid Viejo — an old prison — in Sta. Cruz, it was an institution that shared the sleazy reputation of other government hospitals. The neighborhood is run-down: beer houses next to dilapidated theaters converted into prayer halls for born-again Christian groups. Unless one was very poor, it was unthinkable to have her baby at Fabella.

Today, the 71-year old institution is still a hospital for the poor. But the babies stand better chances of survival than other expensive private hospitals. Credit this to a full rooming-in policy that the hospital began to implement in 1986, after several years of partial "experimenting". Fabella's program has been so successful it has captured the attention of UNICEF, the World Health Organization (WHO) and other international groups. Unfortunately, as with many other pioneering projects, the efforts of Fabella are still largely unrecognized in the Philippines.

Rooming-in involves immediate contact between the mother and her newborn. They call it "latching on", where the newborn, still wet with the fluids that came with it at birth, is put to the mother's breast even as she lies on the delivery table. The baby receives its first immunization, not with a needle and syringe but with the mother's first milk, a yellowish fluid called colostrum that is packed with nutrients and immunoglobulins. It is only after that first feeding that the baby is washed. The mother is brought to the ward, to be followed shortly after by the baby. That is another sight — bassinets sometimes with as many as four pink newborn babies wriggling away, still full from their first feeding but apparently ready and waiting for the next round.

If there are no problems, the mothers stay for a day or two and continuously feed their babies. There are no "feeding hours" — the baby feeds on demand, and takes in as much as it can. "Breastfeeding chairs", designed to reduce backache, are provided for the mothers. Fabella's director, Dr. Ricardo Gonzales, explains that this is part of the hospital's working philosophy of providing comfort, as well as dignity and safety.

The newborn child is never put into a nursery, even if the mother is sick. There is a special isolation room for mothers who have infectious disease. This is to separate her from other mothers and newborn babies but her own baby is kept at her side so she can continue to breastfeed. Her own child is usually producing antibodies against the mother's infection, and the breastmilk gives the child additional protection against other diseases.

Even mothers who deliver by caesarian section — about 4350 of them last year — eventually breastfeed within 24 hours if there are no post-operative complications.

This rooming-in policy insures that the mother will be able to breastfeed. Studies in many countries have shown that the main reason why many mothers "cannot" breastfeed is because breastfeeding was not initiated within the first hour after delivery. Nature's cycles are disrupted by hospital procedures, which wreaks havoc for the mother and the child.

Premature babies at Fabella are put in an intensive care ward with incubators but again, the mother stays close, ready to give milk when needed. There is also a milk bank, which stores milk collected from the mothers. In most cases, the premature babies are able to eventually breastfeed. In a "breastfeeding corner" next to the intensive care unit, I saw mothers busily nursing their premature babies.

One nurse proudly showed me one baby who was born two months ahead of time, weighing only 900 grams (about 2 pounds). It had put on another 200 grams since then and was now able to take breastmilk from a medicine glass. The child, and the mother, would soon be ready to go home.

Infant formula, as well as feeding bottles, artificial teats or pacifiers, are strictly forbidden in the hospital. By excluding infant formula and bottles, Fabella saves about P6.5 million a year, and this does not include the costs of maintaining nurseries and rooms for preparing infant formulas. The P6.5 million is important given the current economic crisis, where budgets of all government institutions have

Rooming-in Policy 1986

been drastically slashed. For Fabella, the savings have been crucial for expanding its other services for mothers and children: new operating rooms, gynecological services and treatment for women with cancer, pre-natal services and pediatric care. The savings have also enabled Fabella's administrators to introduce other supportive services for its rooming-in policies. Babies born with cleft palates, for instance, are immediately fitted for dental plates made in the hospital itself.

Each cost-cutting measure leads to more measures resulting in savings. In the past, the average stay of a mother with an infection was 12 days... because the hospital did not have money for medicines. Today, the savings from the rooming-in policies mean more funds to provide medicines and other supplies that the patient needs. Beyond administrative cost-cutting measures, rooming-in and mandatory breastfeeding at Fabella work together to insure a baby-friendly environment, baby-friendly because we are talking about increasing the chances of infant survival.

There are many reasons to support the argument that "breast is best". Nutritionally, no artificial formula can beat breastmilk. Breastfed babies suffer less from diarrhea, respiratory illnesses and allergies. In fact, one noticeable difference between Fabella and maternity wards in other hospitals is the absence of that distinct smell that comes with infant diarrhea. Economically, breastmilk is free while artificial formula (plus bottles and fuel costs

for boiling water and the feeding paraphernalia) can consume up to one-fourth of a minimum wage earner's salaries.

Promotion of breastfeeding has to be continuous. At Fabella, pre-natal counselling includes advice on breastfeeding. About 30% of the mothers who go to Fabella for childbirth have not gone through such counselling; yet, they too breastfeed, coaxed on by supportive hospital staff and "Lactation Brigades", volunteers moving around the hospital.

There are only two hospitals in the Philippines where the rooming-in and breastfeeding policy is fully implemented — Fabella in Manila and the Baguio General Hospital (now called Dr. Efraim C. Montemayor Memorial Medical Center). If Fabella and Baguio General have been so successful with rooming-in, why aren't other hospitals doing the same?

The Health Department actually requires all government hospitals to have this rooming-in policy. Fabella is, in fact, a national lactation management training center for government hospital staff. But implementation of rooming-in policies has been weak in most of the hospitals. Doctors and nurses, despite being aware of the advantages of breastfeeding, start believing that many mothers can't breastfeed. Market forces — promotions and incentives from infant formula manufacturers

The results can be dangerous. Mothers, convinced they cannot breastfeed, spend their meager family budgets on expensive formula. The formula is prepared with dirty water, and the child comes down with diarrhea that can be fatal. Other mothers scrimp on the amount of formula to use, and the child becomes malnourished. Reversing that trend will be difficult, and has to start with the doctors and hospitals that have come to control the lives of the new mother and her child.

The measures can be draconian — Fabella's doctor, Dr. Ricardo Gonzales, has been criticized for requiring mothers to breastfeed before they can be discharged. But Dr. Gonzales explains that this is a life-saving measure that physicians must implement.

Dr. Gonzales has no illusions about what could happen after the mothers leave the hospital. A Milk Code (Executive Order 51) signed by President Aquino in 1986 forbids advertising and promotions of formula for the newborn but many companies get around it by promoting "follow-on" formulas. For many mothers, regardless of class, the distinction is not clear: infant formulas are projected as superior and "modern", even if there is a three-second rejoinder at the end of each ad explaining that breastmilk is still best for babies.

Other mothers "cannot" breastfeed because of economic reasons. Maternity leave in the Philippines is too short and they have to return to work, bringing home paltry earnings that will go into purchase of infant formula. Visiting their pediatric clinics, I found several mothers bringing in their babies... and the inevitable bottle. When I interviewed them, most explained (almost apologetically) that they had no choice — most were working mothers whose maternity leaves were ending so they were "preparing" their infants for the shift to bottle-feeding. When I explained to one mother that she could still express her milk and leave it in the refrigerator for other family members to feed to her child when she goes to work, she responded, "Wala po kaming refrigerator." It is easy to forget how economic realities work against both mother and child.

Despite these obstacles, the rooming-in revolution can make a difference. In 1990, there were about 36,000 births in Fabella representing about 12% of all births in the National Capital Region. The rooming-in policies may still give a fighting chance for the infants considering that nearly half of infant deaths in the Philippines occur within the first month of life.

Restoring a "breastfeeding culture" is only one measure that helps in overcoming the tremendous odds against the infant's survival, but it is an important first step.

Health Alert

(The author is a medical anthropologist and a professor at the UP Dillman and Executive Director of the Health Action Information Network (Hain))



Where it all began

THE FIRST full rooming-in policy in the Philippines was initiated at the Baguio General Hospital (now the Dr. Efraim C. Montemayor Memorial Hospital) way back in 1975 by Dr. Natividad Clavano-Relucio, then pediatrics head.

Clavano-Relucio had gone to London to train in pediatric allergies. Instead, she discovered the tropical child health program of Dr. David Morley, a pioneer in creating appropriate child health programs in Third World countries. Clavano-Relucio admits she was like other Filipino physicians, whose medical education did not include any mention of the benefits of breastfeeding and the dangers of bottle-feeding. When she returned to the Philippines, she banned bottle-feeding and infant formula promotions at the hospital.

Clavano-Relucio was able to document the hospital's experiences and provide important research data showing how the breastfeeding and rooming-in policy improved infant survival. One of the most dramatic findings, first published in the "Journal of Tropical Paediatrics" in 1982, was the difference in mortality and morbidity before and after rooming-in. In the two years prior to the rooming-in policy,

hospital records showed 64 babies dying with clinical signs of infection (mainly diarrheas). In the two years after rooming-in, only three infants died.

At Baguio General, breastfeeding and rooming-in have become institutionalized. Breastfeeding is recommended not just as an early postnatal practice but also for the times the baby is sick and has to be hospitalized.

Relactation services are available for mothers who have stopped breastfeeding but need to resume the practice as part of their care of the sick child.

The degree of institutionalization affects even staff recruitment policies, with preference given to nurses who are breastfeeding mothers themselves.

Today, the Baguio "experiment" continues to move on. The promotion of breastfeeding is no longer just a hospital policy; it has been integrated into the hospital's Under Six Clinic.

From a baby-friendly hospital, Baguio General is now developing into a child-friendly institution.

Dr. Michael Lim Tan - Health Alert

VISIT TO THE DR. JOSE FABELLA MEMORIAL HOSPITAL

CONTEXT OF THE VISIT

Infant mortality in the Philippines is relatively low by developing country standards (34 of every 1000 children die before their first birthday) but the urban poor who make up most of the patients at Dr. Jose Fabella Hospital are relatively unsophisticated about infant care. The Hospital, located in old Manila, is an internationally-recognized public health facility which focuses on delivery services (an average of 80 to 100 babies are born in the 700 bed hospital every day), "well baby" care (treatment of newborns for respiratory illness, diarrhea and measles), and breastfeeding programs. It envisions becoming a national training center for the promotion of breastfeeding. Many women in the Philippines, as in other developing countries, are not aware of the early and prolonged benefits of breastfeeding.

You will tour the hospital with Mrs. Ramos and will meet the hospital's director, Dr. Gonzales, and the Philippine Secretary of Health, Juan Flavier (Flavier's population program has been the source of some controversy in the Philippines. See attached briefing on Population in the Philippines for more information). After the tour, you will participate in a discussion with Flavier, Gonzales and other hospital officials to discuss the hospital's progress and health issues in the Philippines.

USAID is currently working with the Philippine Department of Health on a comprehensive child survival strategy. The Department of Health is especially interested in training more health professionals in delivery techniques, educating women to space births to reduce the risk of maternal and infant mortality, reducing maternal anemia and malnutrition (about 30 percent of all pregnant women are malnourished) and increasing the birth weight of new-borns.

YOUR OBJECTIVES

- To express U.S. interest in, and support for, the Philippine Government's efforts to promote safe deliveries, infant care, post-natal maternal assistance and nutrition.
 - To note that programs like the ones being pioneered at the Fabella Memorial Hospital and which provide new mothers with health information about themselves and their babies can serve as models not just for the Philippines but for other developing countries as well.
- Mrs. Ramos will likely also be interested in your views on the U.S. health care system and your and President Clinton's efforts to reform it.

TALKING POINTS

- o Delighted to have an opportunity to learn about the Hospital's programs.
- o Understand that you have a pioneer facility here which offers family planning on both an in-patient and out-patient basis. Pleased that USAID was able earlier to work with your clinic.
- o It is important that we give pregnant women and new mothers as much information about new-born children as possible so that they can make intelligent and informed choices about child care and feeding.
- o An integrated program of maternal and child care means working with women and families on maintaining their own health so that they will be physically and emotionally fit to handle their responsibilities.
- o Good progress has been made in immunizing children between the ages of 12 and 23 months in the principal childhood diseases. Our goal should be 100 percent immunization.
- o Programs such as the ones here at Fabella can serve as models not just for the Philippines but for other developing countries as well.
- o These programs are important as they empower women to make important choices about themselves and their families. We look forward to continuing to explore these programs with you in the run up to the Fourth World Conference on Women in Beijing in September.
- o Pleased that the United States, through grants from the U.S. Agency for International Development and in cooperation with various non-government organizations, is able to work with the Department of Health to assist private health care providers meet the difficult challenges of program planning, budgeting, and training.

HEALTH CARE IN THE PHILIPPINES

Since 1992, under the dynamic leadership of the affable and popular Health Secretary Juan Flavio, health issues have received greater attention in the Philippines. Dr. Flavio's Department of Health, with USAID assistance, has made gains in limiting population growth, improving maternal and child health, and curtailing the spread of AIDS. The Health Department has featured a public campaign to increase awareness of family planning and to promote the use of contraception. The Health Department is making significant inroads at the local level. Working through a variety of non-government organizations and private clinics, the Department has improved service delivery and generated new ideas for affordable health care, especially at the local level.

Health Outcomes: Recent Trends

- o The Philippines has achieved significant progress in reducing mortality from 1960 to 1990 but progress falls short of achievements made by other ASEAN countries.
- o Progress has also been made in controlling infectious diseases but pneumonia, tuberculosis, and diarrhea continue to be the major causes of death.
- o USAID assistance to family planning has been instrumental in lowering the total fertility rate from 6.0 to 4.1 over the past 20 years. Today, 40 percent of Filipino women practice contraception.

Health Care Utilization Patterns

- o A large percentage of the population has serious medical problems without easy access to needed medical care.
- o Pre-natal care has increased with eight of ten mothers receiving care from a health professional.
- o Post-natal care has improved considerably in the past 10 years, with 72 percent of children aged 12-23 months fully immunized against the six major childhood diseases.
- o There is a large gap in knowledge and use of modern therapy for diarrhea.
- o Preventive dental care remains rare.

The Philippines is currently developing a national health insurance plan. A USAID-funded study supported the research for the legislation. The plan would establish a national health insurance corporation and offer universal coverage. Funding would come from "sin" taxes, primarily a tax on cigarettes.

POPULATION IN THE PHILIPPINES

The population of the Philippines grows at roughly 2.3 percent each year. If this trend continues, it will double from 65 million to 130 million in approximately 30 years.

The population program is one of the Philippine government's most visible programs. President Ramos, who believes that the current growth rate adversely affects social and economic development, has made it clear that reducing population growth is one of his highest priorities. Ramos, a Protestant in a country that is 85 percent Catholic, has staunchly supported the program.

According to public opinion, the Ramos administration is delivering services that Filipinos both need and want. Despite broad support, President Ramos, his highly visible Secretary of Health, Juan Flavio, and the population program itself are centers of great controversy, with opposition coming primarily from the Catholic Church. The controversy was elevated to a new level during the period leading up to and following the International Conference on Population and Development in Cairo in September. The Church attacked the Ramos administration and the U.S. government, both for its role in the conference and for its direct support for the Philippines family planning program through USAID.

The point person for Church attacks on the population program has been Cardinal Jaime Sin. Behind the scenes and over the years, Opus Dei has worked actively to derail family planning programs. The Church's opposition to the population program culminated on August 14, 1994 when Cardinal Sin led an anti-family planning rally in Manila. The Church estimated that nearly one million people were in attendance. Police estimated a more modest 200,000.

During meetings with Church leaders after the August 14 rally, Ramos reiterated his administration's opposition to abortion. He also slightly revamped the delegation to the Cairo conference, asking the Secretary of the National Economic Development Authority to chair the delegation in place of Secretary Flavio. Still, Ramos continues to defend forcefully the population program, as well as the right of women and families to determine the number and timing of their children.

Family planning issues are potentially explosive in the Philippines and will likely remain on the public agenda over the coming months, particularly as Filipino officials prepare for a scheduled Papal visit to Manila in January, 1995.

USAID and the Philippines government have recently launched a new, more decentralized and integrated family planning and maternal/child health program. This expanded five-year program is budgeted at \$100 million.

Juan M. FLAVIER

(Phonetic: flahveeEHR)

PHILIPPINES

Secretary of Health (since 1992)

Addressed as: Mr. Secretary

Background: Medical doctor with 30 years of experience in rural health programs, including presidency of International Institute of Rural Reconstruction (1978-92) . . . prominent crusader against AIDS, smoking, contagious diseases . . . teaches at University of the East's College of Medicine, University of the Philippines' Institute of Public Health.

Languages: Speaks fluent English .

Personal Notes: Born in 1936 . . . graduate of University of the Philippines (1960), Johns Hopkins University (1969) . . . married to the former Alma Susana Aguila.



11/94

Globe TANG-92

DR. JUAN FLAVIER

Q&A: FLAVIER, JUAN

4' 11" of knowhow and humor

By MARILOU CRISOSTOMO

Globe Staff Writer

FOUR feet and eleven inches. That's all there is of Dr. Juan Martin Flavier, the new health secretary physically, that is. But there is so much more to this man than what meets the eye: a sense of humor, the desire to serve, his eagerness to learn, an open-mind to criticisms and a great dose of excitement to perform his role as secretary of health, to say the least.

"We need to make a difference in this life. Thus, we need to be excited (over what we do)," Flavier remarked, "otherwise we would be in trouble."

Flavier had been referred to as "the unknown factor" in President Fidel Ramos's Cab-

inet. The new Health Secretary had never been in government service before his recent appointment. But his exposure to public service, particularly to rural folk, has earned him the title "Doctor of the Barrios."

Flavier earned his Doctor of Medicine degree at the University of the Philippines in 1960 and was later selected Outstanding Intern at the UP-PGH Medical Center.

In 1969, Flavier finished his Masters in Public Health at the Johns Hopkins University under the auspices of the First Asian Commonwealth Fund Scholar.

To date, the country's top health leader brings with him 31 years of experience as a Doctor of Medicine.

A TOYM (Ten Outstanding Young Men) awardee in 1967 in Rural Medicine, Flavier is the author of various publications, among these include *Doctor to the Barrios*, *My Friends in the Barrios*, *Back to the Barrios* and *Parables of the Barrio*.

He also received the Ramon Magsaysay Institutional Award for International Understanding in 1986.

In a question-and-answer interview, Dr. Flavier showed his deep knowledge of the health situation. The interview follows:

Q: You've been very active as a rural doctor. Is this by choice?

A: I come from a poor family so my bias is for the underserved, the poor, the deprived. Rural development



FLAVIER: Pal of poor.

can help narrow this gap.

Q: Do you have a health program for the rural areas?

A: We have no program yet, but our emphasis is to promote primary health care and herbal medicine. My bias is for people in the barrio, the underserved. Our vision is to upgrade the the rural folk's

quality of life through health.

Q: Do you plan to pursue a more aggressive family planning program?

A: We will put emphasis on information and education to make couples arrive at an enlightened decision. We want them to know the benefits, the side effects, the failure rates which will help them decide (what method to use).

Q: Do you see problems with the Catholic church with regard to promoting contraceptives?

A: This early, I may already be getting the ire of the Church (because of earlier statements made). But just to show good faith, I (placed natural method in the front liner) and met with 800 agencies promoting natural methods.

material girl who never has her fill of talking or shopping... 2. FRANK SINCLAIR: Fat's even-tempered wife Although somewhat a curmudgeon, her husband and kids are

The Manila
Chronicle,
1/92

A quiet revolution



A baby-friendly, mother-friendly hospital

Picture: PHILIP DUQUATAN

While most public hospitals
make do with meager resources,
José Fabella rises as one success story

Q U I C K B I L L
S. 969 by Sen. Bill Bradley (D-NJ)
New Borns' and Mothers' Health Protection Act of 1995

Title, Overview, Outlook:

S. 969 by Sen. Bill Bradley (D-NJ)
New Borns' and Mothers' Health Protection Act of 1995

Official Title (Caption):

A bill to require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes.

Introduced on Tuesday, June 27, 1995

Narrative Description:

Description and Status of S. 969,
New Borns' and Mothers' Health Protection Act of 1995,
as of Monday, September 18, 1995

The bill was introduced in the Senate on Tuesday, June 27, 1995 by Sen. Bill Bradley (D-NJ). At the present time there are 13 cosponsors of this bill, 10 Democrats and 3 Republicans.

The bill's official title stated its purpose as follows:

"A bill to require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes."

The bill was referred to the Senate Committee on Labor and Human Resources

The most recent action on the bill was on Tuesday, September 12, 1995: Hearings recessed by Senate Committee on Labor and Human Resources subject to the call of the Chair.

There is currently no committee action scheduled on this bill.

Also, 4 other bills have been located that are counterparts or companion bills to S.969:

① H.R.1948 by MILLER, GEORGE (D-CA) -- New Borns' and Mothers' Health Protection Act of 1995

S. 969 -- Bill Bradley Co-Sponsored by Nancy Kassebaum

13 cosponsors - 10 Dem, 3 Rep / 4 other Bills are counterparts or companion

4 billion savings / guaranteed?
Public hearing held Sept 12, by Senate Committee on Labor & Human Resources - hearing recessed subject to call of Chair

H.R.1950 by PALLONE (D-NJ) -- Newborns' and Mothers' Health
Protection Act of 1995
H.R.1968 by SOLOMON (R-NY) -- Postnatal Protection Act of 1995
H.R.1970 by TORRICELLI (D-NJ) -- Mothers' and Infants' Good Health Act
of 1995

CRS Abstract and Digest:

terms

Digest
(from Congressional Research Service, Library of Congress)

① New Borns' and Mothers' Health Protection Act of 1995 - Requires a health plan to provide maternity benefits for a minimum hospital stay for a mother and her newborn following the birth of the child. Provides an exception for home births.

② Prohibits a health plan from modifying the terms and conditions of coverage if the enrollee requests less than minimum coverage.

③ Requires a health plan to provide written notice, prominently positioned in any literature or correspondence, to each enrollee regarding the coverage required by this Act.

Counterpart or Companion Bills:

H.R. 1948 by Rep. George Miller (D-CA) -- New Borns' and Mothers' Health Protection Act of 1995
H.R. 1950 by Rep. Frank Pallone, Jr. (D-NJ) -- Newborns' and Mothers' Health Protection Act of 1995
H.R. 1968 by Rep. Gerald B. H. Solomon (R-NY) -- Postnatal Protection Act of 1995
H.R. 1970 by Rep. Robert G. Torricelli (D-NJ) -- Mothers' and Infants' Good Health Act of 1995

Washington Post Articles:

Currently, no articles found with reference to S. 969

National Journal Articles:

Currently, no articles found with reference to S. 969

CQ Weekly Report Articles:

Currently, no articles found with reference to S. 969

LEGI-SLATE News Articles:

09/12/95 -- ISSUE FOCUS: Congress Seeks Longer Hospital Stays for Mothers, Newborns [Article No. 25501, 122 lines]

BNA Online:

BNA Health Care Daily: Wednesday, September 13, 1995

Post-Natal Care: PHYSICIANS BLAME INSURANCE PROFITS FOR TREND IN EARLY
HOSPITAL RELEASES [Article No. 22560704, 163 lines]

BNA Pensions & Benefits Daily: Friday, September 15, 1995
Health Insurance: PHYSICIANS BLAME COMPANY PROFITS FOR TREND IN EARLY
HOSPITAL RELEASES [Article No. 22581611, 160 lines]

Report is Completed

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8TH STORY of Level 1 printed in FULL format.

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Sacramento Bee

September 13, 1995, STATE FINAL

SECTION: MAIN NEWS; Pg. A11

LENGTH: 974 words

HEADLINE: NEW PUSH FOR LONGER MATERNITY STAY

BYLINE: Tom Webb, Knight-Ridder Newspapers

DATELINE: WASHINGTON

BODY:

Are **newborn** babies and their mothers being sent home from the hospital dangerously early, simply to save on insurance costs?

Many doctors say yes, and so do plenty of mothers. On Tuesday, another group agreed: a growing list of U.S. senators, who believe insurers should be required to provide a minimum 48-hour hospital stay after a regular birth or 96 hours after a Caesarean delivery.

The bipartisan 1 bill, authored by Sens. Nancy Kassebaum, R-Kan., and Bill Bradley, D-N.J., has 11 co-sponsors in the Senate. Although it would require insurers to pay for a 48-hour maternity stay, a mother or her doctor could opt for a shorter period. In that case, the insurer would have to pay for a follow-up home nursing visit.

Unlike previous generations, millions of American women today are sent home 12 to 24 hours after having babies. But some doctors believe the trend is dangerous and threatens the health of both mother and child.

Michelle and Steve Bauman of New Jersey told the Senate Labor Committee of their recent tragedy. On May 16, their baby girl was born. The next day, mother and daughter were discharged from the hospital. The day after that, the infant died from a common and treatable condition that almost certainly would have been detected in the hospital.

"This is our baby the day she was born," Steve Bauman said, holding up a photograph of his **newborn** daughter. "This is the family that should have been. Instead of a christening we had a funeral."

Similar horrifying stories have led a dozen states to consider laws that would require health insurers to cover minimum hospital stays after a birth.

Both the Senate and House are considering laws that would apply in all 50 states.

In California, a bill by Assemblywoman Liz Figueroa, D-Fremont, would require insurance companies that offer maternity coverage to pay for a 48-hour hospital

Sacramento Bee, September 13, 1995

stay after normal births and a 96-hour stay when the delivery is by Caesarean section.

With just a few days left of the Legislative session, AB 1841 must pass the Senate and return to the Assembly. Lawmakers must agree to waive rules to hold a committee meeting or debate the bill for the first time on the Assembly floor. If it doesn't reach Wilson's desk this year, it could be carried over until the 1996 session.

The idea has opponents, too. Insurance companies argue that politicians should not be making medical decisions. And studies show there can be huge cost savings from shorter maternity stays -- \$ 4 billion a year, by one rough estimate -- while few studies show that babies or mothers are really worse off for being sent home early.

Those arguments do not convince the American Medical Association or the American College of Obstetricians and Gynecologists, both of which strongly endorse the proposed legislation.

"The physician, not the insurance company, should decide when to discharge a patient," said Dr. Palma Formica with the American Medical Association.

Augusto Sola, a San Francisco pediatrician, found a growing number of newborns are now suffering permanent brain damage due to jaundice -- an outcome that was virtually nonexistent until recently. He blames shortened hospital stays.

Shorter stays "were imposed without controlled clinical trials to evaluate the associated risks of such changes," Sola argued. "Moreover, they have been implemented without any evidence of associated health benefits. Therefore this practice can be considered experimental. Since no informed consent has been obtained from parents before being subjected to this experiment, these imposed changes are also unethical."

Bee news services contributed to this report.

LANGUAGE: ENGLISH

LOAD-DATE: September 14, 1995

7TH STORY of Level 1 printed in FULL format.

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Information Bank Abstracts
MIAMI HERALD

September 13, 1995, Wednesday

SECTION: Section A; Page 1, Column 5

LENGTH: 65 words

HEADLINE: BILL WOULD REQUIRE LONGER HOSPITAL STAY FOR NEWBORNS, MOMS

BYLINE: BY TOM WEBB

JOURNAL-CODE: MH

ABSTRACT:

Growing number of US senators join list of those backing legislation that would require insurers to pay for a minimum 48-hour hospital stay after a regular birth and 96-hour stay after a Caesarean delivery; millions of American women currently are sent home 12 to 24 hours after having babies, but some doctors believe trend is dangerous and threatens health of mothers and children

LANGUAGE: ENGLISH

LOAD-DATE: September 14, 1995

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LEGI-SLATE Report for the 104th Congress Mon, September 18, 1995 4:17pm (EST)

Q U I C K B I L L
S. 969 by Sen. Bill Bradley (D-NJ)
New Borns' and Mothers' Health Protection Act of 1995

Major Actions on Bill:

06/27/95 -- In The SENATE
Introduced by BRADLEY (D-NJ)
Referred to Senate Committee on Labor and Human Resources
Full text of measure printed in "Congressional Record" (CR Page S-9176)

09/12/95 -- In The SENATE
Public hearing held by Senate Committee on Labor and Human Resources
Hearings recessed by Senate Committee on Labor and Human Resources
subject to the call of the Chair

Report is Completed

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'REPORT' if you have concluded your search: report/2/1/2 3

LEGI-SLATE Report for the 104th Congress Mon, September 18, 1995 4:17pm (EST)

Search of 4,258 Bills and Resolutions to Find 2...

With reference in caption to 'NEW BORNs'

Bill, Sponsor and Short Title:

H.R.1948 by MILLER, GEORGE (D-CA) -- New Borns' and Mothers' Health
Protection Act of 1995

Official Title (caption):

A bill to require that health plans provide coverage for a minimum
hospital stay for a mother and child following the birth of the child, and for
other purposes.

Introduced on Wednesday, June 28, 1995

-----No. 2 of 2-----

Bill, Sponsor and Short Title:

S.969 by BRADLEY (D-NJ) -- New Borns' and Mothers' Health Protection Act of
1995

Official Title (caption):

A bill to require that health plans provide coverage for a minimum
hospital stay for a mother and child following the birth of the child, and for
other purposes.

Introduced on Tuesday, June 27, 1995

Do you wish to store these bills in a LEGI-SLATE

FILE for tracking or future reference? ('Y' or 'N')

AMERICAN ACADEMY OF PEDIATRICS

Management of Hyperbilirubinemia in the Healthy Term Newborn

(AC0014)

Provisional Committee for Quality Improvement and Subcommittee on Hyperbilirubinemia

Each year approximately 60% of the 4 million newborns in the United States become clinically jaundiced. Many receive various forms of evaluation and treatment. Few issues in neonatal medicine have generated such long-standing controversy as the possible adverse consequences of neonatal jaundice and when to begin treatment. Questions regarding potentially detrimental neurologic effects from elevated serum bilirubin levels prompt continuing concern and debate, particularly with regard to the management of the otherwise healthy term newborn without risk factors for hemolysis.¹⁻¹⁶ Although most data are based on infants with birth weights ≥ 2500 g, "term" is hereafter defined as 37 completed weeks of gestation.

Under certain circumstances, bilirubin may be toxic to the central nervous system and may cause neurologic impairment even in healthy term newborns. Most studies, however, have failed to substantiate significant associations between a specific level of total serum bilirubin (TSB) during nonhemolytic hyperbilirubinemia in term newborns and subsequent IQ or serious neurologic abnormality (including hearing impairment).¹⁻⁵ Other studies have detected subtle differences in outcomes associated with TSB levels, particularly when used in conjunction with albumin binding tests and/or duration of exposure.^{3,15,17,18} In almost all published studies, the TSB concentration has been used as a predictor variable for outcome determinations.

Factors influencing bilirubin toxicity to the brain cells of newborn infants are complex and incom-

pletely understood; they include those that affect the serum albumin concentration and those that affect the binding of bilirubin to albumin, the penetration of bilirubin into the brain, and the vulnerability of brain cells to the toxic effects of bilirubin. It is not known at what bilirubin concentration or under what circumstances significant risk of brain damage occurs or when the risk of damage exceeds the risk of treatment. Concentrations considered harmful may vary in different ethnic groups or geographic locations and may be lower outside North America or northern Europe. Reasons for apparent geographic differences in risk for kernicterus are not clear; the following practice parameter may not apply worldwide.

There are no simple solutions to the management of jaundiced neonates. Continuing uncertainties about the relationship between serum bilirubin levels and brain damage as well as differences in patient populations and practice settings contribute to variations in the management of hyperbilirubinemia. Early postpartum discharge from the hospital further complicates the management of jaundiced newborns, because it places additional responsibilities on parents or guardians to recognize and respond to developing jaundice or clinical symptoms.

Some conditions significantly increase the risk of hyperbilirubinemia, including history of a previous sibling with hyperbilirubinemia, decreasing gestational age, breast-feeding, and large weight loss after birth. Although newborns of 37 weeks' gestation and above are considered "term," infants 37 to 38 weeks of gestation may not nurse as well as more mature infants, and there is a strong correlation between decreasing gestational age and risk for hyperbilirubinemia. Infants born at 37 weeks' gestation are much more likely to develop a serum bilirubin level of 13 mg/dL or higher than are those born at 40 weeks' gestation.¹⁹⁻²²

METHODOLOGY

The Task Force on Quality Assurance (now designated the Provisional Committee on Quality Improvement) selected the management of hyperbilirubinemia as a topic for practice parameter development and appointed a subcommittee that performed a comprehensive literature review. Two independent MEDLINE searches identified primarily retrospective epidemiologic data derived almost exclusively from North American and European literature. The subcommittee also relied heavily on

The practice parameter, "Management of Hyperbilirubinemia in the Healthy Term Newborn," was reviewed by the appropriate committees and sections of the American Academy of Pediatrics (AAP), including the Chapter Review Group, a focus group of office-based pediatricians representing each AAP District: Gene R. Adams, MD; Robert M. Corwin, MD; Lawrence C. Pakula, MD; Barbara M. Harley, MD; Howard B. Weinblatt, MD; Thomas J. Herr, MD; Kenneth E. Matthews, MD; Diane Fuguay, MD; Robert D. Moses, MD; and Delora A. Young, MD. The clinical algorithm was developed by Carmie Margolis, MD; Agnatha Golan, MD; Professor Michael Karpilis, Ben Gurion University of Negev, Beer Sheva, Israel; and James R. Cooley, MD, Harvard Community Health Plan.

The American Medical Association (AMA) Specialty Society Practice Parameter Partnership reviewed the neonatal hyperbilirubinemia practice parameter and found it to be in conformance with AMA attributes for practice parameter development.

The recommendations in this statement do not indicate an exclusive course of treatment or procedure to be followed. Variations, taking into account individual circumstances, may be appropriate.

PEDIATRICS (ISSN 0031-9005). Copyright © 1994 by the American Academy of Pediatrics.

both the data and analyses contained in a 1990 report by Newman and Maisels.³ Moreover, the total experience analyzed involved a relatively limited number of healthy term infants with bilirubin levels in excess of 25 mg/dL (428 μ mol/L) making it difficult to draw firm conclusions from the published data. The recommendations that follow stem from careful consideration of currently available information, as analyzed and interpreted by subcommittee members and consultants, and are based on evidence when appropriate data exist and derived from consensus when data are lacking. The subcommittee's recommendations are supported by a technical report containing a world literature search and analysis, and updated literature review. The technical report is available from the Publications Department of the American Academy of Pediatrics (AAP).

RECOMMENDATIONS

The following recommendations were developed by the AAP to aid in the evaluation and treatment of the healthy term infant with hyperbilirubinemia. Important in the development of these guidelines is the general belief that therapeutic interventions for hyperbilirubinemia in the healthy term infant may carry significant risk relative to the uncertain risk of hyperbilirubinemia in this population. In these guidelines, the AAP has attempted to describe a range of acceptable practices, recognizing that adequate data are not available from the scientific literature to provide more precise recommendations.

Evaluation

1. Maternal prenatal testing should include ABO and Rh(D) typing and a serum screen for unusual isoimmune antibodies.²³
2. A direct Coombs' test, a blood type, and an Rh(D) type on the infant's (cord) blood are recommended when the mother has not had prenatal blood grouping or is Rh-negative.
3. Institutions are encouraged to save cord blood for future testing, particularly when the mother's blood type is group O. Appropriate testing may then be performed as needed.
4. When family history, ethnic or geographic origin, or the timing of the appearance of jaundice suggests the possibility of glucose-6-phosphate dehydrogenase deficiency or some other cause of hemolytic disease, appropriate laboratory assessment of the infant should be performed.
5. A TSB level needs to be determined in infants noted to be jaundiced in the first 24 hours of life.
6. In newborn infants, jaundice can be detected by blanching the skin with digital pressure, revealing the underlying color of the skin and subcutaneous tissue. The clinical assessment of jaundice must be done in a well-lighted room. Dermal icterus is seen first in the face and progresses caudally to the trunk and extremities. As the TSB level rises, the extent of cephalocaudal progression may be helpful in quantifying the degree of jaundice; use of an icterometer or transcutaneous jaundice meter may also be helpful.²⁴⁻²⁶
7. Evaluation of newborn infants who develop abnormal signs such as feeding difficulty, behavior changes, apnea, or temperature instability is recommended—regardless of whether jaundice has been detected—to rule out underlying illness (Table 1).
8. Follow-up should be provided to all neonates discharged less than 48 hours after birth by a health care professional in an office, clinic, or at home within 2 to 3 days of discharge.²¹
9. Approximately one third of healthy breast-fed infants have persistent jaundice after 2 weeks of age.²⁷ A report of dark urine or light stools should prompt a measurement of direct serum bilirubin. If the history (particularly the appearance of the urine and stool) and physical examination results are normal, continued observation is appropriate. If jaundice persists beyond 3 weeks, a urine sample should be tested for bilirubin, and a measurement of total and direct serum bilirubin obtained.

Treatment

Decisions about therapeutic intervention are tempered by clinical judgment based on the infant's history, course, and physical findings and are balanced by comparing the potential benefits with the risks. As appropriate, physicians are encouraged to discuss management options and their recommendations with parents or other guardians. The guidelines in Table 2 are recommended for infants initially seen with elevated TSB levels, as well as for infants who have been followed up for clinical jaundice. Similar guidelines have been used in Great Britain.^{28,29} Direct bilirubin measurements vary substantially as a function of individual laboratories and their instrumentation. For the purposes of the otherwise

Table 1. Factors To Be Considered When Assessing a Jaundiced Infant*

Factors that suggest the possibility of hemolytic disease
Family history of significant hemolytic disease
Onset of jaundice before age 24 h
A rise in serum bilirubin levels of more than 0.5 mg/dL/h
Pallor, hepatosplenomegaly
Rapid increase in the TSB level after 24-48 h (consider G6PD deficiency)
Ethnicity suggestive of inherited disease (G6PD deficiency, etc)
Failure of phototherapy to lower the TSB level
Clinical signs suggesting the possibility of other diseases such as sepsis or galactosemia in which jaundice may be one manifestation of the disease
Vomiting
Lethargy
Poor feeding
Hepatosplenomegaly
Excessive weight loss
Apnea
Temperature instability
Tachypnea
Signs of cholestatic jaundice suggesting the need to rule out biliary atresia or other causes of cholestasis
Dark urine or urine positive for bilirubin
Light-colored stools
Persistent jaundice for >3 wk

* TSB indicates total serum bilirubin; G6PD, glucose-6-phosphate dehydrogenase.

Table 2. Management of Hyperbilirubinemia in the Healthy Term Newborn*

Age, hours	TSB Level, mg/dL ($\mu\text{mol/L}$)			
	Consider Phototherapy†	Phototherapy	Exchange Transfusion if Intensive Phototherapy Fails‡	Exchange Transfusion and Intensive Phototherapy
≤ 24 §	...	...	...	...
25-48	≥ 12 (170)	≥ 15 (260)	≥ 20 (340)	≥ 25 (430)
49-72	≥ 15 (260)	≥ 18 (310)	≥ 25 (430)	≥ 30 (510)
> 72	≥ 17 (290)	≥ 20 (340)	≥ 25 (430)	≥ 30 (510)

* TSB indicates total serum bilirubin.

† Phototherapy at these TSB levels is a clinical option, meaning that the intervention is available and may be used on the basis of individual clinical judgment. For a more detailed description of phototherapy, see the Appendix.

‡ Intensive phototherapy (Appendix) should produce a decline of TSB of 1 to 2 mg/dL within 4 to 6 hours and the TSB level should continue to fall and remain below the threshold level for exchange transfusion. If this does not occur, it is considered a failure of phototherapy.

§ Term infants who are clinically jaundiced at ≤ 24 hours old are not considered healthy and require further evaluation (see text).

healthy appearing jaundiced newborn, it is recommended that the direct bilirubin measurement not be subtracted from the TSB level and that the TSB level be relied on as the relevant criterion.

Determination of the rate of rise of TSB and the infant's age may help determine how often to monitor bilirubin levels and whether to begin phototherapy. Continued observation may be an appropriate alternative to repeated TSB testing and phototherapy.

There is continuing uncertainty about what specific TSB levels warrant exchange transfusion. Intensive phototherapy (Appendix) is recommended in infants initially seen with a TSB concentration in the exchange transfusion range (Table 2) while preparations are being made for exchange transfusion. Intensive phototherapy should produce a decline in the TSB level of 1 to 2 mg/dL within 4 to 6 hours, and the decline should continue thereafter. If the TSB level does not decline but persists above the level recommended for exchange transfusion, most experts recommend exchange transfusion (Table 2). Exchange transfusion is also indicated in infants whose TSB levels rise to exchange transfusion levels in spite of intensive phototherapy. In any of the above situations, failure of intensive phototherapy to lower the TSB level strongly suggests the presence of hemolytic disease or some other pathologic process and warrants further investigation.

These guidelines apply to infants without signs of illness or apparent hemolytic disease. It may be difficult to rule out ABO hemolytic disease as well as rarer causes of hemolysis.

The evaluation and treatment of hyperbilirubinemia in the healthy term infant is presented in the clinical Algorithm.³⁰

Management of Hyperbilirubinemia in the Healthy Term Newborn by Age (in Hours)

1. Infants ≤ 24 hours old are excluded from Table 2, because jaundice occurring before age 24 hours is

generally considered "pathologic" and requires further evaluation. Although some healthy infants appear slightly jaundiced by 24 hours, the presence of jaundice before 24 hours requires (at least) a serum bilirubin measurement and, if indicated, further evaluation for possible hemolytic disease or other diagnoses. Phototherapy and/or exchange transfusion may be indicated for rapidly rising TSB levels in the first 24 hours of life.

2. For the treatment of the 25- to 48-hour-old infant, phototherapy may be considered (see Table 2 for definition) when the TSB level is ≥ 12 mg/dL (170 $\mu\text{mol/L}$). Phototherapy should be implemented when the TSB level is ≥ 15 mg/dL (260 $\mu\text{mol/L}$). If intensive phototherapy fails to lower a TSB level of ≥ 20 mg/dL (340 $\mu\text{mol/L}$), exchange transfusion is recommended. If the TSB level is ≥ 25 mg/dL (430 $\mu\text{mol/L}$) when the infant is first seen, intensive phototherapy is recommended while preparations are made for an exchange transfusion. If intensive phototherapy fails to lower the TSB level, exchange transfusion is recommended. The higher TSB levels in a 25- to 48-hour-old infant suggest that the infant may not be healthy and indicate the need for investigation into the cause of hyperbilirubinemia, such as hemolytic disease.
3. Phototherapy may be considered for the 49- to 72-hour-old jaundiced infant when the TSB level is ≥ 15 mg/dL (260 $\mu\text{mol/L}$). Phototherapy is recommended when the TSB level reaches 18 mg/dL (310 $\mu\text{mol/L}$). If intensive phototherapy fails to lower the TSB level when it reaches or is predicted to reach 25 mg/dL (430 $\mu\text{mol/L}$), an exchange transfusion is recommended. If the TSB level is ≥ 30 mg/dL (510 $\mu\text{mol/L}$) when the infant is first seen, intensive phototherapy is recommended while preparations are made for exchange transfusion. If intensive phototherapy fails to lower the TSB level, an exchange transfusion is recommended.
4. For the infant > 72 hours old, phototherapy may be considered if the TSB level reaches 17 mg/dL (290 $\mu\text{mol/L}$). Phototherapy needs to be implemented at a TSB level of ≥ 20 mg/dL (340 $\mu\text{mol/L}$). If intensive phototherapy fails to lower a TSB level of ≥ 25 mg/dL (430 $\mu\text{mol/L}$), exchange transfusion is recommended. If the TSB level is ≥ 30 mg/dL (510 $\mu\text{mol/L}$) when the infant is first seen, intensive phototherapy is recommended while preparations are made for an exchange transfusion. If intensive phototherapy fails to lower the TSB level, an exchange transfusion is recommended.

In all of the above situations, intensive phototherapy (Appendix) should be used if the TSB level does not decline under conventional phototherapy. Intensive phototherapy should produce a steady decline in the concentration of TSB. If this does not occur, the presence of hemolytic disease or some other pathologic process is suggested and warrants further investigation.

Table 3. Treatment Options for Jaundiced Breast-fed Infants

Observe
Continue breast-feeding; administer phototherapy
Supplement breast-feeding with formula with or without phototherapy
Interrupt breast-feeding; substitute formula
Interrupt breast-feeding; substitute formula; administer phototherapy

Treatment of Jaundice Associated With Breast-feeding in the Healthy Term Newborn

The AAP discourages the interruption of breast-feeding in healthy term newborns and encourages continued and frequent breast-feeding (at least eight to ten times every 24 hours). Supplementing nursing with water or dextrose water does not lower the bilirubin level in jaundiced, healthy, breast-feeding infants.²¹ Depending on the mother's preference and the physician's judgment, however, a variety of options are presented in Table 3 for possible implementation beyond observation, including supplementation of breast-feeding with formula or the temporary interruption of breast-feeding and substitution with formula, either of which can be accompanied by phototherapy.

DOCUMENTATION

This practice parameter is designed to assist the pediatrician and other health care providers by providing a framework for the management of hyperbilirubinemia in the healthy term newborn. It is not intended to replace the physician's clinical judgment or to establish a single protocol applicable to all such newborns with hyperbilirubinemia. It is understood that some clinical problems may not be adequately addressed by the practice parameter, which cannot be considered to represent an exclusive standard of care. Physicians are urged to document their management strategies, including any significant deviation from these or other guidelines and the rationale for the course of action taken.

Finally, all physicians and other health care providers caring for jaundiced newborns are encouraged to continue appraising and incorporating into their practices new scientific and technical advances as clinical evidence of their effectiveness becomes established.

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APPENDIX

Phototherapy

There is no standardized method for delivering phototherapy. Phototherapy units vary widely, as do the types of lamps used in these units. The following factors strongly influence the efficacy of phototherapy:

The energy output (or irradiance) of the phototherapy light in the blue spectrum, measured in $\mu\text{W}/\text{cm}^2$;

The spectrum of light delivered by the phototherapy unit, determined by the type of light source.

The surface area of the infant exposed to phototherapy.

Commonly used phototherapy units contain a number of day-light, cool white, blue, or "special blue" fluorescent tubes. Other units use tungsten-halogen lamps in different configurations, either free-standing or as part of a radiant warming device. Most recently, fiberoptic systems have been developed that deliver light from a high-intensity lamp to a fiberoptic blanket. Most of these devices deliver enough output in the blue-green region of the visible spectrum to be effective for standard phototherapy use. When bilirubin levels approach the range at which exchange transfusion might be indicated, maximal efficacy should be sought. This can be achieved in the following manner.

The use of special blue tubes in standard fluorescent phototherapy units. Note that special blue (narrow spectrum) tubes carry the designation F20 T12/BB are not the same as blue tubes (F20 T12/B).¹ Special blue lights have the disadvantage of making the infant look blue, but in healthy newborns this is generally not a concern during the relatively brief period that phototherapy is necessary. To mitigate this effect, four special blue tubes may be used in the central portion of a standard phototherapy unit and two daylight fluorescent tubes may be used on either side.²

Regardless of the type of light used, its maximum irradiance should be employed. Standard fluorescent lamps accomplish this by bringing the light as close to the baby as possible. In the full-term nursery, this is most easily achieved by placing the infant in a bassinet (not an incubator) and lowering the lamps to within 15 to 20 cm of the infant. If this treatment causes slight warming of the infant, the lamps need to be elevated slightly. With halogen phototherapy lamps, however, there are no data to indicate how close to the baby the lamp can be positioned without incurring the risk of a burn. When halogen lamps are used, manufacturers' recommendations should be followed. The reflectors, light source, and transparent light filters (if any) should be kept clean.

The third way to improve phototherapy efficiency is to increase the surface area of the infant exposed to the lights. This is done, most simply, by placing the infant on a fiberoptic blanket while using a standard phototherapy system described above.³ If fiberoptic units are not available, several phototherapy lamps can be placed around the infant. When a single phototherapy unit is used, the area of exposure can be increased by placing a white reflecting surface (such as a sheet) around the bassinet so that light is reflected onto the baby's skin. Removing diapers will also increase the exposed surface area.

Intermittent Versus Continuous Phototherapy

Clinical studies comparing intermittent with continuous phototherapy have produced conflicting results.⁴⁻⁶ Because all light exposure increases bilirubin excretion (compared with darkness), no plausible scientific rationale exists for using intermittent phototherapy. In the majority of circumstances, however, phototherapy does not need to be continuous. Phototherapy may be interrupted during feeding or brief parental visits. Individual judgment should be exercised. If the infant is admitted to the hospital with a bilirubin level $\geq 25 \text{ mg/dL}$ ($428 \mu\text{mol/L}$), intensive phototherapy should be administered continuously until a satisfactory decline in the serum bilirubin level occurs or exchange transfusion is initiated.

Intensity of Phototherapy

The intensity of the phototherapy (number of lights, distance from infant, and use of double phototherapy, use of special lights) should also be tailored to the infant's needs. In many circumstances intensive phototherapy is not necessary. However, if the serum bilirubin level is rising in spite of conventional phototherapy or the infant is admitted with a serum bilirubin concentration within the exchange transfusion range, the necessary steps should be taken to increase the intensity of phototherapy during preparation for exchange transfusion. With the light sources commonly used, it is impossible to overdose the patient.

Hydration

To our knowledge, no evidence exists that excess fluid administration affects the serum bilirubin concentration. Some infants who are admitted with high bilirubin levels are also mildly dehydrated, however, may need supplemental fluid intake to correct their dehydration. As these infants are almost always breast-fed, the best fluid to use in these circumstances is a milk-based formula, because it inhibits the enterohepatic circulation of bilirubin and helps lower the serum bilirubin level. Because the photoproducts responsible for the decline in serum bilirubin are excreted in both urine and bile, maintaining adequate hydration and good urine output should help improve the efficacy of phototherapy.⁷ Routine supplementation (with dextrose water) of infants receiving phototherapy is not indicated.

When Should Phototherapy Be Stopped?

A recent study found that, in infants who do not have hemolytic disease, the average bilirubin rebound after phototherapy is less than 1 mg/dL ($17 \mu\text{mol/L}$).⁸ Phototherapy may be discontinued when the serum bilirubin level falls below 14 to 15 mg/dL . Discharge from the hospital need not be delayed in order to observe the infant for rebound and, in most cases, no further measurement of bilirubin is necessary. If phototherapy is initiated early and discontinued before the infant is 3 to 4 days old, additional outpatient follow-up may be necessary.

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Push on to require minimum hospital stays after childbirth

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

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

When insurance companies' efforts to cut medical costs run up against

mothers' pleas for more care, the choice is obvious to many politicians.

"It's outrageous for insurance companies to push women out of hospitals after a day, after 12 hours in some cases," says Sen. Bill Bradley (D, N.J.). "I was appalled that this was happening."

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

At the state level, Maryland's legislature passed the first such bill in April. Lawmakers quickly followed suit in New Jersey — where one newborn's

death is blamed on early discharge.

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

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

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

The American Medical Association says that, in the absence of definitive empirical data, the clinical judgment of the attending physician should determine a new mother's length of stay.

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

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

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

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

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

"We believe any legislation that mandates hospital length of stay is a bad idea," says Barbara Gracey, spokeswoman for the industry group Health Insurance Assn. of America.

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

"With my daughter, I had classes on breast-feeding, bathing and how to learn to read the signs" of trouble, Sarah Pallone said. "With my son, they handed me a videotape as I left."

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

Michelle and Steve Bauman of Williamstown, N.J., lobbied for passage of that state's minimum-stay law after their first child died of meningitis May 18, two days after birth.

Steve, a 30-year-old truck driver, says Michelle, 28, and little Michelina Alanna were discharged from a Gloucester County hospital 23 hours after birth.

"The baby looked beautiful" and was taking formula well, he recalls.

But after a long night up with a crying baby who wouldn't eat or sleep, they started calling their pediatrician at 6 a.m. Despite several calls to report escalating symptoms — jaundiced skin, cloudy eyes, a pin-dot rash — Steve Bauman said the doctor told them not to worry. About 5:30 p.m., the baby stopped breathing and died despite resuscitation efforts.

Medical experts, citing a few studies and anecdotal reports of other serious illnesses developing right after early discharges, blame health plans that provide little or no follow-up care.

"A certain number of women, particularly women who are first-time mothers who are going back to a setting where they don't have a lot of help or resources, just aren't ready to leave in 24 hours," says Fredric Frigoletto, MD, ACOG's president-elect.

Doctors concede it's probably OK to discharge the healthiest, best-prepared mothers in 24 hours — if the physician is certain they will return soon to have the baby examined and tested for metabolic and other disorders best detected after the baby starts feeding, which usually takes more than a day. But AAP President-elect Ed Keenan, MD, insists, "There's no data to show it's safe to send babies home in 24 hours."

A University of California, San Francisco, study found that UCSF Medical Center treated five babies for irreversible brain damage caused by undetected jaundice from 1992 to '94, a period when 200,000 babies were born in that area. By comparison, the study found only one such case among 2.8 million babies followed in the previous 20 years.

Dartmouth Medical School Associate Professor Judith Frank studied 15,000 infants born at New Hampshire's 23 hospitals in 1993. Of those discharged early, 1.61% were readmitted to hospitals and another 2.04% needed emergency care, while among those who spent at least two days in the hospital after birth 1.09% were readmitted and 1.17% treated in emergency departments.

But Frank's study also showed the savings: Medical costs for all 361 infants who returned to the hospital totaled about \$670,000, while adding a day to the stays of the 3,547 newborns discharged early would have cost nearly \$7.5 million.

"Early discharge of infants is a cost-effective approach to health care," Frank concludes, stressing that only works if proper follow-up care is given.

Individual insurers said in interviews that their customers get plenty of prenatal and follow-up care, and that doctors make all decisions on when patients are discharged.

At Kaiser Permanente in Los Angeles, obstetrics-gynecology chief Faustina Nevarez, MD, says there's always a small risk with early discharge, but her hospital has "so much support care it's not funny." She says fear of malpractice suits helps keep doctors and insurers from going too far.

But doctors and nurses say pressure from insurers to meet their discharge guidelines is enormous.

Ann Twomey, president of a New Jersey union representing thousands of hospital nurses, says obstetrical nurses worry about new mothers they see going home unprepared.

"The nurses are giving out their home phone number, saying, 'Call me if you need anything,'" Twomey says.

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Allowing loan interest to compound is fair to graduates and taxpayers

Regarding "Investment in the future" (Editorial, June 19):

The late Sen. Everett Dirksen has been quoted as saying, "A billion here, a billion there, pretty soon you are talking about real money."

Even though eliminating the Stafford Loan Program would save "only" \$12.4 billion over five years, its continuation sends the wrong message.

The ability to pay back a loan depends on one's income and expenditures after

payback is initiated, and not dependent on family income before entering school. College graduates make significantly more money than nongraduates, and they should be glad to pay back a loan with interest if it allowed them to reach goals not otherwise attainable.

I believe it is reasonable to allow compounding of interest during school, but graduate school graduates should be able to bear the burden better than the taxpayer.

It is also more fair for the beneficiary to pay than for the taxpayer to pay. Someone has to pay.

BARTON C. GROOMS, MD
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AMA on 'dangerous course' regarding Medicare, politics



Regarding "Moving Medicare into the Marketplace" (July 3/10):

As an alternate delegate to the AMA House, I attended this year's meeting in June. This article accurately reflects the feeling of pride our AMA leadership projected over the Republican's invitation to sit at the "table."

It did not seem to matter that the politicians in power at this time have a stated policy of balancing the national budget on the back of the Medicare system.

It seems to me that the AMA has embarked on a very dangerous new course. To merge our identity as physicians with any political ideology is extremely short sighted. At one time the AMA could gather physicians of all political persuasions under the tent of universal coverage and patient protection. We now have the oxymoronic policy of "incremental universal coverage" — whatever that is. And with this new shift we are willing to experiment with the health of our elderly based on simplistic political solutions.

Before we slap ourselves too hard on the back we should think out the unintended consequences of such a policy shift. The fate of those who ride on the backs of tigers is quite well known.

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Guidelines, priorities needed in era of limited resources



Regarding "Lessons a young physician learned from a dying man" (Other Opinion, June 26):

The article by Barney Maynard, MD, demonstrates some of the problems inherent in placing monetary values on a patient's decisions. But we also need to realize that we live in an era of limited health care resources.

If resources were unlimited, I agree that it would be inappropriate to mandate decisions for our patients based on our own predetermined set of values. But we do not live in an era of unlimited resources. Therefore, we must realize that money spent on one patient is money not available to spend on another.

In Dr. Maynard's article, the dying man made a decision to receive aggressive treatment and extend his life for three months. Although it made no difference in terms of his medical outcome, it was very important to him and his family. I understand and respect his decision.

But we must also look at the resources utilized by this individual that may have then not been available to others. For example, what if his treatment resulted in an extra \$50,000 in medical expenses? That \$50,000 bought him an extra three months. Although it was very important to him, it was also money that could not be utilized by others.

What if it had been used to fund Pap smears for several thousand women, thereby preventing the death of an otherwise healthy young mother? Or a life-saving operation for a 10 year-old-boy?

Nobody likes the thought of rationing health care services. But we must face the fact that we are entrusted to provide the best possible care for hundreds of millions of people while dealing with limited resources. As such, guidelines based on good cost-benefit analysis are useful tools that can help ensure equitable distribution of these resources among all people.

EDUARDO ORTIZ, MD
Salt Lake City

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Date: 09/12/95 Time: 15:11

Couples Testify For Longer Hospital Stays After Birth

WASHINGTON (AP) Steve Bauman's hands trembled Tuesday as he showed lawmakers a picture of his daughter Michelina, who died two days after birth in their home in Williamstown, N.J.

He and other parents urged the Senate Labor and Human Resources Committee to pass a bill that would require insurers to cover minimum hospital stays for mothers and their newborns.

The bill was sponsored by the panel's chairwoman, Sen. Nancy Kassebaum, R-Kan., and Sen. Bill Bradley, D-N.J.

The measure would require insurers to cover at least a 48-hour stay for mothers and infants after normal births, and 96 hours after Caesarean births. The measure allows shorter hospital stays if neither the mother nor doctor object, and if follow-up home care is provided for mother and infant.

Proponents say cost pressures are forcing hospital discharges after 24 hours, before many health problems such as dehydration, infections and jaundice can be detected.

Opponents counter that Washington should not follow the lead of New Jersey and Maryland, which have enacted state laws similar to the Senate bill. They said insurers do pay for longer stays when needed, but that lawmakers should not set one standard when no evidence exists that one measure is best for all.

``Focusing on length of hospital stays for infants and their mothers is too narrow,'' said Dr. Sharon Levine, associate medical director of the Permanente Medical Group Inc. in Oakland, Calif.

``The focus must be on assuring that mothers and children have access to appropriate care throughout the pregnancy and after delivery.''

Sen. Bill Frist, R-Tenn., a heart transplant surgeon, also raised concerns about where else Congress might legislate minimum hospital stays. He noted that heart bypass patients' post-surgery discharges have been reduced to four days from 12 even though complications can develop.

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The bill is S969.

APNP-09-12-95 1521EDT

pregnancy turned away the visiting nurse who called because she was sure that all the books she was reading would explain everything she needed to know. If that wasn't sufficient, she expected to rely on her mother, who planned to arrive as soon as the baby did. But her mother turned out to be too sick to travel when the baby came, and my friend found herself alone at home with her new baby. When the nurse came knocking on the door again, my friend pulled the startled woman inside and began babbling questions at her.

No matter how much advice and information is available to a new mother, however, she and her baby need adequate time to recover from the rigors of childbirth before she can put it to use. Yet increasingly, American insurance practices are forcing hospitals to discharge mothers and newborns as quickly as possible, often within twenty-four hours of a vaginal birth and three days of a caesarian. [OK?] For many women, that just isn't enough time to emerge from exhaustion, let alone to learn how to breastfeed properly or to adjust to a new sleeping schedule and the other changes that arrive along with the baby.

Routinely sending mothers and babies home so soon is not only

callous but dangerous. Across the country, apparently healthy babies are leaving the hospital a day after birth only to show up a few days later suffering from jaundice, which can cause permanent brain damage or death if it is not treated, or dehydration from inadequate breast feeding, which can lead to seizures and other serious problems. [Pediatricians emphasize that many newborns' systems do not stabilize until at least 48 hours after birth.] [FROM INQUIRER ARTICLE, UNCLEAR WHICH CITY] ?

In the face of pressure to control health costs, patients have to become more knowledgeable and demanding about their care, but they may not be the best ones to decide when to be discharged. In the dizzying aftermath of childbirth, some mothers may decide they're ready to leave prematurely; others might choose to stay for weeks if they were permitted. Policies regarding the length of stay of mothers and infants after birth vary widely in the United States and throughout the world, but the ^{trend} ~~the~~ in the U.S. toward shorter stays "appears to be driven primarily by financial motivations," according to the American College of Obstetrics and Gynecology.

^{In 1995} ~~^~~ The College and the American Academy of Pediatrics [WHEN?] ?
released a set of "Guidelines for Perinatal Care" recommending that

discharge decisions take into account the medical stability of the mother and infant, whether the mother has learned to feed her baby adequately and been instructed in other basic care, and the availability of appropriate follow-up supports and services. All of these factors are dependent on the evaluation of the doctors and nurses who care for mothers and babies, not the insurers. Unfortunately many doctors feel trapped by the regulations imposed by HMOs and insurers, and they may be reluctant to speak up on behalf of their patients for fear they will lose their practice privileges. One doctor testifying ^{before the New Jersey legislature} [BEFORE CONGRESS?] about the need for legislation to mandate length of hospital stays described physicians as indentured servants" to managed care. [WASHINGTON POST, JUNE 27, 1995]

In response to patients' and physicians' concerns, two states, Maryland and New Jersey, ~~have~~ ^{in 1995} passed legislation governing postnatal care that includes guidelines for discharge decisions. During the hearings for the New Jersey bill, Dominick A. Ruggiero, Jr., a retired transit worker, testified about the death of his grandniece, Michelina. His niece had had an uneventful pregnancy and childbirth, and had been discharged the next day. At home, however, the baby's health had rapidly deteriorated, and she died in her cradle. On the eve of the bill being signed into law, Mr. Ruggiero

said, "I will always remember this as the Michelina bill." [INQUIRER]

This is not a partisan issue. Maryland had a Democratic governor and legislature when it acted; New Jersey's bill, which requires that women be allowed to stay in the hospital a minimum of 48 hours after uncomplicated vaginal deliveries and 96 hours following caesarean deliveries, was passed by a Republican legislature and signed by a Republican governor. Other states and the Congress are expected to pass similar legislation. (For any doubters out there, this is a prime example of why the health care market, like any other market, needs sensible regulation.)

But it is at home that the real work of parenting begins, and the responsibility can be overwhelming, as every parent knows. Babies don't come with handy sets of instructions about how to water and feed them and how many hours of direct sunlight they need to bloom. No matter how much help is available, beginning parenting inevitably includes trial and error.

Nothing I learned in college or law school or anywhere else prepared me for the joy or mystery of motherhood, or the uncertainties. I remember Chelsea crying her heart out one night soon after Bill and I brought her

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HOSPITAL STAYS FOR MOTHERS AND BABIES

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Senate Committee on Labor and Human Resources

S. 969 Newborns' and Mothers' Health Protection Act of 1995

September 12, 1995

Written Statement

by

Karen L. Davies

Chairman Kassebaum, members of the Committee, my name is Karen Davies. I work as a curriculum coordinator for the Lawrence public schools. I am pleased to have the opportunity to talk with you this morning about the impact that early dismissal after childbirth had on me and my baby.

On December 16, 1994 my daughter, Maria Chereese, was born at St. Luke's Hospital in Kansas City, Missouri. My husband and I planned to have a baby after we had been married several years. We carefully considered birthing options and decided that we wanted our baby delivered by an obstetrician in a hospital setting. It was important to us that we pursue high quality care. Consequently, we were extremely selective when choosing an obstetrician and hospital I wanted my baby born at St. Luke's because it has one of the very few Level III nurseries in the Kansas City area. It was comforting to know that if there were any problems with my baby, I would be at the best place for treatment. My husband and I went to all of my prenatal appointments. In addition, I underwent an amniocentesis which indicated I was carrying a normally developing baby girl. My obstetrician often reassured me that I was a "normal, healthy pregnant lady." We prepared for our daughter's birth by attending childbirth classes in November. I also made a decision to try to breastfeed my daughter. As required by my health insurance, I pre-certified for my hospital admission and was told that I was approved for 24 hours. Maria was born three weeks early, yet her delivery was uncomplicated and relatively easy. I had no pain medication during the delivery. I was so pleased and relieved that everything had gone smoothly. My husband and I, like most new parents, were euphoric after such a tremendously positive experience.

The nurses at St. Luke's were extraordinary. They attempted to teach me as quickly as possible all the particulars of being a first-time mom and a first-time nursing mom. Unfortunately, all of the teaching was accelerated and difficult to absorb in such a short time. Because I was breastfeeding, the

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nurses were very attentive. I attempted to feed Maria approximately every 2-3 hours or when ever I thought, or the nurses thought, she was hungry. Maria was extremely difficult to wake for her feedings. Each time I tried, a nurse was present to help me get started. Although I had read that breastfeeding was something that both mother and baby had to learn, I did not anticipate that I would have problems. A few hours before I went home, two of my nurses saw that I was having difficulties and took special interest in Maria and me. They showed me feeding and waking techniques and gave me lots of encouragement.

My daughter was examined during our short stay by her pediatrician. Maria had some bruising on her head, but otherwise appeared fine. Although she was 3 weeks early, at 37 weeks she was considered a full-term baby and didn't meet my insurance company's criteria to secure more than a 24 hour stay in the hospital. All of my nurses expressed displeasure at our early dismissal. They were giving us encouragement and advice all the way to our car as we were leaving. It was overwhelming.

My doctor and the nurses at St. Luke's were not in favor of our dismissal after 24 hours, yet were required to follow the medical criteria set by the insurance company. The insurance company did not take into consideration my maternal age, 39, the fact that I had no support system at home, that this was my first child, that she was 3 weeks early, and most importantly that I was having difficulty waking and feeding her when they determined the allowable number of days, or hours, in the hospital. Out length of stay had been predetermined. Although my husband and I did not feel comfortable leaving the hospital so quickly, and asked several if we could stay, we left happy but apprehensive. We took our baby home along with several sheets of written instructions and booklets on caring for me and her.

Within 48 hours of her birth, Maria began developing jaundice. Her skin was noticeably yellow on her face, arms and chest. Fortunately, my husband and I had accepted the offer from my insurance company for a home health nurse. The nurse came to our home to check on both of us within 48 hours of Maria's birth. She observed the jaundice but told us not to worry, many newborns develop jaundice. The nurse observed one very brief feeding. My husband insisted on a follow-up visit.

Upon entering our home and seeing our daughter, the second nurse immediately called our pediatrician. The jaundice now extended to all parts of Maria's body. The doctor gave orders to draw blood for a test to measure the level of bilirubin. The nurse told us that the test results would determine what treatment would be necessary. She drew the blood and took the sample to the hospital. A short time later, a nurse from our pediatrician's office called our home and told us to bring Maria in as quickly as possible. There was urgency in here voice as she instructed us to pack a bag because we would probably be staying at the hospital. The hospital lab had determined that Maria's bilirubin level was 28. Later, we found out that treatment is often instigated for bilirubin levels of 14-15. We bundled Maria into the car and hurriedly drove the 40 miles to our pediatrician's office. As I sat next to my baby on the way to the doctors office, I imagined that she was becoming increasingly yellow. I looked at her lips and soft spot for signs of dehydration. I tried to wet her lips. I was horrified that my baby might be seriously ill so soon after her release from St. Luke's. I felt awful that I hadn't recognized my baby was ill. Maria was immediately admitted to the hospital where her pediatrician was affiliated because of a condition identified as hyperbilirubinemia. The

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treatment for her condition was to administer phototherapy, temporarily stop breastfeeding and substitute commercial formulas. The nurse placed Maria naked in an isolette under phototherapy lights. She wore a protective mask over her eyes. I was not allowed to breastfeed her, so she was given formula upon her admission and then approximately every three hours. She underwent a series of diagnostic tests to determine possible causes of her rapid rise in bilirubin levels. We were told that she would be under the lights until her level dropped to around 11-12. Maria's bilirubin level did not drop as quickly as it had elevated so we spent the next four days and three miserable nights at the hospital.

I don't know if I can sufficiently describe my feelings upon taking Maria to a hospital and seeing her under the bili-lights. The experience was wretched and distressing. My confidence in caring for my daughter plummeted. Emotionally, it was very difficult. What we imagined would be a time for us to get to know to learn to feed and care for our baby and delight in our new family had into a nightmare.

The ride to the hospital was approximately an 80 mile round trip from our home. We did not want to leave Maria by herself at the hospital, so my husband and I took turns staying overnight with her. Because I wasn't supposed to drive for several days, a family friend helped with transportation. Maria was admitted to the pediatric ward, so we were also concerned about exposing her to other illnesses. We got to leave the hospital on December 23. We drove back to the outpatient lab for a blood test and a follow-up visit at her pediatrician's office the next day, Christmas Eve.

While at the hospital, we were terrified to learn of the possible consequences of hyperbilirubinemia. We learned that some instances of hyperbilirubinemia was neurological damage, cerebral palsy or hearing loss. Although our pediatrician assured us that there was no immediate indication that Maria had neurological damage, there was concern that she might have a hearing loss as a consequence of the elevated bilirubin level. Her pediatrician ordered an audiological examination at the Children's Mercy Specialty Center Hearing and Speech Department. The examination took place about two weeks after her dismissal. The test was an auditory brainstem response test which involved attaching electrodes to her head. We were relieved to find out that the tests indicated normal conditions for both ears. Two more blood tests and checkups by her pediatrician followed because Maria still was jaundiced. I am delighted to report, that Maria is now a healthy and thriving 9 month old.

Our pediatrician took a conservative approach, with our support, to lower our daughter's bilirubin level. However, my husband and I simply believe Maria's admission to the hospital could have been avoided if we had been allowed the option by our insurance company to stay in the hospital just 24 more hours. The opportunity for us to take preventative steps such as establishing breastfeeding, learning how to keep our baby well-hydrated and having plenty of time for support was eliminated by the early dismissal. My husband and I had no experience in assessing potential medical complications in newborns. We have learned since Maria's hospitalization that early and frequent feedings are often effective in preventing more severe increases in jaundice and are essential for breastfed infants. It is possible that supplemental feeding in the form of pumped milk may have kept the jaundice from getting to the point that it became necessary to treat. But, again the early dismissal prevented us from being observed and cared for by supportive, knowledgeable personnel. For us, 24

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hours was simply not enough time. Although the home health care program is a good one, in our situation, it was not an adequate substitute for 24 more hours of care, observation, learning and monitoring. My husband and I were told by nurses that the jaundice would have been discovered during an initial 48 hour stay at the hospital.

My daughter's hospital bills, out-patient lab costs, hearing test and follow-up visits to the pediatrician totaled \$3,500.00. Additionally, my husband had to take emergency family sick leave from his job as a lieutenant with the Lawrence, Fire Department. Consequently, the city had to absorb the cost of replacing him for 72 hours. The price of the stress and worry tire incalculable.

Because of our experiences, my husband and I are in favor of legislation that would compel insurance companies offering maternity benefits to provide coverage for newborns and mothers for 48 hours if needed. We are appalled that insurance companies can discontinue benefits for newborns and mothers after 24 hours postpartum. It is essential that insurance companies recognize that mothers and newborns can not be compartmented; we are not all the same. Although my daughter and I were under the care of outstanding physicians, the decision-maker for the length of our hospitalization was my insurance company. We believe health our child's health was jeopardized because our insurance company decided before our daughter was born that neither of us required more than a 24 hour stay in the hospital. It angers me that the philosophy of preventative care was so easily and quickly abandoned under the guise of cost-cutting. For us, it is a ethical issue not a cost issue. What price can be placed on a newborns health?

We feel so fortunate that Maria is healthy, happy and growing. My husband and I have many hopes and dreams for our daughter, one of which is good health. But, until the time returns that patients and doctors have control over medical and health decisions she, along with all of us, must have protection under legislation such as S, 969.

I want to thank Senator Kassebaum and Senator Bradley for introducing this Important legislation. Also, my thanks to the members of the committee for this opportunity to testify. I'll be happy to answer any questions that you may have.

LANGUAGE: ENGLISH

LOAD-DATE: September 14, 1995

Good morning, Senators. Thank you for the opportunity to tell you our story.

We are here today for our daughter Michelina Alanna Bauman, who passed away last May, two days after she was born. She was our first child. She and her mother were discharged about 28 hours after she was born. This was not enough time for doctors to discover that Michelina was born with streptococcus, a common and treatable condition. Had she remained in the hospital an additional 24 hours her symptoms would have surfaced and professional trained staff would have taken the proper steps so that we could have planned a christening instead of a funeral. Her death certificate listed the cause of death as meningitis when it should have read death by the system.

Our daughter has done more good by her death than most people do in a lifetime. Her death encouraged New Jersey to pass a law to stop the "O.B. Express". But there is still more to do. A law needs to be passed to make sure that no other babies, anywhere in the country, ever die because their HMO made them leave the hospital too soon.

We are here today for all future babies. Life must be the consideration, not the dollar sign that our HMO carriers have placed before anything. That little life not yet grown must be given a chance to make a difference. There is anger mixed with grief. This should not have happened, not today, not in America. Yet it did and there are no words that can change the situation. Our daughter is now an angel who can look over everyone and say yes I made a difference.

(The next page describes our daughter's symptoms and how the HMO and doctor responded.)

Discharged from the Hospital 5-17-95,

Dr [REDACTED] explained what to look for about Jauntice, the hospital gave us a booklet. In the booklet the book explains that if the baby looks jauntice to contact the Pedetirican which we did.

The baby was given a clean bill of health by Dr [REDACTED], the baby was drinking 1½ to 2oz of formula each feeding while in the hospital. Dr [REDACTED] also said if we noticed anything different, please contact her office, we did exactly what she asked us to do. But not once did she tell us to bring the baby into the Emergency Room during the phone calls that were made to her office, we relyd soley on her decision as we are new parents. Had she told us to bring the baby into the Emergency room the first time we called her there would have been no need to make an additional 3 phone calls and our baby would be alive today.

H.M.O.: Little Appleseed Program

Visiting nurse was to have called to set up appointment for a Nurse to come to our home, when we made the phone call they were not aware that the baby was born. I spoke to the nursing supervisor she said she would have someone call us back which she did, while we were on the phone with the supervisor we had explained the babys symptoms she had advised us to call the Pedetician again which we did. The little appleseed program called my husbands place of employment on the 19th of May.

May 16,1995; Michelina Alanna Bauman 6lbs 12oz,19½" long

May 17,1995: Released from Hospital,Kennedy Memorial Washington Township Division.

May 18,1995 Michelina Alanna Bauman died in her home,

May 17th,1995 Baby began fussing about 10pm that evening,she fussed all evening into the morning of the 18th, at approx 6am on the morning of the 18th of May,my husband put in the first call to the Pediatrician,Dr [REDACTED],he explained the symptoms about the baby not sleeping, not eating,and was uncomfortable all evening throughout the night of the 17th, she explained that the baby had gas,and her days and nights mixed and we were to give her Mylacon drops with her next feeding.throughout the morning of the 18th,the baby didnot drink more then about a ½ oz of formula, at about 10am we noticed that the babys skin color was yellow,another call was placed to the office, by my husband and we were told that the yellow was normal as long as it was not in the white of her eyes we explained that her eyes were cloudy. The third phone call was placed to the Pediatrician that the baby had a rash on her arms and legs, that looked like pen dots,we at that point spoke to the doctors service,The Pediatrician called back approx 5:30 pm of the 18th of May by that time it was to late the baby had stopped breathing. Inbetween the phone calls to the Pediatrician H.M.O. was called because we were entitled to a visiting nurse after 24hrs that mother and child is released, we were told that they were unaware that the baby had been born, and that they would get back to us soon. They called my husbands place of employment on the 19th of May it was too late.The baby was dead.The baby was diagnose Strep a Coctis B a common treatable condition,had the Pediatrician asked that we bring the baby to the emergancy room,or had H.M.O.allowed another 24hrs in the hospital, the babys symptoms would have appeared in the nursery and professional personnel would have been able to save my babys life.

SYMPTOMS:

1. Baby not eating
2. Up all night long
3. Rash on hands and legs,(marks like pen point dots)
4. Change in skin color Yellow
5. Cloudy Eyes

DISCHARGED Too Soon?

BY SANDRA G. BOODMAN

M

ahiri G. MacDonald thought she'd seen her last case of kernicterus, a rare and devastating complication of advanced, untreated jaundice, during her medical training 25 years ago. But in the past two years MacDonald, director of the neonatal intensive care unit at

Children's National Medical Center in Washington, has treated four newborns with the preventable disorder. One infant died and three others may have permanent brain damage. All had been discharged from area hospitals less than 48 hours after delivery.

The Washington cases are not isolated. Between 1992 and 1994 five newborns were admitted to the neonatal intensive care unit of San Francisco General Hospital for treatment of brain damage due to bilirubin encephalopathy, also caused by untreated jaundice. All five, who doctors say have suffered permanent brain damage, were born healthy, and all were discharged from California hospitals less than 28 hours after birth. When he searched records for similar cases, the hospital's chief neonatologist said he found only one case among 23 hospitals, including San Francisco General, between 1972 and 1991, when maternity stays were longer.

Between 1992 and 1994, a period when the average stay after a normal delivery dropped from 72 to 24 hours in Cincinnati, doctors at Children's Hospital Medical Center saw a 30 percent increase in readmissions for jaundice and a threefold increase in readmissions for severe dehydration in breast-fed infants less than 4 weeks old. Three babies suffered serious blood vessel problems, according to chief neonatologist Reginald Tsang; one required a leg amputation.

Micheline Alanna Bauman was discharged from Kennedy Memorial Hospital in Washington Township, N.J., on May 17, about 28 hours after her uneventful birth. She died at home a day later of a massive, undetected bacterial infection, a problem the hospital's vice president for medical affairs said probably would have been detected and treated with antibiotics had she remained in the hospital a day longer.

These infants and their families are part of a profound shift in medicine: the trend toward shorter hospital stays for virtually every ailment. In 1970, the average stay after an uncomplicated vaginal delivery was about four days. By 1992 it had been cut to about two days; today the average for an uncomplicated delivery is about 24 hours. In California, where short stays were pioneered by Kaiser Permanente, the nation's largest health maintenance organization, some insurers are authorizing only a 12-hour stay, according to officials at the American College of Obstetricians and Gynecologists (ACOG), which opposes the routine imposition of early discharges.

Critics call these short hospitalizations "drive-through deliveries" and say speedy discharges amount to a dangerous, uncontrolled experiment by insurers and health maintenance organizations eager to cut costs. Insurance companies maintain, however, that short stays are both good medicine and good business. They note that hospitals, by their very nature, are teeming with germs that pose an unnecessary risk to healthy babies and mothers who don't need to be there.

There is no dispute that shorter stays represent an enormous cost savings. Childbirth is the most common cause of hospitalization—about 4 million babies are born annually in the United States—and an additional night in the hospital costs between \$700 and \$1,110.

States Strike Back

Last month ACOG, which recommends that new mothers spend at least 48 hours in the hospital after an uncomplicated birth and 96 hours after a Caesarean delivery, called for a moratorium on shorter stays and challenged insurers to prove that they are safe. That view was echoed last week by the American Medical Association, which passed a resolution urging that postnatal discharges be "determined by the clinical judgment of attending physicians and not by economic considerations."

These views have received a sympathetic hearing in the state legislatures of Maryland and New Jersey. Both states recently passed bills that prescribe postnatal care. Maryland's bill, signed into law several weeks ago by Gov. Parris N. Glendening (D), requires that mothers and infants discharged within 24 hours meet certain criteria and receive a home visit by a nurse.

New Jersey's more far-reaching bill, which sailed through the Republican-controlled legislature with strong bipartisan support, requires that insurers pay for a stay of at least 48 hours if requested by the doctor or mother. Gov. Christine Todd Whitman (R) is likely to sign the bill tomorrow. Lawmakers in New York are planning to introduce a similar measure in the next few months.

"I don't know if this is a trend or not," said Kathryn Moore, a lobbyist for ACOG. "It is indicative of the frustration with managed care and with insurance company edicts that make no sense."

Geni Dunnells, executive director of the Maryland Association of HMOs, said that the Maryland law, which takes effect Oct. 1, "sets a bad precedent" by legislating medical care. The chief reason for its passage, she said, was not evidence but emotion. "There are a lot of emotions surrounding how long a woman should stay in the hospital" after childbirth, she said.

Kylanne Green, executive vice president of the Health Insurance Association of America, the Washington-based trade association for 230 commercial insurers, agreed. "I don't think we have any empirical evidence one way or the other that it's safe," she said.

"Keeping a baby in what is essentially a high-risk situation [a hospital nursery] simply for observation is not wise," Green added. "I truly believe that a lot of what is stimulating all of this is that the mothers are pushing this. A lot of mothers are working mothers. They work up to the time of delivery and they're tired. While we can sympathize with that, do you use health insurance dollars to pay for this?"

Cost is not the primary consideration, added Susan Pisano, communications director for Group Health Association of America (GHAA), the trade association that represents the majority of the nation's 574 HMOs. Pisano said that shorter hospital stays work well for most families and that if a patient needs a longer hospitalization, a doctor can authorize it. "We think that medical decisions should be made by medical people on a case-by-case basis and not by legislators," Pisano said. "It comes down to this: providing the right care in the right place at the right time."

Few doctors would disagree with that premise, and even the most ardent critics of early discharge acknowledge that most babies and mothers are not going to have serious medical problems. "Most people are not going to have a catastrophic event," said Maureen Edwards, chief of neonatology at George Washington University Medical Center, who believes short stays have yielded mixed results. "We did one thing that probably wasn't bad, which was to shorten the stay of people who didn't need to be in the hospital. The problem is the piece that comes after the hospital—we didn't have any other system in place" for noninstitutional care.

Nevertheless, the pressure by insurers to discharge patients as soon as possible is unrelenting, Edwards added. "We have patients going home at 10 or 11 o'clock at night—it's crazy," she said. In some cases when a mother develops an infection or other complication and requires an extra day or two of hospitalization, some insurance companies are demanding that the newborn be discharged, something Edwards said she refuses to do.

How Early Is Too Early?

The first experiments in early discharge occurred in the late 1970s and involved small, select groups of women who wanted to decrease the medical interventions that surround childbirth. The push to get women out faster began in earnest in the early 1990s with the rise of managed care.

Some doctors say 24 hours is too soon to accurately assess an infant's condition. "There are many things that go on after 24 hours of life, many transitions that occur in a newborn," said Augusto Sola, chief of neonatal clinical services at the University of California, San Francisco. "Jaundice doesn't start to happen until the second or third day of life, and dehydration never happens until after two to five days," he said. Certain infections and serious heart defects also do not show up during the first 24 hours and may occur after babies go home. Early discharges also mean that babies are being sent home before certain tests can be performed, such as the screening for phenylketonuria (PKU), an inherited disorder that is treatable in the early days after birth; if untreated, it causes mental retardation.

In addition, there is little or no time to teach women how to breast-feed or to care for a newborn; even if such instruction does take place, most babies are too sleepy to eat much on their first day of life.

"When mothers and babies are discharged early, they miss having somebody troubleshoot," said Carol Miller, director of San Francisco General's well-baby nursery. "Breast-feeding is less likely to be successful. It's not instinctive. It takes support and education and training. What happens is that mothers continue to breast-feed and it isn't until the babies are really sick [because they are getting little or no milk] that they are brought in."

Some doctors worry that home care, while it is touted as a substitute for longer hospital stays, may not be sufficient.

"The question is what kind of home care and by whom and with what frequency?" asked Michael Mennuti, chairman of obstetrics and gynecology at the University of Pennsylvania School of Medicine and of ACOG's committee on obstetrical practice. "This is not standardized. The component of these home-care elements needs to be systematically evaluated."

MacDonald of Washington's Children's Hospital agreed. She said the four babies she treated for kernicterus had an inherited enzyme deficiency that increased the risk of severe jaundice. Yet in all but one case no follow-up care had been arranged, she said. One infant was seen at home by a nurse who failed to recognize the severity of jaundice. Two days later, after the baby stopped eating, he was admitted to Children's, where doctors discovered he had sustained a profound hearing loss. That may not be his only problem.

"The trouble is that unless a baby is totally devastated, you really can't tell for about a year whether he or she has sustained permanent [brain] damage," she said.

Like its counterparts in San Francisco, Cincinnati and elsewhere, Children's has seen three recent cases of life-threatening dehydration in breast-fed babies.

"These cases used to be very few and far between," MacDonald said. Most of these babies are slightly older; they tend to be seen in the second week of life. At first they cry from hunger, then they get too weak to cry and sleep a lot. Some neophyte parents mistakenly regard this as the behavior of a good baby, not a starving baby.

Green said that HIAA has no policy on follow-up care. Educating prospective mothers about newborn care and breast-feeding before delivery might solve some problems, she said.

Ob-gyn Michael B. Grossman, vice president of Kennedy Hospitals in Cherry Hill, N.J., is skeptical. "It's one thing to practice on a mannequin in a class," he said. "It's quite another to do it with your own real, live baby."

Doctors Fear Challenging the System

Insurance industry officials say discharge guidelines are merely that: parameters from which doctors can deviate based on their clinical judgment.

Some doctors, however, say adherence to such guidelines

Holly H. Roberts, an obstetrician-gynecologist in Red Bank, N.J., recently told a New Jersey Senate hearing that she was threatened with termination by a large HMO if she didn't reduce her patients' average length of stay from 48 to 24 hours after a normal delivery. "They told me the only thing keeping me in the system was that I didn't do that many C-sections," said Roberts, who added that the HMO, which she declined to name, provides more than half of her patients.

"If I had a patient with a 24-hour labor who had been torn from vagina to rectum, who was exhausted and in pain and catheterized and they wanted her out of the hospital just because she could be wheeled to the car, I would try to help her by keeping her an extra night," Roberts said.

Roberts said she concluded, "It was either me or the patient. If I was nice to them I would lose my practice."

Length of stays must be legislated, she said. "It can't come from us. We're indentured servants" to managed care.

To compensate for early discharges, some pediatricians are moving up the time of the first checkup from two weeks to three days after birth to spot potential medical problems that could become serious. The American Academy of Pediatrics recommends that babies sent home within 24 hours receive a medical checkup within 48 hours of discharge.

Mahiri MacDonald said she has received calls from Washington area pediatricians asking if they should see babies before the standard two-week visit. "I tell them, yes, by all means, if they want to avoid a fat-malpractice suit."

But MacDonald said she's been told that some pediatricians are encountering another problem: Some managed care companies are refusing to pay for an early check-up.

One Family's Tragedy

Micheline Bauman was discharged from Kennedy Memorial Hospital in Washington Township, N.J. shortly after 4:30 p.m. on May 17, about 28 hours after her uneventful birth.

She seemed fine, her mother said, until 11:30 p.m., when she began making a moaning sound and refused to drink her bottle. "We thought she didn't know how to cry," her mother recalled.

Bauman and her husband, Steve, first-time parents, and Michelle's mother spent a sleepless night walking the floor, trying to soothe and feed the baby, who refused to eat or sleep. At 6 a.m., Steve Bauman made the first of what his wife said were four calls that day to the pediatrician's office. Michelle Bauman said the doctor told him that the baby probably wasn't eating because she had gas and wasn't sleeping because she had her days and nights confused. Two hours later, Steve Bauman called the pediatrician again to report that Micheline looked yellow and that her eyes were cloudy. The pediatrician said that the baby had a slight case of jaundice and not to worry.

At 3 p.m., after the baby had neither slept nor eaten in more than 15 hours, Steve Bauman called the pediatrician again to report that she had purple pinpricks on her hands. A nurse said that the problem was probably a newborn rash. At 5 p.m., Michelle Bauman said she put her daughter in an infant swing. Fifteen minutes later she noticed that the baby's lips were purple and that Micheline was not breathing. The Baumans called 911.

The baby was pronounced dead on arrival at Kennedy hospital. An autopsy revealed that the cause of death was septicemia, blood poisoning caused by a streptococcus B infection the baby contracted from her mother before or during delivery. The infection, which is not harmful to the mother, is treatable with antibiotics if detected in time.

"This was a healthy mother who delivered a healthy baby," said emergency medicine specialist James McCabe, who saw the baby when she was brought back to the hospital. "Kids at

Michael B. Grossman, Kennedy Hospital's chief of medical affairs, said Michelle Bauman was not tested for streptococcus B before delivery because she did not meet the medical criteria for such a test. An internal review by the hospital of the events surrounding the baby's discharge and the pediatrician's actions revealed no wrongdoing, he said. The pediatrician, whom he and the family declined to identify, is a member of the hospital staff and is "devastated," Grossman said.

Michelle Bauman said she and her husband are convinced that an extra day in the hospital might have saved their daughter's life. "I think they would have caught whatever she had and treated her," she said. "They can't expect you to take a baby home and diagnose it. The pediatrician said we had nothing to worry about."

It is impossible, Grossman said, to say for sure whether an additional 24 hours in the hospital would have saved the baby's life; streptococcus B infections in newborns have a high mortality rate, he noted. "Would the death have been prevented if this baby had been in the hospital? Maybe. Would the baby's illness have been caught somewhat earlier had she been in the hospital? Probably." ■

feed my daughter, and also gave me a chance to recover from the emotional and physical toll of a Caesarean section.

Nowadays, experiences like mine, ^{although we also} are almost unheard of. As insurance companies look for new ways to cut costs, new mothers routinely are rushed out of the hospital 24 hours after an uncomplicated birth and three days after a caesarean.

For many women, that just isn't enough time to emerge from exhaustion, let alone learn how to breastfeed properly, adjust to a new sleeping schedule or other changes that arrive with a new baby.

I have one friend who was pregnant with twins and began hemorrhaging during labor. She had to undergo an emergency caesarean under full anesthesia. After the delivery, she was severely anemic and was placed in intensive care.

Even so, her insurance company insisted that she leave the hospital after three days. In the end, she was allowed to stay longer, but only because her doctor spent hours on the phone arguing with insurers that it was medically unsafe to send her home.

checklist
Most doctors fear punished bc not adding to certain rules - "industrial standards"

Insurance companies say that shorter stays not only save money, but limit a baby's exposure to hospital germs. There is

Some critics are now complaining that efforts to safeguard the health of new mothers and infants is simply another example of heavy-handed government intrusion into the health care system.

In fact, this is hardly a case of intrusion, but a clear case of where government regulation *is* needed. No government employee is going to tell a patient when to leave the hospital. But the government can ensure that doctors and nurses, not insurance agents, decide what is medically best for newborns and their mothers.

little health risk to most new mothers and babies who are discharged in the first 24 hours, they say, because most patients are provided with follow-up visits by a nurse in the home.

But what happens if the baby develops an infection or other complication like jaundice that only becomes apparent on the second or third day after birth? What if the new mother has difficulty learning to breastfeed properly, which could result in dehydration and other problems for her baby?

The reality is that many insurance companies only allow one home visit per patient; others simply provide for a phone consultation with a nurse in the days after childbirth. And cases have been reported in which the nurse or home visitor simply didn't have time to show up / or wasn't even aware / the child had been born out.

A retired transit worker in New Jersey, Dominick A. Ruggiero, Jr, told this story to the New Jersey legislature earlier this year:

His niece had an uneventful pregnancy and childbirth and was discharged after 23 hours. At home, however, her baby, Michelina, suddenly took a turn for the worse. A nurse provided by the family's health maintenance organization was supposed to visit the home on the second day, but she never came.

← (Kavanaugh)
epitomizes

← Some say govt has no big regulati in this area -
- about interven, so that docs + nurses make final decisions

The baby died from a treatable infection at two days old.

Thanks in part to Mr. Ruggiero's testimony, New Jersey now has a law that allows women to stay in the hospital a minimum of 48 hours after uncomplicated deliveries and 96 hours following caesarean deliveries. Maryland passed similar legislation last spring, and Congress and others states are expected to follow soon.

These new laws will begin to bring the United States in line with many other countries -- including Australia, Germany, Japan, Ireland, and France -- where new mothers typically stay in the hospital for five days to two weeks.

Nobody is suggesting that new rules can avert every tragedy or horror story involving new mothers and infants. Clearly, patients have to become more knowledgeable and demanding about the care they receive. And no matter how much help is available, many aspects of parenting are only learned through trial and error.

It's just that in the dizzying aftermath of childbirth, a time of joy, excitement, mystery, and uncertainty for most new parents, the health of new babies and their mothers should not be unnecessarily jeopardized.

I don't know about you, but I don't want the decision about whether I am ready to leave the hospital left to accountants and bookkeepers in insurance offices thousands of miles away.

I'd rather take the advice of doctors and nurses at my bedside who are actively involved in my care.

###

draft #1

FIRST LADY HILLARY RODHAM CLINTON
COLUMN # 11 -- SEPTEMBER 31, 1995
TALKING IT OVER/CREATORS SYNDICATE

Before my daughter was born, I did everything I could think of to prepare for the arrival of a new baby.

I asked my doctor hundreds of questions. I read every book I could get my hands on. I made ^{and I went} my husband ~~quiz me about the~~ ^{together to} ~~lessons we had learned in childbirth class~~ ^{es.}

Even so, I was in for some surprises.

like a book [A few days after Chelsea's birth, while she was breastfeeding, I noticed bubbles in her nose. Fearing the worst, I called for a nurse. The problem, it turned out, wasn't serious at all. The nurse just told me I was holding Chelsea at an awkward angle, making it difficult for her to swallow.

Although neither Chelsea nor I had any complications during the [xx] days we spent in the hospital, we both benefited greatly from the attention and teaching the nurses provided. Not only did I learn to hold my baby properly, as well as bathe and feed her,

I had a chance to recover from the physical and emotional toll of childbirth.

Unfortunately, that kind of experience is fast becoming a thing of the past.

Today, new mothers are routinely rushed out of the hospital 24 hours after an uncomplicated birth and three days after a caesarean. For many women, that just isn't enough time to emerge from exhaustion, let alone learn how to breastfeed properly, adjust to a new sleeping schedule or other changes that arrive with a new baby.

No wonder this new practice is referred to as "drive through delivery."

Insurance companies, eager to save money by forcing hospitals to discharge mothers and new borns as quickly as possible, argue that shorter stays are better for babies because they are not ~~to~~ exposed to germs in the hospital. They also say that home visits from nurses are available to most new mothers who are discharged right away.

But many doctors and nurses say that sending mothers and babies home so soon is not only callous, but dangerous. I agree.

Across the country, seemingly healthy babies are leaving the hospital a day after birth, only to show up a few days later suffering from jaundice or dehydration.

Jaundice can cause permanent brain damage or death if it is not treated. According to the American Academy of Pediatrics, more than half of the 4 million babies born in the United States each year become clinically jaundiced. Dehydration, caused by inadequate breast feeding, can lead to seizures and other serious problems.

This year the American College of Obstetrics and Gynecology and the American Academy of Pediatrics recommended that decisions about discharging mothers and infants take into account their medical stability, as well as whether a mother has learned to feed her baby adequately and has access to nursing help once she is home.

While early discharges are not dangerous for many new mothers -- and some women even prefer them -- there are tragic cases in which death or permanent damage could have been avoided if the mother and her baby had not been sent home so soon.

A retired transit worker in New Jersey, Dominick A. Ruggiero, Jr, told this story to the state legislature earlier this year:

His niece had an uneventful pregnancy and childbirth and was discharged the next day. At home, however, her baby, Michelina, suddenly took a turn for the worse and died in her cradle [from complications that could have been treated had she been in the hospital?].

Thanks in part to Mr. Ruggiero's testimony, New Jersey now has a law that allows women to stay in the hospital a minimum of 48 hours after uncomplicated deliveries and 96 hours following caesarean deliveries. Maryland passed similar legislation last spring. Congress and several other states are expected to follow soon.

Nobody is suggesting that these laws will avert every tragedy or horror story involving new mothers and infants. Clearly, patients have to become more knowledgeable and demanding about the care they receive. And, no matter how much help is available, many aspects of parenting are only learned through trial and error.

It's just that in the dizzying aftermath of childbirth, a time of joy, excitement, mystery, and uncertainty for most new parents, the health of new babies and their mothers should not be unnecessarily jeopardized.

Judgements about how long a woman and her infant need to be

in the hospital should not be left to bureaucrats at insurance companies, but to the doctors and nurses who are involved in their care.

###



draft #2

FIRST LADY HILLARY RODHAM CLINTON
COLUMN # 11 -- SEPTEMBER 31, 1995
TALKING IT OVER/CREATORS SYNDICATE

Before my daughter was born, I did everything I could think of to prepare for the arrival of a new baby.

I asked my doctor hundreds of questions. I read every book I could get my hands on. And my husband and I went together to childbirth classes.

Even so, I was in for some surprises.

I remember lying in bed a few days after Chelsea's birth, when I was still learning how to breastfeed. Suddenly I noticed foam in her nose. I ^{Flair Noel} ~~thought~~ she was convulsing ^{and} ~~and~~ pushed every call button within reach.

When the nurse arrived, she assured me that I was simply holding the baby at an awkward angle, making it difficult for her to swallow the milk she took in.

That wasn't the only time ^a nurse^s came to my rescue during the four days I was in the hospital. I ^{she helped me} learned how to bathe and

feed my daughter, and ^{she} I also had a chance to recover from the emotional and physical toll of a Caesarean ^{delivery} section.

^{however, my experience is needed as a lawyer, not as a doctor}
Today, we don't seem to care as much about taking care of the needs of new mothers and babies.

New mothers are routinely rushed out of the hospital 24 hours after an uncomplicated birth and three days after a caesarean. For many women, that just isn't enough time to emerge from exhaustion, let alone learn how to breastfeed properly, adjust to a new sleeping schedule or other changes that arrive with a new baby.

I have one friend who was pregnant with twins and began hemorrhaging ^{badly} during labor. She had to undergo an emergency Caesarean under full anesthesia. After the delivery, she was severely anemic and was placed in the intensive care unit.

Even so, her insurance company insisted that she ~~should be ready to~~ leave the hospital after three days. In the end, she was allowed to stay longer, but only because her doctor spent hours on the phone arguing with insurers that it was medically unsafe to send her home.

Insurance companies are forcing hospitals to discharge new mothers and infants as quickly as possible because they say the

practice saves money and shorter stays limit a baby's exposure to hospital germs.

In addition, insurers argue that early discharges pose little risk to new mothers or babies because follow-up home visits from nurses are usually provided.

But what happens if the baby develops an infection or other complication that only becomes apparent on the second or third day after birth? What happens if the new mother has difficulty learning to breastfeed properly, which could result in dehydration and other problems in her baby in the aftermath of birth?

Jaundice, for example, occurs in more than half of the 4 million babies born each year in the United States. Often it is not serious enough to require treatment. But in its most serious form, jaundice can cause permanent brain damage or death if it is not treated.

In theory, a serious case of jaundice would be detected by a nurse during a home visit following an early discharge. But the reality is that many insurance companies only allow one home visit per patient; others simply provide for a phone consultation with a nurse in the days after childbirth. And cases have been reported in which the nurse or home visitor simply didn't have

time to show up.

A retired transit worker in New Jersey, Dominick A. Ruggiero, Jr, told this story to the New Jersey legislature earlier this year:

His niece had an uneventful pregnancy and childbirth and was discharged the next day. At home, however, her baby, Michelina, suddenly took a turn for the worse. A nurse provided by the family's health maintenance organization was supposed to make a follow-up visit ~~the next day~~, but she ^{didn't come to a} ~~never came~~ nor called the home. _{hus car.}

The baby died from a treatable infection when she was two days old.

Thanks in part to Mr. Ruggiero's testimony, New Jersey now has a law that allows women to stay in the hospital a minimum of 48 hours after uncomplicated deliveries and 96 hours following caesarean deliveries. Maryland passed similar legislation last spring. Congress and several others states are expected to follow soon.

Nobody is suggesting that these laws will avert every tragedy or horror story involving new mothers and infants. Clearly, patients have to become more knowledgeable and demanding

about the care they receive. And, no matter how much help is available, many aspects of parenting are only learned through trial and error.

It's just that in the dizzying aftermath of childbirth, a time of joy, excitement, mystery, and uncertainty for most new parents, the health of new babies and their mothers should not be unnecessarily jeopardized.

~~After~~ ^{Decide} Judgements ^{how} about how long a woman and her infant ^{should} ~~need~~ to be in the hospital should not be left to accountants and bookkeepers, but to the doctors and nurses who are involved in their care.

###

Column

(Book)

Newborns don't usually stabilize until 48 hrs.
less extended family around now

All Western European countries have
either home health visitors or
maternal + child health clinics

England - - after mom/baby → home
qualified nurse-midwife
from local hosp visits each
day for at least 10 days -

"~~family~~ fully qualified
nurse is also available for

Phone consult or home
visits until kid is 5

anecdote of friend - living in England
decided knew enough - ^{her} mom couldn't
come; all alone - when

nurse showed up, she questioned her

I was hardly able to get around for first 3
days after my c/sarean

Came home 4 1/2 days after delivery -
had to turn around & go back bc of fever / infection
while mom was home, I had help at
home + all the other from a husband
+ doctor anyone could want.

Touchpoints Dr. Brazelton talks abt
Japanese islands of the Goto Archipelago a
new mother stays in bed for a
month after delivery wrapped in a quilt
w/ her baby. Her only job is to
feed her newborn, while her female
relatives attend to her.

A month might be a little long to
be wrapped in a quilt - but this rite
of passage is admirable
in its celebration of new
parent's most important task -
helping child develop a "secure
attachment".

For financial

don't have in place support system -

managed care & don't have networks in place

- Decision should be made by bookkeepers
& acct

When I found out that I was pregnant with Chelsea, I read all the books and asked hundreds of questions to my very patient obstetrician. I had a husband ready to share the challenge that a new baby brings. And we both had supportive families who were eager to help. I was lucky.

That's why I was taken completely by surprise when [story about breast feeding Chelsea and bubbles appear].....

That nurse came to my rescue more than a few times during my first days with Chelsea. Like all new mothers, in the hospital I learned to support her head, change her diaper and bath her. I also slept a little and began to recover from the physical and emotional experience of childbirth.

I was fortunate enough to stay in the hospital [....] days. Today, many women are being rushed out of the hospital too quickly. Insurance companies, in an effort to save money, are refusing to cover hospital stays beyond 24 or even 12 hours.

Insurers claim that this practice is better for the babies because they are not exposed to germs in the hospital. The doctors don't agree. The American College of Obstetrics and Gynecology and the American Academy of Pediatrics recommend that women stay in the hospital up to 48 hours after uncomplicated vaginal delivery and up to 96 hours following uncomplicated cesarean delivery.

Doctors and patients, not insurance companies, should decide when a woman and her baby are ready to leave the hospital after childbirth.

Several states have passed legislation requiring insurers to allow women to stay in the hospital for a minimum amount of time after delivery. New Jersey's law, signed by Governor Whitman in June, requires 48 or 96 hours, depending on the type of delivery. A Maryland law simply states that postpartum hospital stays should conform to the guidelines published by ACOG and the American Academy of Pediatrics. A number of other states are considering similar legislation.

Federal legislation has been introduced by Democratic Senator Bill Bradley and Republican Senator Kassebaum. Congress should work quickly to pass legislation protecting mothers and their babies across the country from the so-called "OB express."

A historical look at alcohol and pregnancy

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

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

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

Continued on page 2

States join effort to oppose insurer-mandated early postpartum discharge

The issue of third-party payers dictating inappropriate short lengths of hospital stays following labor and delivery has been a growing concern among physicians and patients. In an effort to curb this practice, legislation was recently passed in two states, New Jersey and Maryland.

Legislators in other states, among them New York and California, are considering similar laws. Many view this legislation as an effective effort to reduce insurer intrusion into accepted medical practice. At the same time, however, others feel that legislation should remain a remedy of last resort for these types of concerns, lest laws interfere too far into medical practice and patient care.

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

Current state legislation

New Jersey's role to this troubling trend is the form

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

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

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

Continued on page 8

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

Inside:

ACOG preparations for
UN conferences—page 2

IOM Report on unintended pregnancy
—page 4

HCFA survey alert
—page 4

Additional ACM Awards—page 8

State legislation aimed at insurers mandating shorter hospital stays

Continued from page 1

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

ACOG's efforts

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

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

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

ACOG's concerns revolve around the effects such mandated early discharges might have on the detection of ma-

ternal and newborn complications. In addition, many mothers who go home early are deprived of instruction in basic infant care and breast feeding.

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

At its annual meeting last June, the American Medical As-

sociation concurred with ACOG, releasing a statement that said in part, "Discharge of mothers and infants should be determined by the clinical judgement of attending physicians, and not by economic considerations."

For now, legislation appears to be the only way to force insurers to recognize the needs of patients and the clear consensus of physicians on the issue of postpartum hospital stays. Nevertheless, Dr. Menuti and others hope that such laws will not always be re-

quired. "While the New Jersey and Maryland laws are good pieces of legislation, I find it unfortunate that this change could be brought about in this manner," he says. Among his concerns is that a state might unintentionally misinterpret the guidelines and suggest that women must be made to stay for 48 hours, in his words, "essentially incarcerating them." 

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

Additional ACM Awards

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

SYNTEX "ISSUE OF THE YEAR" AWARD

For a thoroughly researched and referenced background paper on a specific issue in gynaecology

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

COMMITTEE ON SCIENTIFIC
PROGRAM AWARDS

For the highest car, car scientific
paper presentations

First Prize: "Pregnancy Outcomes Following False Positive Marker Screening Tests"

Shelley J. Chapman, MD; Cynthia G. Brumfield, MD; Katherine Wenstrom, MD; Mary B. DuBard, MA
The University of Alabama at Birmingham

Second Prize: "Immunohistochemical Characterization of Oncoprotein (P35, HER2/NEU) Expression and Proliferative Activity (PCNA) in Uterine Papillary Serous Carcinoma"

Susanna M. Waish, MD; Michael Jones, MD; Hector Tarraza, MD
Maine Medical Center, Portland

Third Prize: "Salpingo-Oophorectomy Following Previous Hysterectomy: Clinical, Surgical and Pathologic Findings"

Clinical, Surgical and Pathologic Findings
John C. Jennings, MD; Jay Moodley, MD; Robert Chin, MS
University of Texas Medical Branch, Galveston

ACOG ANNUAL AUDIOVISUAL
AWARDS

AWARDS
For the best of color films

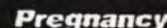
ACOG-Davis and Geek Film Festival Award
"Management of Multiple Gestation"
Frank A. Chervenak, MD, New York, NY

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

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

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STEEL
REINFORCEMENT
PRODUCTION
AND DISTRIBUTION
AND PLANT CARE



ACOG
Patient
Education



45

49

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

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

Finally...

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



Glossary

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

Arcola: The darker skin around the nipple.

Birth Control (Contraception): Method to prevent pregnancy.

Cervix: The lower, narrow end of the uterus.

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

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

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

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

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

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

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

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

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

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

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

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

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

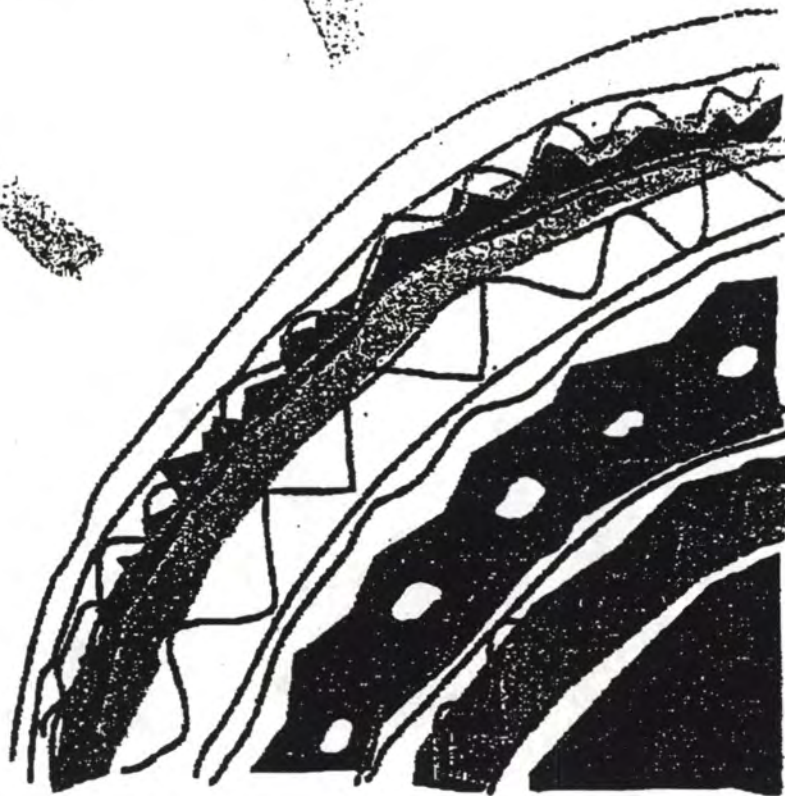
Uterus: A muscular organ that is located in the female abdomen and contains and nourishes the developing embryo and fetus during pregnancy.

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



Bright Futures

Guidelines for Health Supervision
of Infants, Children, and Adolescents



Chapter 2.

CARING FOR YOUR BABY

YOUR NEW BABY

Getting to know your new baby. Talking to, touching, feeling, and handling your new baby from the start—even right in the delivery room—is good for you and your baby.

Ask to have your newborn placed beside you in bed. Look your baby over from head to foot—with your partner, if he is with you. Caress and pick up your baby. Ask your doctor or nurse to show you how. Get to know how your baby feels. If you plan to breastfeed, this is a wonderful time to start.

Later, undress and dress your baby. change diapers, give him or her a bath. Babies are really very sturdy. They can take a lot of handling and usually enjoy it. However, you should take care to support your baby's head. If both you and the baby are comfortable, you are doing all right. You will know something is wrong if your baby continues to cry or struggle.

If you or your partner have questions about how to pick up, hold, bathe, dress or undress your baby, ask the hospital staff to show you how. Then do it yourself until you are comfortable. Also, let the staff show you how to take the baby's temperature by rectum, and how to perform other simple tasks such as clipping finger and toe nails.

Get to know the feel and the fun of handling and playing with your baby and breastfeeding while you are in the hospital. Insist on being with your baby as soon as possible and for as long as possible. Your partner should also be there as much as possible. Use this time to learn all you can about your new baby—it will make caring for him or her much easier when you get home.

Newborn tests. Right after your baby is born he or she will be checked for healthiness.

Your doctor or other staff will give your baby a complete physical exam, including checking your baby's

- appearance or color
- heart rate
- reflexes
- activity
- breathing

These factors will help determine whether your baby needs any type of special attention.



Chapter 2. CARING FOR YOUR BABY

Take care of yourself
Involve your family
Love your baby

Take care of yourself. Your own health as a mother is vital to your baby's health and comfort. Giving birth to a baby is exhausting. Don't be surprised if you don't feel like yourself for several weeks. Your body will take some time to adjust; you have experienced many physical changes. If you are having any problems, be sure to call your doctor.

Also, some women may feel "blue"—irritable, restless, overwhelmed, teary-eyed or helpless. These feelings may change back and forth between "the blues" and feelings of happiness and energy. Talking with your partner, another family member, another mother, or doctor may help. Be sure to ask your doctor or clinic any questions you may have about your own health or just about taking care of yourself.

Involve your family. Although you will be tired when you get home from the hospital, you will probably have enough strength and energy and time to care for your baby and yourself. But housework, the care of other children, and meal preparation for the whole family are extra tasks that must be taken care of. During the first few days at home, try to get someone else in your family to help with these other responsibilities.

Your partner should be able to take a role in helping, but he will be going through a period of adjustment, too. New responsibilities are stressful for both of you; sharing of feelings between you is very important at this time, when the new baby is often the center of everyone's attention.

If you have other children, you will want some help with your newborn so that you can spend some time with them. Introduce them to the baby. With your help, let them touch and play with their new brother or sister.

You may want to postpone visitors for several weeks in order to reserve your energy for your family.

Love your baby. These first weeks are when new parents and older brothers and sisters should spend time together and with the new baby, getting used to the youngest member of the family. Let everyone get to know the baby by holding, touching, talking, singing or just watching him or her. Brothers and

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YOUR NEW BABY

Brothers and sisters

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sisters should be encouraged to enjoy or help care for baby with adult supervision. New fathers need to spend as much time as possible enjoying and getting comfortable with baby, just like new mothers.

Brothers and sisters. You should introduce your new baby to his or her brothers and sisters as soon as possible. Let them touch (or hold, if they are old enough) your baby with careful supervision. It may take them some time to get used to having a baby brother or sister. You'll need to be patient with them during this period of change and adjustment. It sometimes helps young children to be told that when they were babies, you took care of them just the way you are now caring for the new baby.



Chapter 2. CARING FOR YOUR BABY

Brother and sisters

It is normal for older children to be jealous of the time that parents spend with a new baby. They may wonder whether you still love them. Try to find some time to give each of them special attention. Don't be surprised if a child between 2 and 5 years old starts thumb sucking, crying more, wetting pants, or asking for bottles or diapers in imitation of your new baby. He or she is trying to get a share of your attention. Both parents should give older children as much attention as possible, but should discourage a return to baby-like habits.

Young children should never be left alone with the baby. They are too young to understand the baby, and may be interested, curious, or jealous. They may pick up and drop, squeeze too hard, sit on, or put dangerous things in the infant's mouth or crib. They may hurt the infant with tools, utensils or furniture. This is not because they are "bad," but because they may not understand what they are doing. Give them the individual attention they need, let them help you and the baby in whatever way they can when you are with the baby, and never leave them alone with the baby.



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After my baby is born ...

TAKING CARE OF BABY ...

- Talking to, touching, and holding your new baby in the delivery room is good for you and your baby.
- This is a wonderful time to start breastfeeding. Tell your care giver not to let anyone else feed your baby so that your baby will only get your breast milk.
- Your health care giver will examine your baby right after birth, checking appearance and color, reflexes, breathing, heart rate, and activity to see whether your baby needs any special care.
- Ask to have your newborn placed beside you in bed. Touch and hold your baby, and get to know how your baby feels.
- Your baby may look different from the way you expected. Ask the hospital staff if you have questions about the way your baby looks.
- Ask the staff to show you how to take your baby's temperature and read the thermometer.
- All infants should be protected against hepatitis B. Some doctors recommend the first shot be given before going home from the hospital.
- You should take your baby to see the doctor when your baby is about 1 week old unless you are told to come in sooner. Call your baby's doctor right after your baby is born for an appointment.
- Before you and your baby leave the hospital, a few drops of blood will be taken from your baby's heel to check for some rare problems.
- You will need a car safety seat (marked "federally approved") to bring your baby home. It is the law—your baby must always be in an approved safety seat when traveling in a car, van, or truck. Ask your health care giver, the hospital where you deliver, or health department about programs that loan federally approved car safety seats.

If you or the baby's father have any questions about how to pick up, hold, feed, bathe, diaper, or dress your baby, ask the hospital staff to help you.

Your new baby needs all of the love and comfort you can give. You cannot love a baby too much. Your entire family can share in the joy of this love.

Next appointment for my baby: _____

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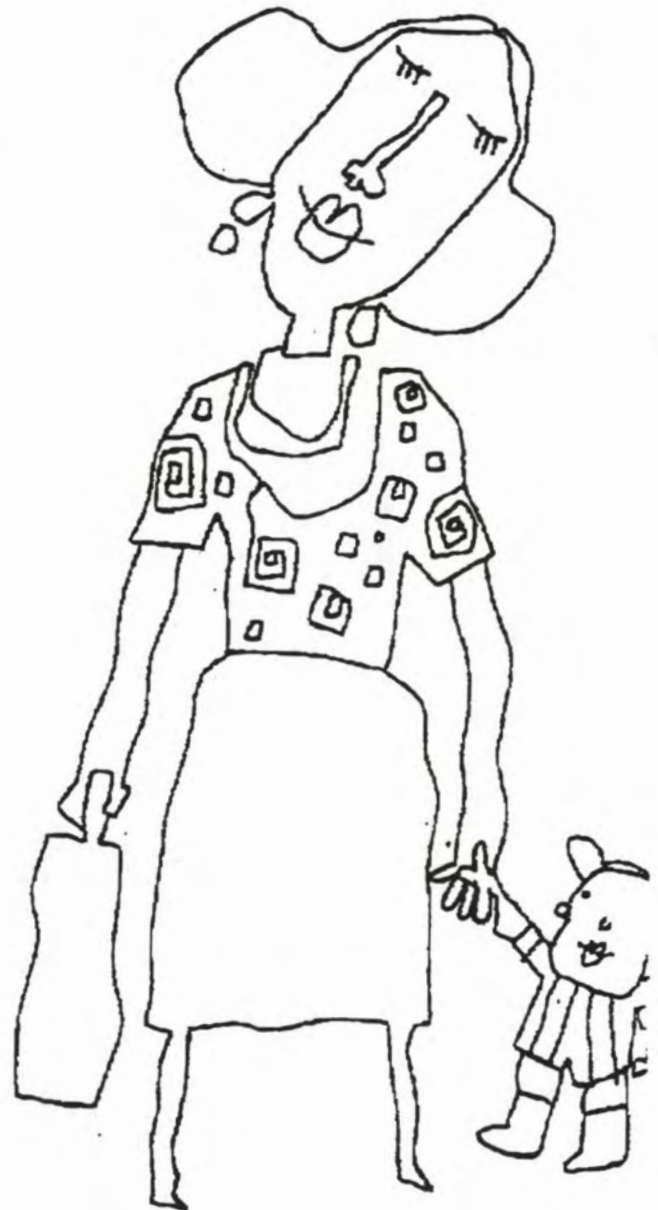
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Volume 11 Number 8

THE OFFICIAL NEWSPAPER OF THE AMERICAN ACADEMY OF PEDIATRICS

August 1995

Current insurance policies might place newborns at risk

Minimum 48-hour postpartum coverage urged

by GERRY CLARK
Assistant Editor

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

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

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

Legislators also are interested in ensur-

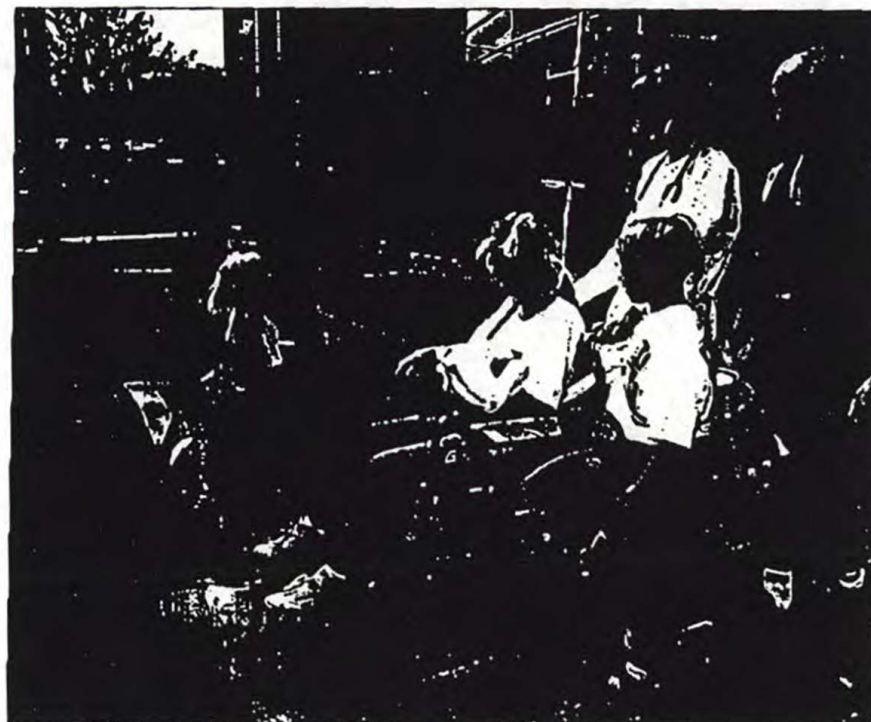
ing longer stays. Two states recently passed legislation requiring insurers to cover specific durations of postpartum hospital stays and other states are considering similar measures. Senators and representatives alike have recently introduced federal postpartum-stay legislation.

Current policy

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

The earliest the proposed AAP policy

See *Hospital stays*, p. 8



Don Bailey

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

Hospital Stays

Continued from p. 1

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

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

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

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

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

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

Legislation

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

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

Bills related to postpartum hospital stays have been introduced into the

coverage for a minimum of 48 hours of inpatient care after vaginal delivery and a minimum of 96 hours of inpatient care after cesarean delivery for a mother and newborn.

A proposed amendment to the Employee Retirement Income Security Act of 1974 (P.L. 93-406) was introduced into the House in late June by Representative Peter DeFazio (D-Ore.) and several co-sponsors. It calls for the same coverage as Bradley's bill. Exceptions may occur if certain post-delivery care is provided, such as follow-up visits at home or in a physician's office.

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

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

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

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

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

Penalties would not be imposed on

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

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



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

At the federal level, Sen. Bill Bradley (D-N.J.) introduced legislation in late June titled "New Borns and Mothers' Health Protection Act of 1995." Co-sponsored by Sens. Nancy Kassebaum (R-Kan.) and Jay Rockefeller (D-W. Va.),

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

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

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

Physicians should decide

While AMA officials and Dr. Oh applaud Bradley's intent, they say physi-

cians of making medical decisions.

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

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

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

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

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

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

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

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

No magic number

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

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

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

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

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

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

Medical experts say that such considerations as jaundice or congenital heart

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

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

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

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

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

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

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

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

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

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

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

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



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

EXECUTIVE SUMMARY

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

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

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

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

1. The AMA is concerned about the trend toward increasingly brief perinatal hospital stays as a routine practice in the absence of adequate data to demonstrate the practice is safe.
2. In the absence of definitive empirical data, perinatal discharge of mothers and infants should be determined by the clinical judgement of attending physicians and not by economic considerations. This decision should be made based on the criteria of medical stability, delivery of adequate predischARGE education, need for neonatal screening, and determination that adequate feeding is occurring. A plan should be in place for psychosocial and medical follow-up, as outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.
3. The AMA urges all state neonatal screening programs to institute procedures that provide for timely follow-up screening for infants whose initial samples are obtained in the first 24 hours of life.
4. Well designed experimental studies are needed to identify safe neonatal practices with regard to the hospital discharge of mothers and infants.
5. The AMA supports the collaborative efforts of the Maternal and Child Health Bureau and other concerned national organizations to examine more thoroughly the issue of appropriate medical care during the perinatal period.

REPORT OF THE COUNCIL ON SCIENTIFIC AFFAIRS

CSA Report 5 - A-95

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

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

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

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

11

12 Background

13

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

23

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

32

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

CISA Rep 5 - A-95 -- page 2

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

3
4 Empirical studies have varied in their definition of early discharge. Most research examines
5 the impact of discharge within 48 hours of vaginal delivery. Most expressions of concern
6 have targeted discharges occurring in substantially less than 24 hours. Consequently, the
7 available literature is limited and often does not focus on the populations of specific concern.
8 Further complicating the analysis is the fact that most studies have had rigorous inclusion and
9 exclusion criteria and have been conducted on mothers requesting early discharge. There is
10 therefore only limited ability to evaluate scientifically the effects of shortening postpartum
11 stays.

12
13 When evaluating the clinical effects of shorter stays, the following considerations are
14 appropriate:

- 15
16
 - health effects on and complication rates in the infant
 - 17 • health effects (both physical and psychological) on the mother
 - 18 • extent of opportunity for maternal and infant-care education
 - 19 • physical and psychological effects on other family members
 - 20 • extent of opportunity for maternal and child psychosocial assessment.

21
22 Available Research

23
24 Studies examining the issue of early discharge have tended to examine model programs that
25 included a pre-screening process to identify low-risk mothers and infants, some degree of
26 prenatal instruction or education, and some degree of follow-up care. The exact nature of
27 these interventions, however, varied from program to program. Follow-up care, for instance,
28 ranged from one home visit and a phone call to three home visits in the first three days home,
29 and telephone consultation available 24 hours a day for two weeks.²

30
31 Methods of participant selection also varied from program to program. In almost all cases,
32 however, the women chose whether they wanted early discharge or traditional hospital stay
33 and the option was only available to a selected population. One study did use a randomized
34 method of participant selection, but the authors acknowledge that "sample sizes were too small
35 to detect significant differences in the outcomes."³

36
37 There are several factors that make interpretation of the available research tentative at best:

- 38
39
 - discrepant definitions of "early discharge"
 - 40
 - 41 • exclusion of women and infants likely to have birth-related complications
 - 42
 - 43 • absence of random assignment
 - 44
 - 45 • no or flawed control groups
 - 46
 - 47 • provision of compensatory services in early discharge groups that may mask or
 - 48 alter the effects of more rapid discharge.

CSA Rep 5 - A-95 -- page 3

1 Type I vs. Type II Error

2

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

8

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

14

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

18

19 What is a Good Outcome?

20

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

29

30 Health of the Infant

31

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

35

36 Clearly, early discharge minimizes the risk of nosocomial infection (for both infant and
37 mother).³ However, it may not provide adequate time for routine medical and social
38 assessment of the dyad.⁶ Most researchers have concluded that early discharge (discharge
39 within 48 hours of delivery) is generally safe for low-risk infants, based on a lack of
40 "significant differences in the levels or types of mortality or readmissions for the early
41 discharge and control groups."²

42

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

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1 results.¹

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

14
15 There are many anecdotal reports about other serious problems such as failure to thrive,
16 missed diagnoses of metabolic disorders such as phenylketonuria, and serious bleeding from
17 circumcision wounds, but these have not as yet been documented empirically.

18 19 Perinatal Screening

20
21 Mandated neonatal screening varies from state to state, but all screening programs are designed
22 to prevent morbidity and mortality through early diagnosis of medical problems and congenital
23 disorders that can have serious sequelae. Adequate screening programs require universal
24 participation, prompt diagnosis, and mechanisms for parental notification and education.
25 Common screening tests include those for persistent hyperphenylalaninemia, including
26 phenylketonuria, galactosemia, maple syrup urine disease, congenital adrenal hyperplasia, and
27 congenital hypothyroidism. Some states also mandate screening for sickle cell disease and
28 various sexually transmissible infections.

29
30 Historically, these screening samples have been taken on the second or third day after delivery.
31 This time period was established to optimize the sensitivity of the tests. PKU screening, for
32 example, has a false negative rate that is quite high (about 33%) during the first 12 hours of
33 life and drops to less than 1% after 48 hours. In contrast, early screening for congenital
34 hypothyroidism, especially using thyrotropin (TSH) as the primary screen, may have a high
35 false positive rate because of the normal TSH surge that accompanies parturition. Some
36 experts argue that screening samples taken in the first 24 hours of life serve merely to notify
37 the system of the existence of the infant. Follow-up screening for PKU or congenital
38 hypothyroidism, for example, must then be completed in a timely fashion, no later than two
39 weeks after birth.¹ Loss of infants to follow-up screening is a serious concern, but data
40 regarding the rates of missed rescreening are not yet available.

41 42 Health of the Mother

43
44 Methodological flaws also plague the few studies examining the impact of early discharge on
45 the physical health of the mother. Research has shown that very few mothers (less than two
46 percent) require rehospitalization after discharge.^{2,7} When they do, the problems are often
47 fairly serious, including significant infection and hemorrhaging. The majority of mothers who
48 did require readmission in one review suffered from endometritis.² In that review, six of the
49 ten readmissions reported in four studies were for endometritis. (Two of the other four

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1 women were readmitted for postpartum hemorrhages, one for severe postpartum depression,
2 and one for a severely abscessed episiotomy.)² Again, however, these findings are not
3 necessarily conclusive
4

5 The MCHB report points out that these studies had "comparison groups . . . [that] were likely
6 to differ on relevant characteristics . . . [and/or] sample sizes were inadequate."⁴ The data on
7 maternal morbidity treated on an outpatient basis are even less certain. Many studies do not
8 provide specific information about complication rates; others provide no information at all.^{2,3}
9 Of the studies that did offer information about morbidity that did not require hospitalization,
10 the most common problems included mild hypertension, anemia, breast or episiotomy
11 problems, and fatigue.^{2,3,7} In a 1990 study that included a control group, the mothers
12 experienced a generally healthy postpartum course, regardless of the time of discharge.³
13

14 The impact of early discharge on the emotional health of the mother is a similarly important
15 area of concern. Emotional health includes such things as postpartum depression, mother-child
16 separation, the mother's confidence in her ability to be a good parent, stress management, and
17 the need for external support. In the randomized, controlled study that compared discharge at
18 12-24 hours, 25-48 hours, and four days, the mothers discharged 12-24 hours after giving birth
19 reported themselves to be significantly less depressed at one month postpartum than the two
20 later groups. In addition, the earliest group reported higher levels of confidence at one week
21 postpartum than the other two groups. At one month postpartum, however, the three groups
22 did not differ significantly with respect to levels of confidence. This suggests that women
23 who assume total responsibility for their baby sooner after delivery may feel more confident
24 initially than those who do not, but the direction of causality is unclear.³
25

26 Another study, which compared women who had domiciliary care after early discharge to
27 women who had hospital care until discharge, found that the difference between the emotional
28 health of mothers in both groups was not statistically significant.⁸
29

30 Although many of the studies mention other aspects of emotional health such as mother-baby
31 bonding and the mother's support system, they do not provide data. A second document
32 commissioned by MCHB reports on an October 1994 consensus meeting in Boston. There, a
33 group of experts with "intimate knowledge of both hospital and community based care for
34 mothers and newborns" found that "women who are from high risk social environments and
35 with limited social support structures may not be best served by a one-day stay." In addition,
36 "separation due to the need to observe either the mother or the newborn was deemed
37 unacceptable . . . Policies that would result in increased rates of separation were viewed by
38 the group as detrimental to mother infant bonding, infant and maternal health, and threatening
39 to breastfeeding. Clinicians recognized a distinction between 24 hours and 72 hours because
40 mother/infant bonding occurs during this early and critical time period."⁹
41

42 Education

43

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

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

4
5 Impact on Other Family Members

6
7 The impact of early discharge on the rest of the family is not as well documented as the
8 impact on the mother and the infant. The studies do cite family togetherness and the
9 involvement of the father in caring for the new baby as sources of parent satisfaction.^{12,11-13}
10 These studies, however, focus on the effect of early discharge on the mother and not on the
11 rest of the family. The existing research does not sufficiently examine the impact of early
12 discharge on other family members.

13
14 Cost-Effectiveness

15
16 The cost-effectiveness of early discharge programs is the final consideration examined in the
17 literature. The literature only investigates the cost-effectiveness for the hospital. It does not
18 address the impact on the patient's costs. Some studies conclude that reduced lengths of stay
19 and the resulting increase in the number of beds available for other patients render early
20 discharge programs cost-effective.¹⁴ Other authors claim that no one has thoroughly
21 analyzed whether early discharge programs truly provide a way to contain costs.¹² Again, the
22 existing data are sketchy and inconclusive.

23
24 Conclusions

25
26 We still do not know how much and what kind of follow-up is needed for maternal and infant
27 safety.¹² In the MCHB review, Braveman "categorized studies of early discharge according to
28 the type of compensatory service provided in the early post-discharge days . . . [b]ecause
29 conclusions from studies about early discharge in the presence of a given compensatory service
30 cannot be generalized to early discharge in the absence of that service."⁴ The reviewed studies
31 that included post-discharge services did indicate that most women were generally satisfied
32 with the care they received for both early discharge and traditional stay. At least two studies
33 (both with postpartum home visiting) report that mothers who were discharged early were
34 more satisfied than mothers who had traditional hospital stay.^{3,8} Satisfaction, however,
35 depends upon expectations, and studies show that the expectations of women who choose early
36 discharge often differ from those of women who choose a traditional hospital stay. This
37 suggests that women should be allowed to choose the maternity care which best suits their
38 individual needs.⁴

39
40 While we can therefore conclude that some women prefer to be discharged sooner than later,
41 definitive studies regarding the safety of doing so are not available at this time. The
42 limitations of the existing research are significant. Inadequate statistical power, absence of
43 random assignment, careful participant selection, and unstable definitions of "early" and "good
44 outcome" render scientific conclusions highly unreliable. One of the major limitations of the
45 studies is that most of the early discharge programs were voluntary. Norr and Nacion
46 acknowledge that "it is likely that families who choose early discharge not only have favorable
47 attitudes about coming home early, but also the resources and social support needed to make
48 the discharge go smoothly." Second, very few researchers have studied the effects of early
49 discharge on disadvantaged populations -- most participants are either middle-class or upper

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1 middle-class, healthy, well-educated, and living in a stable home environment.²³ The
2 outcomes of the studies, therefore, cannot be generalized to high-risk populations. Further,
3 there is no national consensus on what constitutes "low-risk" versus "high-risk." The October
4 1994 consensus meeting concluded that "neither the AAP/ACOG Guidelines for Perinatal Care
5 regarding eligibility for 24 hour discharge nor the specifications concerning follow-up seemed
6 adequate from the perspective of clinicians."⁹

7
8 Some physicians worry that the current trend toward reduced hospital stays will have dire
9 results. Arthur Eidelman, MD, for example, notes that "it is assumed [that] the mother will be
10 discharged into a supportive family unit where another responsible adult is present and where
11 there exists an accessible medical care system for follow-up and ongoing care." Fully aware
12 that many women do not enjoy such luxuries, Eidelman warns that allowing high-risk mothers
13 such as "an adolescent primipara, or a single mother subsisting on welfare . . . into a system
14 that does not have any backup visiting nurse program or community health clinics is simply
15 committing medical and social suicide."⁶ Eidelman's concerns reinforce the necessity of
16 limiting early discharge to low-risk mothers or providing comprehensive care that would
17 ensure a safe and healthy discharge for high-risk mothers.

18
19 The commissioned MCHB review concludes, "Although many studies have examined early
20 discharge, when standard scientific criteria are applied it becomes clear that the currently
21 available literature provides little scientific knowledge to guide discharge planning for
22 apparently well newborns and their mothers. . . . Rigorously designed studies are needed to
23 examine the impact of early discharge and a range of post-discharge practices not only on
24 newborns but on mothers and families. . . . [I]nformation from sound research is needed to
25 inform policy addressing third party reimbursement as well as clinical care standards."⁶

26
27 In December 1994, the MCHB convened a group that included the American Medical
28 Association and other concerned organizations, academicians, and experts to begin the process
29 of examining the issue of early perinatal discharge. It was agreed that there may be cause for
30 concern in the present trend toward more and more rapid postpartum discharge. Principles
31 agreed upon at that meeting include:

- 32
33 • Discussions of an acceptable vs. unacceptable number of postpartum hours are
34 unproductive and should be replaced by work to identify the essential
35 prerequisites for timely and appropriate perinatal discharge of mother and
36 infant
37
38 • Discharge policies that result in separations between mothers and infants due
39 to staggered hospital releases are undesirable
40
41 • There needs to be concentrated work on developing national standards for
42 adequate and sufficient care during the early neonatal period
43

44 Recommendations

45
46 The Council on Scientific Affairs recommends that the following statements be adopted in lieu
47 of Resolution 135 (A-94) as policy and that the remainder of this report be filed.

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- 1 1. The AMA is concerned about the trend toward increasingly brief perinatal hospital
2 stays as a routine practice in the absence of adequate data to demonstrate the practice
3 is safe.
4
- 5 2. It is the policy of the AMA that in the absence of definitive empirical data, perinatal
6 discharge of mothers and infants should be determined by the clinical judgement of
7 attending physicians and not by economic considerations. This decision should be
8 made based on the criteria of medical stability, delivery of adequate predischage
9 education, need for neonatal screening, and determination that adequate feeding is
10 occurring. A plan should be in place for psychosocial and medical follow-up, as
11 outlined in the Guidelines for Perinatal Care developed by the AAP and ACOG.
12
- 13 3. The AMA urges all state neonatal screening programs to institute procedures that
14 provide for timely follow-up screening for infants whose initial samples are obtained
15 in the first 24 hours of life.
16
- 17 4. The AMA should encourage well-designed experimental studies are needed to identify
18 safe neonatal practices with regard to the hospital discharge of mothers and infants.
19
- 20 5. The AMA supports the collaborative efforts of the Maternal and Child Health Bureau
21 and other concerned national organizations to examine more thoroughly the issue of
22 appropriate medical care during the perinatal period.

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

RECOMMENDATION A:

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

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

** Adopted change
to orig. Report*

HOD DECISION: Adopted recommendation of Reference Committee

RECOMMENDATION B:

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

HOD DECISION: Adopted recommendation of Reference Committee

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

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

Several speakers mentioned the need for immediate action and implementation of these recommendations. Your Committee did not feel that an additional recommendation requesting a report back at 1-95 on implementation status was required, since this information already is provided to delegates in a memo on the implementation of business from the previous House of Delegates meeting. In addition, the CSA proposed to monitor the implementation of these recommendations.

healthreport

by Isadore Rosenfeld, M.D.

Estrogen replacement and breast cancer

Whether or not to take supplemental estrogen after menopause is one of the most confusing decisions a woman ever faces, and the recent medical news isn't making it any easier.

In June, Harvard University researchers announced the results of a study showing that women who took estrogen supplements—with or without progestin—had a 30 to 40 percent higher than normal incidence of breast cancer. But only a month later, researchers at the Fred Hutchinson Cancer Research Center, in Seattle, produced contradictory findings. After reviewing the medical histories of 1,029 northwestern Washington women, aged 50 to 64, they found no link between breast cancer risk and supplemental hormone use. In fact, hormone replacement was associated with a small reduction in risk.

Before any woman decides not to take estrogen after menopause, she should consider some of estrogen's other effects. It cuts in half the risk of death by heart attack—which is especially impressive when you consider that a woman between the ages of 50 and 60 is six times more likely to die of a heart attack than of breast cancer. Supplemental estrogen also decreases the incidence of strokes, the

severity of Alzheimer's disease, and the risk of colon cancer. The overall death rate is 11 percent lower in women taking estrogen. Finally, there's the question of osteoporosis. Approximately 300,000 women fall and break a hip each year, and one-quarter of them never regain full mobility. Estrogen therapy is the most effective way to keep bones strong.

You may not want to take estrogen if you have a family history of breast cancer; if you yourself have had breast, uterine, or ovarian cancer; if you have had liver or gallbladder disease; or if you have a history of embolisms (traveling blood clots). On the other hand, the following risk factors make you a good candidate for estrogen replacement therapy:

- Strong family history of heart disease
- High cholesterol and a low HDL level
- Obesity
- High blood pressure
- Smoking
- Diabetes
- Family history of osteoporosis

I recommend that women who take hormones after menopause have their breasts examined each time they visit their doctors, and that they have a mammogram at least once a year.

Prozac for PMS

Almost every woman has experienced premenstrual syndrome (PMS) at one time or another. The symptoms are usually mild and tolerable, but in about 3 to 8 percent of cases (two to five million women in this country), PMS can be severe and crippling. A recent Canadian study found that Prozac is an effective treatment in such cases. In the double-blind study (neither the patient nor the doctor knew who was getting the active drug and who the placebo), a daily 20-milligram tablet reduced the severity of symptoms by at least 50 percent, while the placebo group had a less-than-25-percent response. Higher doses resulted in a greater incidence of side effects, including loss of sex drive, difficulty reaching orgasm, insomnia, fatigue, and nervousness. But most of the 313 women in the study tolerated the drug well.

Every doctor has his or her favorite solution for PMS, but it's often a hit-or-miss affair. In recent years, the most popular therapies have been the tranquilizer Xanax, Lupron (which stops menstrual cycles), relaxation techniques, and exercise. In a recent study, progesterone, another widely used PMS treatment, was found to be ineffective.

It does not surprise me that Prozac would fight PMS as well as it fights depression; there is increasing evidence that activity of the brain chemical serotonin is low both in people who are depressed and in those with severe PMS, and Prozac increases the activity of serotonin in the brain.

It's still not clear how the drug should be taken. The Canadian researchers gave it to their subjects continuously. In other research now in progress, the drug is being administered only for ten days to two weeks before the onset of each period. □

Drive-through-delivery dangers

The American Medical Association has recently drawn attention to a new trend in hospital care after childbirth. Many managed-care health plans require that new mothers be discharged within 24 hours after an "uncomplicated delivery." Women in Oregon and Utah are even getting cash payments of \$100 or more as an added incentive to go home fast. Although it is probably OK for many mothers to be

discharged after an overnight stay, complications occur often enough to cause me to worry about the safety of this policy. The mother can suffer from delayed heavy bleeding, phlebitis (an inflammation of a vein in the leg or pelvis that can lead to traveling blood clots), toxemia, wound infection, endometritis (infection of the uterine lining), fever, or mastitis (breast infection)—all of which can occur within 72

hours after delivery, especially if the labor has been long and difficult. Also, the baby may appear fine immediately after birth but become jaundiced after going home. Then there are the human considerations: The mother may not have the stamina to take care of herself and her infant right after delivery, especially if this is her first baby. Fear, insecurity, and depression are not uncommon. An extra day or two in the hospital can help her regain the strength she needs in order to cope.

I believe that every woman should remain in the hospital for two days after giving birth. However, if discharge after 24 hours becomes the rule, then in my view the insurer should arrange for home care by professionals for two days afterward. If you plan to have a baby sometime in the future, study the fine print in your insurance policy or managed-care contract for any reference to early discharge after delivery.

■ HEALTH

Check in, deliver, go home

Hospitals are hustling new mothers out in a day—or less. Is it risky?

Nicole Jundanian, 28, an annuities company co-owner and manager from Chevy Chase, Md., did everything by the book to prepare for the arrival of her first child in October. She ponied up for Lamaze classes and read how-to manuals even as she toiled through labor. Still, she was in such a stupor after delivering at 1:25 a.m. and being discharged the next day that she failed to recognize how poorly Jack Joseph was nursing. "He was jaundiced and dehydrated, and I didn't even know it," she says. Nor had the hospital staff picked up the baby's problems.

Luckily, Jundanian had hired a caregiver trained in assisting new mothers, who spotted the condition in time. But the baby and his mother—still sore and bleeding heavily from the delivery—spent much of their first week together commuting back and forth to the doctor's office. "I was a basket case," recalls Jundanian. "If I'd just been in the hospital longer, I would have had an easier time."

Six and out. In today's cost-conscious climate of managed care, however, that has become a luxury for most new moms. Maternity stays have shrunk dramatically from the weeklong sojourn common in the 1950s and still common overseas (box) to a national average of about 2½ days in 1992, the latest available figure. That's roughly five hours shorter than the 1991 average but still munificent compared with the 24 to 36 hours most health care plans now stipulate for routine vaginal deliveries—which can mean a late-night discharge. Three days is standard for Caesarean births. Some providers, primarily on the West Coast, are working toward turn-arounds as short as six hours—a practice obstetrical hands jokingly refer to as "drive-through OB."

Many health professionals contend that abbreviated stays afford little opportunity for mothers to rest, let alone



House call. A specialist in home maternal care spotted trouble in Jack Joseph Jundanian.

learn such basics as umbilical-cord care or breast-feeding; indeed, lactation may not occur for four days. Moreover, while most newborn problems surface during the first six hours, jaundice, heart murmurs and some other poten-

tial ills tend to develop later. Some screening tests, such as the one for the metabolic disorder phenylketonuria, or PKU, which is treatable if caught early, may even prove unreliable if performed too soon. Other tests might simply go undone in the brief time available.

"The issue is safety, and it's a big one," says Rachel Schwartz, associate director of the National Perinatal Information Center in Providence, R.I., who has surveyed the research on early discharge for a conference this week sponsored by the Department of Health and Human Services' Maternal and Child Health Bureau. "We don't have enough experience with one-day stays to know if we can prevent the train wrecks."

Maternity wards are hardly alone in feeling managed care's tightening grip, of course. Some medical centers now perform outpatient mastectomies. Others no longer routinely keep chest-pain sufferers for overnight observation. Even cardiac cases are getting the boot earlier: Reconfigured staffing and medical advances have allowed Fairfax Hospital in Northern Virginia, for example,

Motherhood abroad

Typical hospital stay for new mothers:

Australia: 4 to 6 days

Canada: 2½ days

France: Up to 2 weeks; 5-day minimum

Germany: 7 days

Great Britain: 3 days

Ireland: 5 to 6 days

Japan: 5 to 7 days

Netherlands: Mostly home births, with all-day nurse for a week

Sweden: 1 to 3 days, with midwife home visit

United States: 24 to 36 hours

USNEWS — Basic data: Embarees, health ministers, health plans and insurers

to pare the average length of stay for bypass patients to just under a week from 12.2 days in 1989.

Cardiac cases, however, are not expected to go home, attack the laundry and wake up for midnight feedings. Moreover, unlike previous generations of mothers, today's mom can't count on having an experienced relative there to coach her on nursing or spot a fever. That kind of child-care education has been a hallmark of the maternity-ward stay—only now there is insufficient time, and fewer nurses, to dispense it. "Our problem is trying to get everything done for a woman and then trying to get her out because she is on a time clock," grumbles Doris Johnson, associate administrator for patient care services at Columbia Hospital for Women in Washington, D.C. "It's very frustrating."

But is it actually dangerous? Medical studies, though scant, show no adverse health impact for mothers or infants discharged early. And a computer analysis of 740,000 deliveries nationwide between 1990 and 1993, done for U.S. News by HCIA Inc., a health care information company in Baltimore, found no significant association between length of stay and readmission rate. If anything, the 2.4 percent of women requiring rehospitalization within a year had enjoyed extended first stays. "The one-day discharge is so common that if people were having complications, they'd show up statistically by now," says Richard Doyle, a San Diego-based internist with Milliman & Robertson, an actuarial consulting group that creates guidelines for health insurers.

Home sweet home. Moreover, early-discharge programs appear to be popular with patients. Some 83 percent of Kaiser Permanente maternity patients polled recently, for example, expressed satisfaction with their hospital stay. Breast-feeding tends to go more smoothly at home than on a busy maternity ward. And the faster mother and child check out, the less likely they are to pick up hospital germs.

Still, anecdotal evidence suggests that some problem cases slip through the system. Three years ago, exhausted new mom Sheryl Mulhall emerged from a long morning shower to find her 3-day-old son blue and lifeless in his bassinet. So in February 1993, when the hospital tried to discharge her a day after giving birth to strapping baby Tyler, the Roch-



Insistent mom. Sheryl Mulhall argued for a second night's stay—and Tyler, unlike a previous baby, lived.

ester, Ill., mother of two dug in her heels. Because Mulhall had the flu, her doctor finagled another night. That evening, Tyler didn't eat; next morning in the nursery, he turned pale and struggled to breathe. "Had we been home, we would have lost him," shudders Mulhall. She

later learned her son—revived with sugar water and now a peppy toddler—has a genetic enzyme deficiency thought to cause 5 percent of some 7,000 crib deaths annually. "I'm thankful I stood my ground," says Mulhall.

Not all mothers are so insistent, nor their babies so fortunate. In the two years since 24-hour turnarounds became common in Cincinnati, Children's Hospital has readmitted five infants suffering from severe dehydration caused by difficulties related to breast-feeding, including one who lost a leg as a result and another who ended up brain damaged. Less severe conditions may simply go uncounted; in an ongoing survey of early discharges by Holy Cross Hospital in Silver Spring, Md., visit-

ing nurses are discovering problems—many of them stemming from a lack of knowledge about lactation and feeding—in a quarter of the mothers or infants checked a day or two later.

The villain, experts contend, is not short stays per se, but lack of follow-up

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or support. "It's unbelievable what we find on home visits," underscores obstetrical nurse Lenore Williams, president of Professional Nurse Associates Inc., a private nursing practice in Cleveland that specializes in maternal health care. "I came across one mom who said, 'All my babies had jaundice,' and when I flipped back the covers, there was this baby as yellow as a banana from a liver infection." Visiting nurses and other maternity experts report seeing everything from blood clots and depression in mothers to infants with infected umbilical cords, collar bones broken from delivery and heart murmurs. One Baltimore nurse recently opened the door to find a newborn vomiting meconium—its own fecal matter, swallowed in utero.

Home follow-ups included in some health plans can prevent such complications from becoming emergencies. In a



Home improvement. Cleveland nurse Beverly Werth educates new moms like Brenda Goines in baby care and breast-feeding.

recent survey of 1,616 Kaiser Permanente families under her firm's care, Williams found infections in 7 percent of the mothers and 3 percent of the infants, yet the rate of hospital readmission was less than 1 percent.

With a day in the hospital now billing

at an average of about \$1,500, the savings can be substantial. The total topped \$500,000 for 925 Ohio Kaiser Permanente patients in a 1990 study by Professional Nurse Associates. Moreover, follow-up care can stave off emergency-room visits by reassuring a mother that her infant's rolling eyes are a sign of sleepiness, not of seizures, or by spotting formula left sitting too long. "It's win-win for everyone," says nurse Williams.

Videotape support. Except, perhaps, for hospitals. To compensate for shorter stays, many are expanding prenatal education beyond the pant-pant-blow of traditional labor classes, to include breast-

feeding and choosing a pediatrician. At Columbia Hospital for Women, new parents soon will be sent home with a videotape that addresses such issues as circumcision care, while Alta Bates Medical Center in Berkeley, Calif., gets newborns back for checkups at 72 hours, even on weekends. Next year, Alta Bates plans to factor a home visit into its per capita maternity costs.

Many managed-care plans, including Kaiser Permanente and Humana, and some insurers also provide home visits. But hurdles—like having to get approval before discharge—can prove deterring. And no guidelines or federal rules mandate such services. That leaves it up to new mothers like Nicole Jundanian to search out their own experts—and foot bills of up to \$800 a week. "It's another situation where women and children are being shortchanged," concludes Edward Bailey, chief of general pediatric services at Bay State Medical Center Children's Hospital in Springfield, Mass., who instituted home follow-ups four years ago to support early discharges and has seen no adverse health impact in 13,000 births.

Neither Bailey nor his peers expect maternity stays to lengthen. But if the bean counters have avoided a train wreck so far, it may only be because "most babies are healthy and very resilient," notes Marcia Charles-Mo, chair of the pediatrics department at Alta Bates. Unless they provide a dose of follow-up support, however, insurers and managed-care plans could find their robust bottom lines bouncing rapidly into the red. ■

By MARY LORD

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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.

2.

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 Draveman P, Egarter S, Pearl M, Marchi K, Miller C. Early discharge of newborns and mothers: a critical review of the literature. *Pediatrics* 1995 (in press).

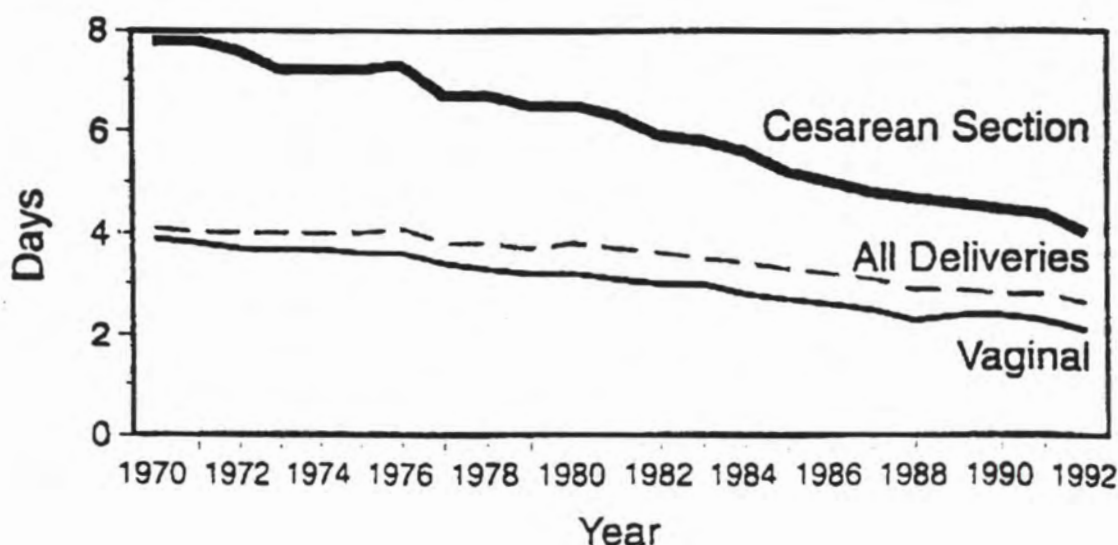
Trends in Length of Stay for Hospital Deliveries — United States, 1970–1992

Obstetric delivery is the most frequent cause of hospital admission in the United States, reflecting the approximately 4 million births in this country each year (1). Because of steadily increasing hospital costs, overall lengths of hospital stay have declined. To assess national trends in length of stay for hospital deliveries, data were analyzed from CDC's National Hospital Discharge Survey (NHDS) from 1970 through 1992, by method of delivery. This report summarizes the results of the analysis.

Since 1965, the NHDS has collected data from U.S. nonfederal, short-stay hospitals. Each year, approximately 200,000 inpatient records are selected from approximately 400 hospitals; data are weighted to represent all hospitalizations nationally (2,3). Selected patient information (e.g., medical diagnoses and surgical procedures) is abstracted from each record. For this analysis, the NHDS provided information about mother's age and race/ethnicity; method of payment; and the hospital's ownership, size, and location. Estimates for average length of stay were derived from the 20,000–33,000 deliveries each year among all records sampled. Hospital stays of <24 hours were recoded as 0 days; these hospitalizations accounted for <1% of all deliveries and were relatively constant by year (i.e., 0.3% in 1970 to 0.7% in 1992). The proportion of all deliveries that occurred outside of hospitals also was stable from 1975 (0.9%) to 1990 (1.1%) (4).

In 1970, the average length of stay for all hospital deliveries was 4.1 days (median: 4 days). By 1992, the average had decreased by 37% to 2.6 days (median: 2.0 days). The average length of stay for women who gave birth vaginally decreased by 46% (from 3.9 to 2.1 days) and for those who gave birth by cesarean section by 49% (from 7.8 to 4.0 days) (Figure 1). The decrease in the average length of stay for all deliveries was smaller than that for either method because the percentage of deliveries by cesarean section increased from 5.5% to 23.5% during this period (5).

FIGURE 1. Average length of stay for hospital deliveries, by delivery method — United States, 1970–1992



Hospital Deliveries — Continued

The average length of stay also was analyzed by mother's age (<20, 20–29, 30–39, and >39 years), race (white or black)*, hospital location (Northeast, Midwest, South, or West regions), hospital ownership (proprietary, government, or nonprofit), and hospital size (<100, 100–299, 300–499, and >499 beds). From 1970 through 1992, the average length of stay decreased similarly for all these groups; decreases ranged from 39% to 52% for vaginal deliveries and from 38% to 53% for cesarean deliveries. NHDS began collecting information about method of payment (i.e., Blue Cross/Blue Shield†, other private insurance, Medicaid, and self-paying) in 1977. From 1977 through 1992, the average length of stay decreased for these payment groups; decreases ranged from 35% to 38% for vaginal deliveries and from 32% to 47% for cesarean deliveries.

Reported by: Div of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion; Prevention Effectiveness Activity, Epidemiology Program Office, CDC.

Editorial Note: The length of stay associated with hospital deliveries steadily decreased during 1970–1992. Early hospital discharge results in reduced health-care costs and enables mothers to return home sooner with their newborns. However, careful postpartum follow-up is necessary to ensure prompt diagnosis and treatment of any maternal or neonatal complications. Early discharge should not preclude efforts traditionally conducted during postpartum hospitalization to educate women about breastfeeding, family planning, care of their newborn, and other topics important for new mothers.

The optimal length of stay for uncomplicated deliveries reflects several factors, including the presence of others in the home who can support the mother after discharge, the mother's awareness of complications, and access to health-care services. Guidelines published by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists suggest that, when there have been no complications, the duration of postpartum hospital stays range from an average of 48 hours for vaginal delivery to an average of 96 hours for cesarean birth (excluding the day of delivery) (6). In addition, specific criteria should be met for a woman to be discharged early, especially within 24 hours of delivery.

One potential limitation of the analysis in this report is that data from the NHDS on length of stay does not distinguish the postpartum period from the rest of the hospitalization. Therefore, this analysis could not determine whether the decrease in the average length of stay resulted from a shorter antepartum stay or postpartum stay. However, since 1970, most of the efforts to decrease length of stay for hospital deliveries has been directed toward the postpartum period.

Since 1970, the rate of health-care costs has increased more rapidly than that of general inflation; efforts to decrease hospital health-care costs by reducing length of stay will probably intensify. Most studies have not detected an increased rate of morbidity in association with early postpartum discharge (7–9). However, these studies—which were conducted among carefully selected women at low risk for postpartum complications—documented rates of complications of up to 14% among women and 11% among their infants (7). In addition, home visits by nurse practitioners after discharge (a practice not routinely used by health-care providers) ensured

*Numbers from other racial/ethnic groups were too small for reliable analysis.

†Use of trade names and commercial sources is for identification only and does not imply endorsement by the Public Health Service or the U.S. Department of Health and Human Services.

Hospital Deliveries — Continued

prompt diagnosis and treatment of postpartum complications. These findings underscore the need to ensure adequate follow-up care for women and infants and to maintain the educational activities traditionally provided during postpartum hospitalization. The prevalence of complications also should be monitored to accurately determine the costs and benefits of early postpartum discharge.

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Deaths from Melanoma — United States, 1973-1992

Approximately three fourths of all skin cancer-associated deaths are caused by melanoma. During 1973-1991, the incidence of melanoma increased approximately 4% each year (1). In addition, the incidence of melanoma is increasing faster than that of any other cancer (2). To characterize the distribution of deaths from melanoma in the United States, CDC analyzed national mortality data for 1973 through 1992. This report summarizes the results of that analysis.

Decedents for whom the underlying cause of death was melanoma (*International Classification of Diseases, Adapted, Ninth Revision*, codes 172.0-172.9) were identified from public-use, mortality data tapes from 1973 through 1992 (3). The denominators for rate calculations were derived from U.S. census population estimates (4,5). Rates were directly standardized to the age distribution of the 1970 U.S. population and were analyzed by state, age group, sex, year, and race. To increase the precision of the rates presented, race was characterized as white and all other races because approximately 98% of deaths from melanoma occurred among whites.

From 1973 through 1992, the overall percentage increase in the rate of deaths from melanoma (34.1%) was the third highest of all cancers; for males, the percentage

(Continued on page 343)

Guidelines for **PERINATAL CARE**

Second Edition



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policy, there is no absolute medical indication for circumcision in the neonatal period, will be modified only if data conclusively demonstrate the value of the procedure.

Parent Education

The hospital experience is to some extent a learning process; however, the reduction in the length of a patient's routine postpartum stay compromises the opportunity for parent education. Hospital resources that have traditionally been extended to parents can no longer be accommodated within the shortened hospital stay. Physicians should be willing to accept, understand, and respond to parent inquiries that arise throughout the perinatal period and make every effort to ensure that educational aspects of care are provided prior to and following hospitalization.

Closed circuit television films previewed and approved by the obstetric and pediatric staff, printed materials, and counseling by hospital personnel (eg, postpartum and nursery nurses, registered dietitians/nutritionists, and physical therapists) have been helpful to parents. Other beneficial activities are group or individual educational sessions held regularly during the postpartum period to teach and discuss patient self-care, including exercises and self-examination of the breasts; parent-infant relationships; infant care, including bathing and feeding; and child growth and development. Family planning techniques appropriate to the patient's needs and desires should be explained in detail.

The newborn undergoes rapid changes in physiology that should be explained to the parents. The neonate's cardiovascular, pulmonary, renal, and neurologic maturation should be observed by the parents with the guidance of qualified personnel. Parents should be familiar with normal and abnormal changes in wake-sleep patterns, temperature, respiration, voiding, stooling, and the appearance of the skin. They should also observe and become familiar with the behavior, temperament, and neurologic capabilities of the newborn. Some believe that parents should also learn infant cardiopulmonary resuscitation techniques.

Visiting

The father or supporting person may be with the mother as much as desired within the constraints of acceptable standards of care and hospital policy. This includes the labor, delivery (including cesarean delivery), recovery, and postpartum periods. Local policies should be

developed and policies for father

Sibling visits in periods. Children when separated mother and new siblings for the next a topic of current viral infectious diseases neonates if hospital allowed to have a place in the mother area if the mother responsibility of parent with a contagious: than siblings should

Other family members see the newborn a special arrangement to the new family.

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No adverse effect units have been recommended a visitation to the newly defined written policy entirely available. The policy formulation:

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PERINATAL CARE SERVICES

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developed and followed consistently. Flexible and liberal visiting policies for fathers are well accepted and should be encouraged.

Sibling visits may be desirable in the early labor and postpartum periods. Children under 6 years of age frequently experience anxiety when separated from their mother. Furthermore, contact with the mother and newborn while they are in the hospital helps prepare the siblings for the new family member. Physical contact with neonates is a topic of current concern, as such direct sibling contact may transmit viral infectious diseases to the newborn and, potentially, to other neonates if hospitalization should be prolonged. If siblings are allowed to have direct contact with the newborn, the visit may take place in the mother's private room or in a special sibling visitation area if the mother is not in a private room. Parents should share the responsibility of preventing the exposure of their newborn to a sibling with a contagious illness. Contact of the newborn with children other than siblings should be avoided.

Other family members and friends should be allowed to visit and see the newborn according to the established policy of each hospital. Special arrangements may be necessary for other persons important to the new family, such as out-of-town visitors.

Whenever possible, parents of neonates in the continuing care, intermediate care, or intensive care areas should be allowed unrestricted visits. Provisions should be made for feeding (particularly breast-feeding), handling, and holding these neonates.

No adverse effects of sibling visitation in neonatal intensive care units have been noted, but more study is needed before a general recommendation can be made. An institution that allows sibling visitation to the neonatal intensive care unit should have clearly defined written policies and procedures based on information presently available. The following guidelines may serve as the basis for policy formulation:

1. Siblings should not have been exposed to known communicable diseases (eg, chickenpox).
2. Siblings should not have fever or symptoms of acute illness, such as upper respiratory infection or gastroenteritis.
3. Children should be prepared in advance for their visit.
4. Parents are responsible for ensuring that children are properly supervised by an adult throughout their hospital visit.

Because available data are limited, there is a need for continued evaluation and reporting of the risks and benefits of sibling visitation.

New Mothers Gain 2d Day In Hospital

Whitman Signs a Bill To Fight Curbs on Care

By JON NORDHEIMER

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

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

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

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

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

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

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

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

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

In addition to the 48 hours for routine

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

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

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

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

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

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

Dr. Knuppel said that a second night in the hospital is particularly helpful to first-time mothers and those from disadvantaged homes

whose babies run a disproportionate risk of being readmitted with medical problems days after discharge. "The mother's stay in the hospital may be the only access she has to this information," he said.

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

Until today, Medicaid patients stood a better chance of getting an extended maternity stay than those covered by many health maintenance organizations, Dr. David Butler, chief of obstetrics and gynecology at Holy Name, said. The hospital

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

was chosen for the bill signing because it was the site of a rally against early discharge in March rally.

Dr. Knuppel and others said a 48-hour hospital stay is no magic answer. Jaundice, a problem for some newborns, is usually not observable until 72 hours, they pointed out, and dehydration caused by breast feeding difficulties may not be observ-

able until after the third day, when a mother's milk becomes abundant. For these reasons, they added, nursing care at home over a three-day period may be preferable to two hospital days if mother and child are healthy enough to go home after 24 hours.

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

Biotechnology Gets a Boost

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

healthreport

by Isadore Rosenfeld, M.D.

Estrogen replacement and breast cancer

Whether or not to take supplemental estrogen after menopause is one of the most confusing decisions a woman ever faces, and the recent medical news isn't making it any easier. In June, Harvard University researchers announced the results of a study showing that women who took estrogen supplements—with or without progestin—had a 30 to 40 percent higher than normal incidence of breast cancer. But only a month later, researchers at the Fred Hutchinson Cancer Research Center, in Seattle, produced contradictory findings. After reviewing the medical histories of 1,029 northwestern Washington women, aged 50 to 64, they found no link between breast cancer risk and supplemental hormone use. In fact, hormone replacement was associated with a small reduction in risk.

Before any woman decides not to take estrogen after menopause, she should consider some of estrogen's other effects. It cuts in half the risk of death by heart attack—which is especially impressive when you consider that a woman between the ages of 50 and 60 is six times more likely to die of a heart attack than of breast cancer. Supplemental estrogen also decreases the incidence of strokes, the

severity of Alzheimer's disease, and the risk of colon cancer. The overall death rate is 11 percent lower in women taking estrogen. Finally, there's the question of osteoporosis. Approximately 300,000 women fall and break a hip each year, and one-quarter of them never regain full mobility. Estrogen therapy is the most effective way to keep bones strong.

You may not want to take estrogen if you have a family history of breast cancer; if you yourself have had breast, uterine, or ovarian cancer; if you have had liver or gallbladder disease; or if you have a history of embolisms (traveling blood clots). On the other hand, the following risk factors make you a good candidate for estrogen replacement therapy:

- Strong family history of heart disease
- High cholesterol and a low HDL level
- Obesity
- High blood pressure
- Smoking
- Diabetes
- Family history of osteoporosis

I recommend that women who take hormones after menopause have their breasts examined each time they visit their doctors, and that they have a mammogram at least once a year.

Drive-through-delivery dangers

The American Medical Association has recently drawn attention to a new trend in hospital care after childbirth. Many managed-care health plans require that new mothers be discharged within 24 hours after an "uncomplicated delivery." Women in Oregon and Utah are even getting cash payments of \$100 or more as an added incentive to go home fast. Although it is probably OK for many mothers to be discharged after an overnight stay, complications occur often enough to cause me to

worry about the safety of this policy. The mother can suffer from delayed heavy bleeding, phlebitis (an inflammation of a vein in the leg or pelvis that can lead to traveling blood clots), toxemia, wound infection, endometritis (infection of the uterine lining), fever, or mastitis (breast infection)—all of which can occur within 72 hours after delivery, especially if the labor has been long and difficult. Also, the baby may appear fine immediately after birth but become jaundiced after going home. Then there are the human considerations: The mother may not have the stamina to take care of herself and her infant right after delivery, especially if this is her first baby. Fear, insecurity, and depression are not uncommon. An extra day or two in the hospital can help her regain the strength she needs in order to cope.

I believe that every woman should remain in the hospital for two days after giving birth. However, if discharge after 24 hours becomes the rule, then in my view the insurer should arrange for home care by professionals for two days afterward. If you plan to have a baby sometime in the future, study the fine print in your insurance policy or managed-care contract for any reference to early discharge after delivery.

Prozac for PMS

Almost every woman has experienced premenstrual syndrome (PMS) at one time or another. The symptoms are usually mild and tolerable, but in about 3 to 8 percent of cases (two to five million women in this country), PMS can be severe and crippling. A recent Canadian study found that Prozac is an effective treatment in such cases. In the double-blind study (neither the patient nor the doctor knew who was getting the active drug and who the placebo), a daily 20-milligram tablet reduced the severity of symptoms by at least 50 percent, while the placebo group had a less-than-25-percent response. Higher doses resulted in a greater incidence of side effects, including loss of sex drive, difficulty reaching orgasm, insomnia, fatigue, and nervousness. But most of the 313 women in the study tolerated the drug well.

Every doctor has his or her favorite solution for PMS, but it's often a hit-or-miss affair. In recent years, the most popular therapies have been the tranquilizer Xanax, Lupron (which stops menstrual cycles), relaxation techniques, and exercise. In a recent study, progesterone, another widely used PMS treatment, was found to be ineffective.

It does not surprise me that Prozac would fight PMS as well as it fights depression; there is increasing evidence that activity of the brain chemical serotonin is low both in people who are depressed and in those with severe PMS, and Prozac increases the activity of serotonin in the brain.

It's still not clear how the drug should be taken. The Canadian researchers gave it to their subjects continuously. In other research now in progress, the drug is being administered only for ten days to two weeks before the onset of each period. □

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