

Agency for Health Care Administration

Maternal and Newborn Early Hospital Discharge Study



Definitions

Early Discharge (24-48 hours)
means a discharge of a mother and/or
a baby between 24 and 48 hours
postpartum

Very Early Discharge (<24hours)
means a discharge of a mother and/or
a baby at less than 24 hours postpartum



National Figures

- ♦ Between 1970 and 1992, nationally,
the average length of hospital stay for all
deliveries has consistently decreased
 - The average length of stay for a
vaginal delivery decreased from 3.9
days to 2.1 days
 - The average length of stay for a
Cesarean section delivery decreased
from 7.8 days to 4.0 days



State Figures

- ♦ 1993 total Florida deliveries = 183,921
 - total vaginal births = 139,838
 - total Cesarean = 44,082

1993 average length of stay
vaginal births = 2.0 days
Cesarean = 3.8 days

- ♦ 1994 total Florida deliveries = 182,169
 - total vaginal births = 140,221
 - total Cesarean = 41,948

1994 average length of stay
vaginal births = 1.8 days
Cesarean = 3.5 days

These numbers continue to reflect the trend of decreasing lengths of hospitalization after delivery



Background

In 1993 the Legislature authorized AHCA to coordinate the development, endorsement, implementation and evaluation of scientifically sound, clinically relevant practice guidelines

- ♦ These are designed to:
 - reduce unwarranted variation in the delivery of medical treatment;
 - improve the quality of medical care; and
 - promote the appropriate utilization of health care services



Maternal and Newborn Hospital Discharge Practice Guideline Development

In August 1995, AHCA established a 20-member multi-disciplinary committee

The purpose of this committee was to look at the establishment of criteria for maternal and hospital discharge

The committee members strongly endorse the following criteria:

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Practice Guideline Criteria

- ♦ Any guidelines or legislative action on this issue must be developed using scientifically sound medical practices that have been endorsed by both state and national medical experts and organizations
- ♦ Discharge of mothers and newborns from the hospital must be based on the clinical judgment of the physician, or other licensed maternity and newborn professionals, in consultation with the family
- ♦ Lengths of stay should not be mandated; but founded on specific medical criteria and allow for choice and flexibility

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Practice Guideline Criteria (cont'd)

- ♦ Careful assessment and an in-depth evaluation of the medical and psychosocial factors, and the family's strengths will allow the maternity and newborn health professionals and the family to determine the most appropriate time for discharge and post discharge follow-up care
- ♦ Appropriate follow-up care after discharge, particularly with very short hospital stays, (48 hours or less for a vaginal delivery and less than 96 hours for a Cesarean section delivery) is critical and requires a well-defined comprehensive plan for both mother and baby



Practice Guideline Criteria (cont'd)

- ♦ The follow-up visit should include an assessment of the mothers' functional status and any health or domestic problems that may interfere with the care of her child, and a repeat of metabolic screening on the infant
- ♦ This follow-up care should be provided by licensed maternity and newborn professionals and reimbursed under individual, group, and HMO health insurance plans



Agency for Health Care Administration Endorsement

**The Agency released the Committee's
document as an Endorsed Practice Guideline
on March 22, 1996**

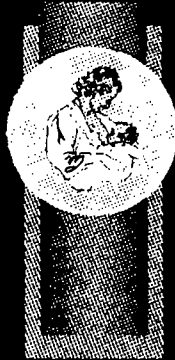
**We encourage all maternal and newborn
health care professionals, hospitals, birthing
centers, insurers, and health maintenance
organization (HMO's) plans to adopt the
agency's voluntary guideline as the basis for
policy formulation used in determining the
optimal time for maternal and newborn
discharge and appropriate postpartum
follow-up care**



Maternal and Newborn Early Hospital Discharge Legislation (Senate Bill 1860)

**Signed into law by Governor Lawton Chiles
On May 22, 1996**

**Effective date
October 1, 1996**



Senate Bill 1860 Legislative Components

Maternal and Newborn Hospital and Post- Delivery Coverage

All individual and group insurance policies and HMOs may not limit inpatient hospital coverage or postnatal follow-up coverage if it is determined medically necessary by the treating obstetrical or pediatric provider.

Active case questions and concerns regarding post-delivery care must be communicated to the treating physician or hospital in written form by insurers.

Insurers must have written protocols for utilization review and quality assurance.



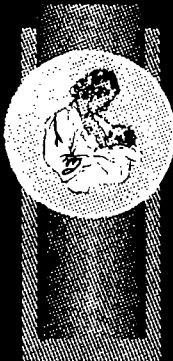
Senate Bill 1860 Legislative Components (cont'd)

Maternal and Newborn Postpartum Follow-up Care

Post-delivery care for the mother and newborn must include a postpartum maternal and newborn physical assessment including performance of any medically necessary clinical tests and immunizations in keeping with prevailing medical standards.

Postpartum assessment may be provided at the hospital, at the attending physician's office, at an outpatient maternity center or in the home

Post-delivery care must be done by a qualified licensed health care professional trained in mother and baby care



Senate Bill 1860

Legislative Components (cont'd)

Maternal Newborn Early Hospital Discharge Study

Senate Bill 1860 directs the agency to conduct a study to evaluate the clinical effects of shorter stays in the hospital on mothers and newborns which must also include the impact of this legislation

Study is to be completed in collaboration with:

- insurers
- birth centers
- hospitals
- obstetrical and pediatric providers

The agency will report its findings to the President of the Senate, the Speaker of the House of Representatives, and the Chairman of the Health Care Committee of the Senate and the House of Representatives by January 1, 1998



Areas of Study Mandated By Senate Bill 1860

- Actual volume of early discharges
- Payor policies
- Health effect on and complication rates in the infants
- Health effects, both physical and psychological, on the mother
- Extent of opportunity for maternal and infant-care education
- Physical and psychological effects on other family members
- Extent of opportunity for maternal and child psychosocial assessment
- Extent of follow-up care provided to mothers and newborns
- Volume of readmissions and catastrophic readmissions
- Costs associated with early discharge



Maternal and Newborn Early Hospital Discharge Study Goals

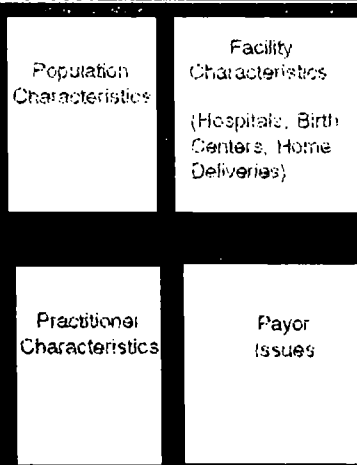
- To Understand the Impact of Early Postpartum Discharge
- To Analyze the Effect of Implementing the Enacted Legislation and Practice Guideline

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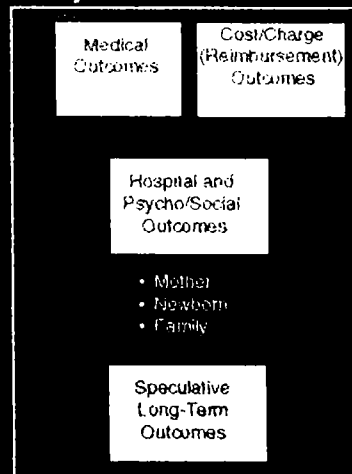


Maternal and Newborn Early Hospital Discharge Study

Independent Variables



Dependent Variables



There will be cross-over between independent variables and dependent variables

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Population Characteristics

- ♦ Age/Race
- ♦ Urban/Rural
- ♦ Cultural factors
- ♦ Educational level
- ♦ Family assessment
- ♦ Prenatal care
- ♦ Post partum characteristics
- ♦ Postnatal feeding patterns
- ♦ Prevailing maternal and infant mortality rates

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Facility Characteristics

(Hospitals, Birth Centers, Home Deliveries)

- ♦ Hospital types (Profit-Non profit)
- ♦ Birth rates
- ♦ Postnatal follow-up programs
- ♦ Child birth education programs
- ♦ Maternal and infant mortality rates
- ♦ Maternal and newborn transport/transfer policies
- ♦ Maternal and newborn hospital readmission rates

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Practitioner Characteristics

- Staffing qualifications
- Prenatal and postnatal education programs
- Specialty status
- Healthy Start pre and postnatal screening rates

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Payor Issues

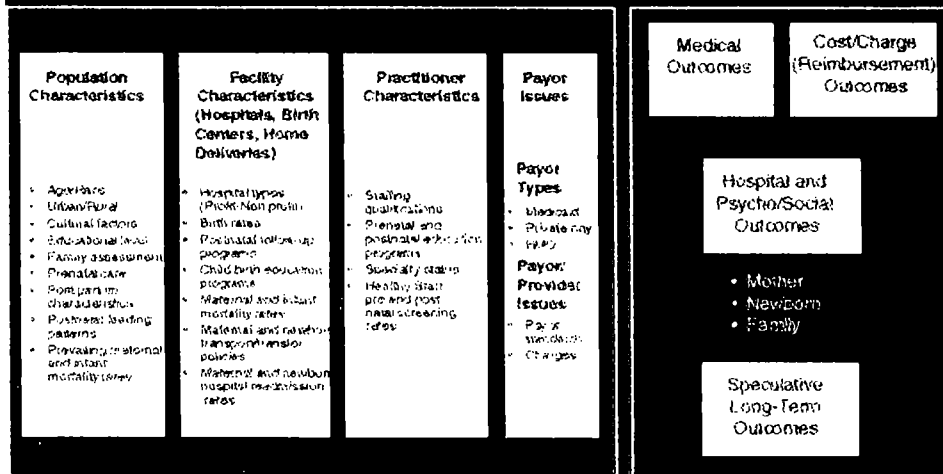
- Medicaid
- Private pay
- HMO
- Payor standards
- Charges

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Maternal and Newborn Early Hospital Discharge Study

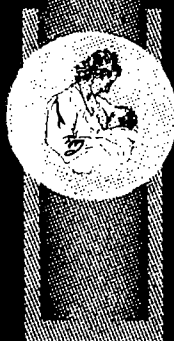
Independent Variables

Dependent Variables



There will be cross-over between independent variables and dependent variables

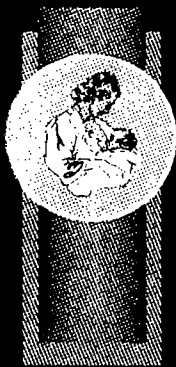
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Study Type: Outcomes Analysis of Potential Problem Areas in the Perinatal and Postnatal Period

- Actual volume of early discharges
- Payor policies
- Health effect on and complication rates in the infants
- Health effects, both physical and psychological, on the mother
- Extent of opportunity for maternal and infant-care education

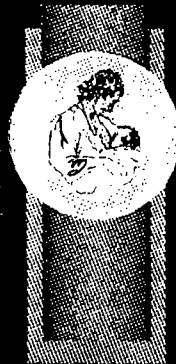
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Study Type:
***Outcomes Analysis of Potential Problem Areas
in the Perinatal and Postnatal Period
(cont'd)***

- Physical and psychological effects on other family members
- Extent of opportunity for maternal and child psychosocial assessment
- Extent of follow-up care provided to mothers and newborns
- Volume of readmissions and catastrophic readmissions
- Costs associated with early discharge

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Study Area Example

Volume of Readmissions and Catastrophic Readmissions

Objective:

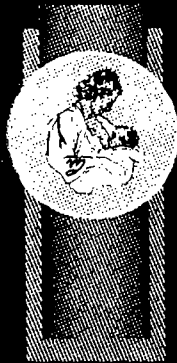
Characterize the actual volume of postpartum mothers and newborn infants who are readmitted to the hospital

In doing this we will also attempt to understand the relationships between associated medical outcomes and current postpartum length of stay policies and practice behaviors used throughout the state

Data and Information Sources:

Center for Health Statistics Hospital Readmission Data, Vital Statistics Records, and onsite review of medical charts

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Study Area Example

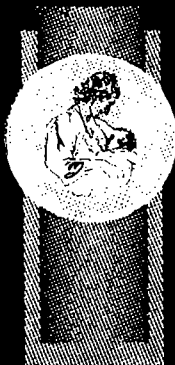
Extent of Opportunity for Education and Psychosocial Assessment

Objective:

Characterize Differences Between Volume of Time and Quality of Time used by Delivering Institutions (i.e., hospitals, birth centers, and postpartum follow-up programs) for teaching opportunities and psychosocial assessments

Data and Information Sources:

Delivery institution surveys and family interviews; review of policies and patient records from hospitals, birthing centers, and statewide Healthy Start data



Maternal and Newborn Early Hospital Discharge Legislation and Study Time Guidelines

- AHCA practice guideline endorsement
March 22, 1996
- Senate Bill 1860 signed by Governor Chiles
May 22, 1996
- Law becomes effective
October 1, 1996
- Early discharge study period:
October 1, 1996 through September 30, 1997
- Final report due to the Legislature
January 1, 1998



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David S. Abernethy
Vice President, Government Relations

M E M O R A N D U M

DATE: June 12, 1996
TO: Marilyn Yeager
FROM: David Abernethy 
RE: HIP's Breast Health Initiative and Lifestarts program

First let me apologize for the time it took me to get back to you about HIP's employee benefits programs. Chris Jennings mentioned to me that we had been too late, and I am sorry about that. I am still new enough to HIP that it takes me a while to find out where information can be located.

As we discussed HIP was a pioneer in the development of breast cancer screening for prevention of breast cancer. HIP's work in the 1950's and 1960's is still cited as the classic study documenting the success of mammographic screening in the early detection of breast cancer. We have since developed the Breast Health Initiative which is described in the attached document. This is a state-of-the-art approach to developing practice guidelines, policies, and procedures to assure the best possible outcomes for women.

Given this Initiative we would be pleased to host an event at one of our medical centers in which the medical and computer equipment associated with the Initiative could be showcased for visual purposes, as well as an overview of the program from our doctors. There are a number of medical centers in medically-underserved areas of New York City, such as Bedford/Stuyvesant which could serve for this purpose. In addition, as I have noted before this would also allow a focus on our single level of care for Medicaid and commercial beneficiaries to demonstrate how you can save money on Medicaid while improving the quality and continuity of care received by this population.

I would also like to tell you about another initiative of HIP's in New Jersey, a state which I presume you are very interested in! I recall the President's radio address on Mother's Day addressed his support for the 48-hour stay rule for maternity. HIP is the only major health plan on record in support of this legislation, and we have actively supported its enactment in New York State and in New Jersey.

In 1991, long before this was a political issue, the HIP Health Plan of New Jersey developed a program called **Lifestarts**, which is a focused home care program for new mothers and their babies which is designed to ease the transition from hospital to home. It also has the benefit of encouraging, but not requiring, women to leave the unhealthy atmosphere of the hospitals for the healthier atmosphere of the home.

Again, we would be happy to host an event which might highlight this caring approach to helping this difficult transition, without forcing mothers to do something they do not want to do.

I would be pleased to discuss this further with you or any other member of the staff.

Thanks for this opportunity, and I look forward to hearing from you.

*Guidelines
for*
**PERINATAL
CARE**

Second Edition



American Academy of
Pediatrics



American College of
Obstetricians and
Gynecologists



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other obligation. The patient should be discharged from the recovery area only at the discretion of the attending physician or the anesthesiologist in charge. A record of vital signs should be maintained and additional signs or events monitored and recorded as they occur.

Subsequent Care

The physician should sign the patient's transfer to the postpartum unit after writing the appropriate postpartum orders. When the patient is taken to her postpartum room, her vital signs, the status of the uterine fundus, and the rate of bleeding should be reassessed and recorded. This assessment should be repeated at regular intervals for the next several hours. While in the postpartum unit, the mother should be taught how to care for herself and her neonate, and problems related to her general health should be discussed. Specific postpartum policies and procedures should be established through cooperative efforts of the medical and nursing staff.

BED REST, AMBULATION, AND DIET. Bed rest is recommended for only a brief time, just long enough to allow the new mother to sleep, regain her strength, and recover from the effects of the analgesic or anesthetic agents that she may have received during labor. It may be necessary to administer fluids intravenously for hydration. Because early ambulation has been shown to decrease the incidence of subsequent thrombophlebitis, the patient should be encouraged to ambulate, with assistance, as soon as she feels able. The patient should not attempt to get out of bed initially without the help of an attendant. The mother may have a full diet as soon as she desires it, unless her physician gives other orders.

CARE OF THE VULVA. The patient should be taught to cleanse the vulva from anterior vulva to perineum and anus rather than in the reverse direction. The application of an ice bag is likely to reduce edema and pain during the first 4-6 hours after repair of episiotomy. Orally administered analgesics are commonly required and are usually sufficient for relief of discomfort from episiotomy. Pain that is not relieved by such medication suggests hematoma formation and mandates a careful examination of the vulva, vagina, and rectum. Beginning 24 hours after delivery, either dry heat with an infrared lamp or moist heat in the form of a warm sitz bath can be applied to reduce local discomfort and promote healing.

CARE OF THE BLADDER. Women often have difficulty voiding immediately after delivery, possibly because of trauma to the bladder during

labor and delivery, region site. In addition, the diu distend the bladder before adequate emptying of th frequently during the fir attention to displacement a fluid-filled bladder abor made to help the patien: catheterization may be ne voiding difficult, the use of to repeated catheterization

BATHING. After the mother may not be comfortable wi day or later.

CARE OF THE BREASTS. The newborn determines the ap for a woman who chooses to woman who does not desire stopping the milk producti stage of engorgement, the supported with a well-fittin; analgesics may be required 24-hour period. If needed, i press lactation.

TEMPERATURE ELEVATION. Th with an elevated temperatur cultures taken (see Chapter 6 mother develops a fever, esp the neonate can be examined

POSTPARTUM STERILIZATION. F after a delivery that has bee general anesthesia reduces the and eliminates the need for a : tubal sterilization necessitates (general), the anesthesiologist : condition. If there is any indica of this elective procedure shou

IMMUNIZATION: RHIG AND RI
woman who delivers an Rho

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 ne a topic of current viral infectious d neonates if

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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:

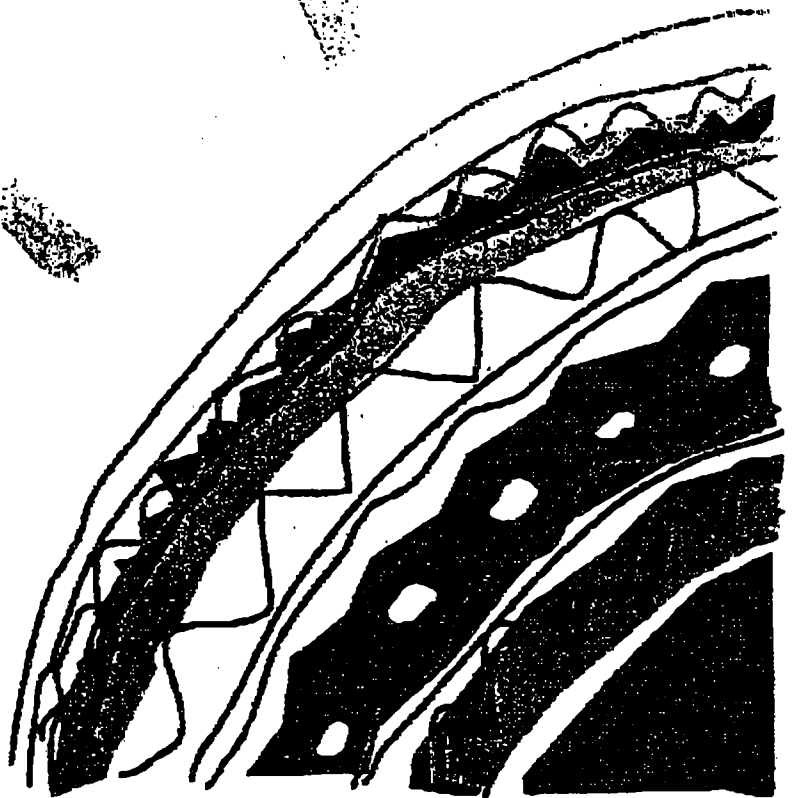
1. Siblings should not have been exposed to known communicable diseases (eg, chickenpox).
2. Siblings should not have fever or symptoms of acute illness, such as upper respiratory infection or gastroenteritis.
3. Children should be prepared in advance for their visit.
4. Parents are responsible for ensuring 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.



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, weary-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.

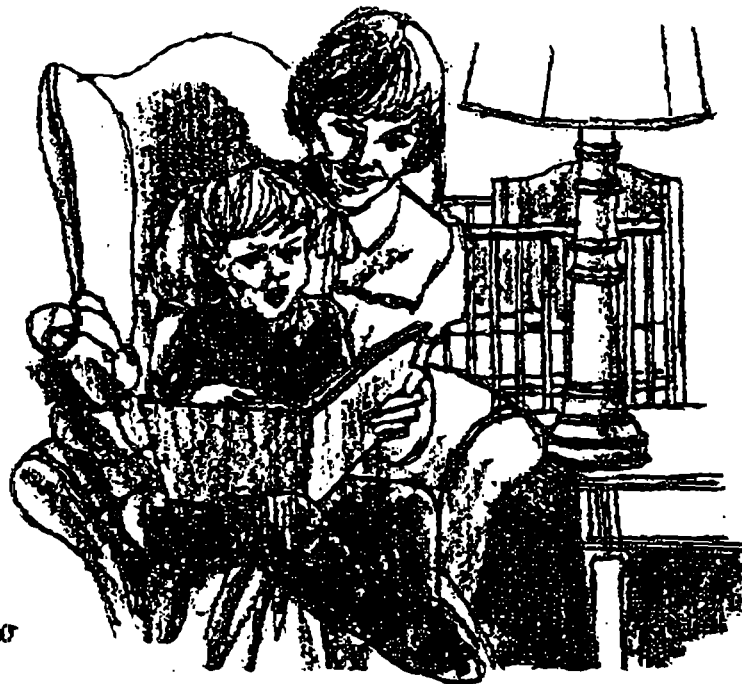


Chapter 2. CARING FOR YOUR BABY

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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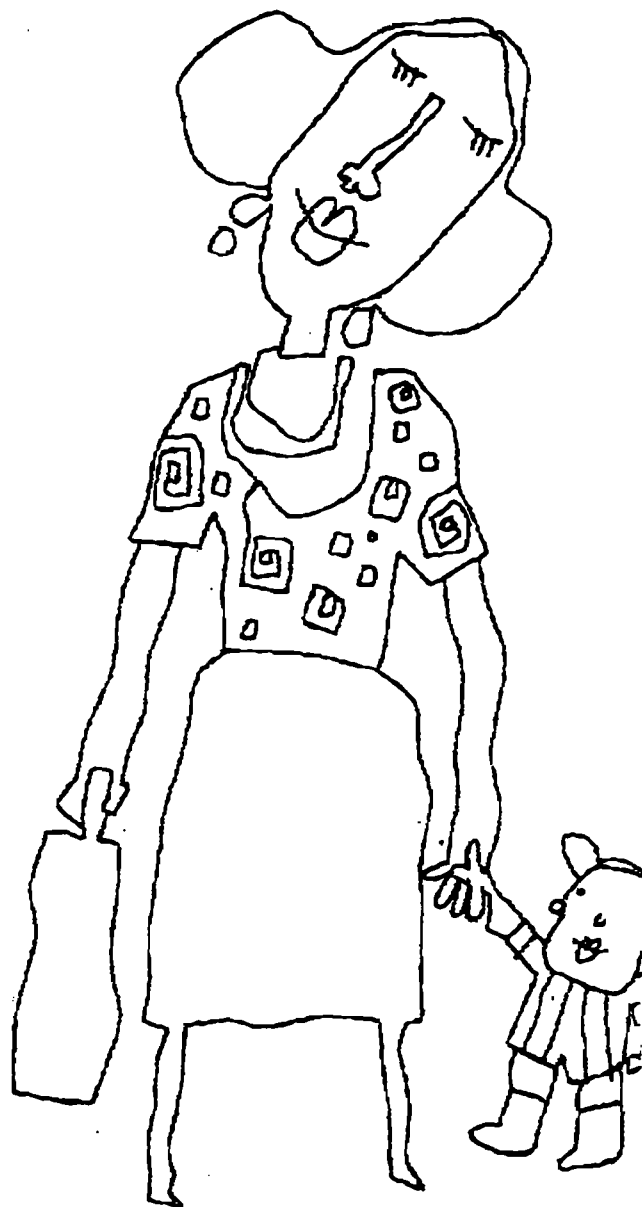
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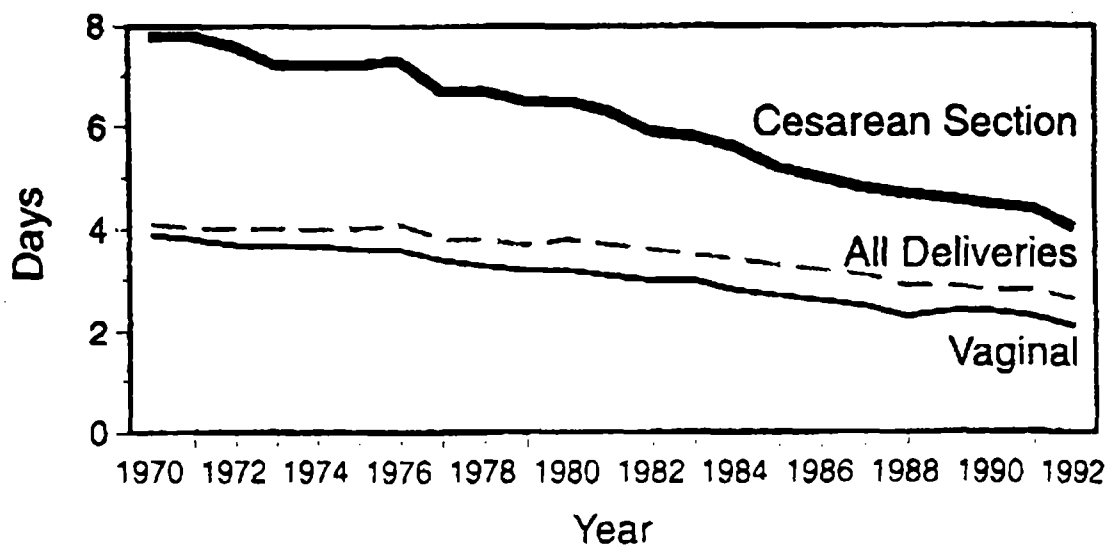
Trends in Length of Stay for Hospital Deliveries — United States, 1970–1992

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)

Colleen Meiman
401-0882

12:20 Friday

Hi Melissa -

Here's a draft background piece
I'd appreciate any
comments you have.
Colleen Meiman

EARLY MATERNAL DISCHARGE

The Issue

Health insurers are increasingly limiting payment for hospital stays for new mothers and their infants to 24 hours or less after a normal birth and 48 to 72 hours after a Caesarian birth. These "early maternal discharge policies" conflict with guidelines developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, which recommend a 48 hour hospital stay following a normal birth and a 96 hour stay after a Caesarian. (Under these guidelines, earlier discharge is acceptable only when certain physical criteria are met, and the pediatricians state that these criteria are "unlikely" to be met in less than 48 hours.)

Insurers argue that they are not setting arbitrary limits on hospital stays, but rather creating incentives for doctors to manage care more appropriately. They also state that:

- Childbirth is a normal, natural process, and should not be treated like an illness requiring extensive hospital stays.
- Hospitals are full of germs, and thus are a less safe environment for infants than home.

Insurers also argue that childbirth is the most common reason for hospitalization in the country, and thus that it is very important to manage it in a cost-effective manner.

On the other hand, doctors report that they are under severe pressure to discharge patients earlier than they think is medically appropriate. They argue that 24 hours or less is unsafe for the following reasons:

- Newborns who are discharged early are more likely to develop undetected jaundice, which can lead to brain damage, stroke, and even death.
- Twenty-four hours does not provide sufficient opportunity for mothers to learn how to breastfeed (since their milk does not come in until 24 hours after birth) and that early discharge can lead to feeding problems and serious dehydration.
- There are serious but treatable genetic disorders which can not be tested for until the second day of life. Infants who are discharged early may never receive these tests until it is too late to prevent the disorder.
- Both mothers and infants can develop serious infections during the second day following birth. While these infections can be successfully treated if caught in time, they can be fatal if not caught early enough. Physicians argue that if the mother and infant are at home, the symptoms are less likely to be observed and treated promptly.
- Many heart defects can not be observed on the first day of life, but the chances of observing them improve on the second day.

It is important to note that there are no data clearly indicating whether or not early maternal discharge policies actually have a noticeable impact on health outcomes. (While studies have been done on this issue, they all contain methodological flaws or are not relevant to the current debate.) Nevertheless, there is considerable anecdotal evidence suggesting that early maternal discharge policies can result in serious negative health impacts. These "horror stories" have become so widespread that there has been a recent groundswell of public support for legislation on this issue.

In response to this public concern, numerous bills have been introduced at both the state and national level which would guarantee mothers a minimum 48 hour hospital stay (96 hours for a C-section). These bills are discussed below.

Overview of Bills

All of the federal bills, and most of the state bills, require health insurers to provide hospital coverage for mothers and their newborns for up to 48 hours following a normal birth and 96 hours following a Caesarian section. These bills all permit the mother to go home earlier if she would like. However, the bills differ in the amount of authority which they give providers in deciding if and when early discharge can occur. For example, some House bills and several State bills say that the mother can insist on staying for 48 hours even if her doctor does not think it is necessary. On the other hand, the Bradley (S.969) and Solomon/Miller (H.R. 3226) bills state that the "provider, in consultation with the mother" can decide if early discharge should occur. It is unclear whether this language would permit a doctor to discharge a patient early without her consent.

All of the national and state bills require that insurers provide coverage for follow-up care if discharge occurs at less than 48 hours. The bills differ in their level of detail regarding how much care must be provided, by whom, and in what setting.

The bills also differ in the populations they cover. The DeFazio bill applies only to ERISA plans, while the original Miller bill applies only to FEHBP. The Bradley (S.969) and Solomon/Miller (H.R. 3226) bills apply to all privately insured patients (but not to Medicaid patients or the uninsured). State bills generally apply to all members of health plans that are regulated by the state (but not to ERISA plans).

Congressional Action

A. Senate

The first and most prominent of the federal bills was introduced by Senators Bradley and Kassebaum. A revised version, known as Bradley/Kassebaum/Frist, was introduced earlier this spring. This bill was approved by the Labor Committee on a 14-2 vote in late April, and is expected to be brought to the floor under a unanimous consent agreement in the next few weeks. It currently has 39 cosponsors (25 Democrats and 14 Republicans).

B. House

On the House side, there are several bills similar to the Bradley-Kassebaum-Frist bill. While Gerald Solomon (R-NY) and George Miller (D-CA) both introduced their own bills last year, they recently introduced a joint bill which is the companion to the Bradley bill. Reps. Torricelli, Pallone, Klezka, DeFazio, Sanders, and Towns each have their own bill. Rep. Dingell plans to introduce his own bill in the next few days.

State Action

Sixteen States have already passed enacted laws seeking to limit early maternal discharge, and another 25 States are currently considering similar legislation. In addition, 2 states have addressed this issue through regulation rather than statute. However, States that have passed laws are finding that, largely due to the ERISA exemption, the provisions do not apply to roughly half of their privately-insured women. Representatives from these states have called for national legislation to close these loopholes.

EARLY MATERNAL DISCHARGE BILLS

Background

Health insurers managing care are implementing policies that limit payment for hospital stays for new mothers and their infants to 24 hours or less after a normal birth and 48 to 72 hours after a Caesarian birth. These early maternal discharge policies conflict with guidelines developed by pediatricians' and obstetricians' groups, which recommend a minimum 48 hour hospital stay following a normal birth and a 96 hour stay after a Caesarian. While there are no data clearly indicating that insurers' early discharge policies are unsafe, there is considerable anecdotal evidence.

In response to the numerous "horror stories" related to these policies, several bills have been introduced both at the state and national level which would guarantee mothers a minimum 48 hour hospital stay (96 hours for a C-section). The first and most prominent of the national bills was introduced by Senators Bradley, Kassebaum, and Frist last June. This bill was approved by the Labor Committee on a 14-2 vote in late April, and is expected to be brought to the floor under a unanimous consent agreement in the next few weeks. There are several similar bills on the House side, including one sponsored by Gerald Solomon (R-NY) and George Miller (D-CA). Rep. Dingell plans to introduce his own bill in the next few days.

While all of these bills are intended to guarantee mothers and newborns a minimum 48 hour stay (96 for a Caesarian), they do have some subtle yet important differences. The most important of these involves who makes the decision about whether a discharge prior to 48 hours is appropriate. Under the Bradley-Kassebaum-Frist bill, this decision is made by "the provider, in consultation with the mother". In other bills, the mother has the right to insist on a 48-hour stay, even if the doctor disagrees.

Also, note that the Bradley/Kassebaum/Frist bill, and the anticipated Dingell bill, do not apply to Medicaid. (However, it is expected that if the bill were passed, some Medicaid mothers would still receive the option of a 48/96 hour stay. This is because a large percentage of them are covered under private managed care plans, and since these plans will be required to offer 48/96 hour stays to their privately-insured patients they may also choose to offer them to their Medicaid patients as well.)

Meanwhile, 14 States have already passed their own bills similar to the Senate bill, and another 23 States are currently considering similar legislation. However, States that have passed laws are finding that, due to ERISA, approximately half of their mothers are not covered under the State bill.

Administration Position to Date

The Administration has not yet taken a formal position on these bills. When pressed by Congressional staff, we have stated that there are no data clearly indicating that

shorter hospital stays pose increased health risks to mothers and newborns, and thus the issue is still under review. The First Lady has spoken on this issue several times, and while she has not endorsed a bill, she has "expressed concerns" about early discharge and has "spoken in favor of the concept" of the early maternal discharge bills. She has also written a newspaper column arguing for "government safeguards" in this area. (A copy of this article is attached.)

Also, the Maternal and Child Health Bureau of HRSA is currently working on a literature review of the health effects of early discharge, and is hoping to convene a summit this summer to seek to "reach a consensus" on the issue.

Recommended Statement of Views

These bills raise an important issue that goes to the heart of health care -- one which is much more relevant to the average American than partisan wrangling over issues such as MSAs. States and employer health plans should be challenged to address this issue. In the meantime, the Administration and Congress should commit themselves to studying the health impacts of early maternal discharge policies so that clear scientific evidence can be established.



American Association of
HEALTH PLANS

Experience of AAHP Members in Maternal and New Born Care

Harvard Community Health Plan

Boston, MA

In 1992, The Harvard Community Health Plan created a program to enhance prenatal and postpartum care while reducing hospital stays to 24-36 hours for women and babies meeting discharge guidelines, subject to the discretion of the discharging clinicians. Our program features free prenatal classes to prepare women for their delivery and postpartum period. A nurse home visit occurs one to two days after discharge, to examine baby and mother, observe breast-feeding if the mother has chosen to do so, and perform follow-up laboratory tests, if needed. Lactation specialists and consultants are available to assist with breast feeding problems.

At present, approximately half of all women are leaving the hospital at 24 to 36 hours after delivery, which is roughly two-thirds of all women with vaginal deliveries. Nearly all have home visits. Readmission rates for newborns are unchanged from the period prior to program implementation with 1.3 percent readmitted within 7 days of age. A member satisfaction survey found that 87 percent of women with one day length of stay satisfied or very satisfied with their childbirth care.

Henry Ford Health System: "Partnership in Pregnancy"

Detroit, Michigan

Henry Ford Health System in Michigan has developed the "Partnership in Pregnancy" program aimed at educating mothers and families-to-be over the course of the entire pregnancy. Recognizing that there is a great deal to learn, HFHS determined that mothers-to-be would receive "chapters" in a thorough curriculum based on the book "What to Expect When You're Expecting." Each chapter is designed to prompt discussion between mother-to-be and her physician or nurse, and as she is close to delivery, a nurse does a thorough assessment to ascertain if the educational program has been successful and what kind of additional information or help she may need.

In the past, mothers were expected to learn everything they needed to know in the hospital after delivery, but with this approach women are well-prepared before they deliver. There is an additional "chapter" given to the mother in the hospital to prompt discussion with her nurse or doctor about the birth and her newborn, and a final chapter is presented at home, where she is visited twice by a nurse who assesses both mother and newborn. Typically the mother is examined to be sure the uterus is firm and to determine how much bleeding is occurring; the nurse also can check the episiotomy and discuss breast feeding. All home-care visit nurses are specially

credentialed in the care of mothers and babies.

Fallon Community Health Plan: "Happy Homecoming"
Boston, MA

Fallon Community Health Plan implemented its "Happy Homecoming" program in 1994. Fallon's standards are based upon the guidelines of the American College of Obstetricians and Gynecologists, the American College of Nurse Midwives, and the American Academy of Pediatrics. Mothers and newborns who are stable and who have had a normal, vaginal delivery are discharged from the hospital within 24 hours with this thorough follow-up program.

Fallon's program is based on in-depth in-service training for the visiting nurses covering the biopsychosocial needs of mother, infant and family during the postpartum period. Typically, a visit from a nurse is conducted within 24 hours of the family going home from the hospital. A complete physical, emotional, social and home environment assessment is done by the nurse at that time. The option for two other follow-up visits is also available and is decided upon by the family and the nurse that day, based upon the nurse's assessment of the family's needs, educational level and coping skills, and/or the family's perceived need for additional teaching.

In 1994, midwives practicing with Fallon delivered 613 babies, and had only one readmission for a complication that occurred one week after the birth. Since Fallon's implementation of the "Happy Homecomings" program, about 80 percent of non-caesarean section, full-term infants go home after one night in the hospital. Fallon has seen no increase in the rate of readmissions which has remained at about 1.2 percent of discharges. As for patient satisfaction with this program, 95 percent of those who participated in the "Happy Homecoming" program would participate again.

U.S. Healthcare: "L'il Appleseed"
Bluebell, PA

U.S. Healthcare has developed the "L'il Appleseed" program to provide their members with access to quality prenatal, delivery, and postnatal care. The L'il Appleseed program offers classes in childbirth education, prenatal and postnatal exercise, newborn care, infant CPR, parenting education and sibling bonding. While most women only require routine prenatal care, U.S. Healthcare recognizes that some women need more specialized medical attention. The L'il Appleseed program requires all pregnant members to complete a pregnancy risk assessment questionnaire as one method of identifying potential risk factors. If it is determined that specialized care is needed, a case management nurse arranges all necessary specialty care.

The L'il Appleseed program, regardless of length of hospital stay, will arrange a well mom/well baby home nurse visit. During this visit, the nurse will examine both mom and baby and address any questions or concerns of the parents. If necessary, a second home visit will be arranged as well. Since the establishment of the L'il Appleseed Program, U.S. Healthcare has seen a drop in readmission rates.

ISSUE BRIEF

NATIONAL
HEALTH
POLICY
FORUM

Postpartum Stay: A No-Win for Managed Care?

Thursday, February 22, 1996

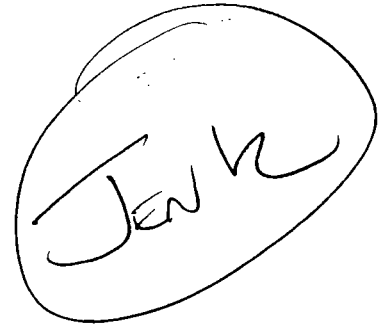
1:00 to 1:30 pm - Refreshments

1:30 to 4:30 pm - Discussion

The Holiday Inn on the Hill

415 New Jersey Avenue, NW

Federal Ballroom



A discussion featuring

David E. Gagnon, M.P.H.
Executive Director
National Perinatal Information
Center

Arnold W. Cohen, M.D.
Corporate Medical Director for
Women's Health Care
U.S. Healthcare

William Oh, M.D.
Sylvia Kay Hassenfeld Professor
of Pediatrics and Chairman
Department of Pediatrics
Brown University School of
Medicine

Judith E. Frank, M.D.
Associate Professor of Pediatrics
Dartmouth Medical School
Chief of the Division of
Neonatology
Dartmouth-Hitchcock Medical
Center

Dean A. Rosen, J.D.
Majority Counsel
Senate Labor and Human Resources
Committee

Registration: Please call **Dagny Canard** at 202/872-1392 as soon as possible.

The
George
Washington
University
WASHINGTON DC

Postpartum Stay: A No-Win for Managed Care?

The length of time women and their newborns stay in the hospital after delivery may seem an unlikely topic for legislative debate, but it ranked high on both federal and state agendas in 1995. Tagged in the press as "early discharge" or "drive-through delivery," the postpartum stay issue centers on mothers and babies who go home—due to the policies of managed care plans—within 24 hours after birth or within 72 hours of a caesarean procedure. HMO stands for "Heave Mom Out," says one cartoon.

Short postpartum stays have led to publicized complaints by mothers and doctors that new moms need more time for rest and establishment of breastfeeding and that their infants may require greater lead time for detection of latent problems. Although evidence of adverse effects is largely anecdotal, the complaints have led Congress and several state legislatures to consider legislation mandating postpartum coverage. The House of Representatives has passed such a provision, and the states of Maryland, New Jersey, North Carolina, and Massachusetts have enacted bills, while New Mexico has taken a regulatory approach. Other bills are pending both in the House and Senate and in various state legislatures. To date, in line with guidelines developed by the American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP), the stay has been set at a minimum of 48 hours of inpatient care after a vaginal delivery and a minimum of 96 hours after a caesarean section for both the mother and her child in uncomplicated cases.

Despite the lack of research data to indicate that short stays are causing harm, mandated coverage arguments are difficult for managed care plans to counter. Plans generally view such coverage as depriving them of a cost-effective method of managing services and expenditures—paradoxically, at a time when majorities in Congress and many statehouses are seeking to downsize government and reduce health cost inflation. With ambulatory services replacing inpatient care for reasons of cost and practice, maternity accounts for the greatest proportion of inpatient utilization and constitutes a large expenditure for plans; short postpartum stay is one way of offsetting that expense. Ironically, hospitals across the country—seeing beds empty as care shifts from the inpatient to the outpatient setting—are keying in on managed care plans' predica-

ment with marketing plans that offer a "free" day of postpartum care to prospective mothers.

The furor over postpartum stay, centered on politically appealing insured mothers and babies, may be indicative of anger over the gradual takeover of health delivery by corporate entities that have wrested control from doctors and, to some extent, patients. The fact that medical organizations such as ACOG, AAP, and the American Medical Association (AMA) favor the bills tends to reinforce this view. Ordinarily resistant to congressional definition and restriction of medical coverage and practice, the medical organizations say that managed care plans have gone too far in overriding the views of doctors and patients on the length of stay issue.

Reflecting the impact of the trend toward managed services on coverage and practice, this Forum session will explore the policy implications of postpartum care. It will examine the nature of postdelivery stays, the relevance of standards of care for mothers and newborns put forth by medical organizations and other groups, the restrictions on coverage imposed or considered by legislators, and the impact on health services and payments. Whenever relevant, it will feature available data on maternal and newborn hospital stays, to probe the role of research in shaping policy.

DECLINE IN LENGTH OF STAY

The United States leads the world in brevity of postpartum stay, although other developed nations are quickly following. When women gave birth to today's

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baby boomers, they stayed in the hospital with their infants for four to five days after vaginal deliveries and one to two weeks after caesarean procedures. Between 1970 and 1992, according to the Centers for Disease Control, median length of stay declined from 3.9 to 2.1 days for vaginal delivery and from 7.8 to 4 days for caesarean.¹ While median figures are not available for 1993 through 1995, ACOG and the AMA indicated at a September 12, 1995, hearing of the Senate Labor and Human Resources Committee that insurers are increasingly limiting coverage for routine deliveries to 24 hours.

"Recently, 1- to 3-day postnatal stays have also become more popular in... countries such as the United Kingdom, Australia, and Scandinavia, where 6- to 10-day hospitalizations had been customary in the past," AAP's journal indicated in 1994.² In Great Britain, where 98 percent of births are under the British National Health Service, "a 24-hour stay is increasingly common, whether the mother wants it or not," according to the December 3, 1995, *New York Times* ("Less Time in Hospitals for Mothers in Britain"). "A recent study in North Essex found that nearly a third of women who gave birth in a six-week period left the hospital in 24 hours or less," sometimes with objections, and most of the rest departed within three days. The system provides midwives to conduct home visits as often as twice a day for the first three days and other workers to stop by as needed over the next few weeks.

In this country, the post-1970 decrease in length of stay was due partly to a new paradigm centered on the positive aspects of childbirth (with less reliance on drugs) and encouragement of breast-feeding. It emphasized that pregnancy and birth are normal, healthy processes and that women who have delivered should not be treated as invalids. It also reflected the notion that healthy mothers and babies should keep hospital use to a minimum, especially because of the risk of nosocomial infections and the difficulty of maternal-infant bonding in an institutional setting. This philosophical shift occurred in non-managed as well as in managed care settings and affected practice patterns in both. It is in line with the position of the American College of Nurse-Midwives (ACNM), which advocates services in "the home, freestanding birth center, or office that augment or substitute for hospitalization."³

There is no doubt, however, that the decrease occurred during a period of heightened policy attention to cost containment, particularly reduction of inpatient hospital utilization. For health plans desiring

to provide cost-effective services, maternity stays offered an opportunity to reduce expenditures while recognizing new practice philosophies, concepts that nonetheless called for a continuum or constellation of postpartum services directed to mothers' and infants' medical conditions and needs.

Those on both sides of the postpartum care debate seem to agree that new mothers need rest and recuperation, support with breast-feeding initiation and follow-through, education about infant care and parenting, and attention to the possibility of immediate anxiety or future postpartum depression. They concur that infants require identification of congenital anomalies, screening for phenylketonuria (PKU) and hypothyroidism and at times for certain other conditions, arrangement for post-discharge screening if infants are discharged within 24 hours, attention to feeding and nutrition problems, and linkage to primary services and immunizations. The debate seems to center on whether the hospital setting is the best site for provision of services, what types of health professionals should provide them, and what the time period should be for optimal fulfillment, as well as who has the ultimate say on these matters—plan or insurer, clinician, patient, or legislator.

ACOG/AAP GUIDELINES

As length of stay declined during the 1970s and early 1980s, the two major medical societies concerned with the issue, ACOG and AAP, reached consensus on optimal length of stay. Based on clinical experience, they said no less than 48 hours. This occurred in 1983, when the two organizations jointly issued *Guidelines for Perinatal Care*, which stated that "a patient who has had an uncomplicated delivery is usually discharged 48 to 72 hours after delivery" and warned that "the patient should not be discharged until the physician is reasonably certain there are no postpartum complications." They did not address caesarean deliveries. In 1988, the two societies issued the second edition of the guidelines, which stated: "When no complications are present, [the postpartum stay] ranges from 48 hours for vaginal delivery to 96 hours for caesarean birth, excluding the day of delivery."

The 1992 edition reiterated the 48- and 96-hour guidelines and added that "early discharge is acceptable as long as certain criteria are met." Among the criteria were uncomplicated pregnancy and delivery, collection of necessary laboratory data for both mother and baby, maternal acceptance of responsibility for the newborn child, and verification of a medical provider for mother

and child, within 48 hours of discharge. Given the current controversy over postpartum stay, the two organizations are reviewing the guidelines.⁴ In June 1995, ACOG called for a moratorium on shorter hospital stays. In October 1995, AAP issued a statement that concluded: "In summary, the fact that a short hospital stay (less than 48 hours of age) for term healthy infants can be accomplished does not mean that it is appropriate for every mother and infant. Each mother-infant dyad should be evaluated individually to determine the optimal time of discharge. The timing of the discharge should be the decision of the physician caring for the infant and not by arbitrary policy established by third-party payers."

Practitioners traditionally have established clinical guidelines addressing health status and made final determinations in individual cases on postdelivery care of mothers and newborns. These policies worked well under fee-for-service medicine and loosely managed financial arrangements. However, they seem less certain as health plans take on financial risk for providing services to their enrollees and develop their own standards. Practitioners, whether because of administrative pressures or financial disincentives (or both), seem to have less leeway to deviate from the norms. This seems to be so across the continuum of care but is most poignantly joined in the case of birthing center and nursery.

PRESS REPORTS AND LEGISLATIVE RESPONSES

Going back to the days of Boss Tweed, the little guy—or the little lady—fighting the big organization has meant good press and good politics. During the past decade, as managed care plans have grown and spread, citizens have sought TV cameras and newspaper headlines to get coverage for bone-marrow transplants and other procedures that they had been refused for reasons of cost or efficacy. While such denials have garnered media attention during the past year or so, the early-discharge issue has clearly acquired the most notoriety.

Indelible images have drawn attention to the issue. The images include a television interview of a mother in New Jersey whose baby died after he had returned home because a birth defect had not been detected, pictures of 15 babies—one shaded out—on the cover of the *Washington Post* "Health Section,"⁵ and headlines such as "Broad Coalition Fights Insurer Limits on Hospital Maternity Stays: If Someone Says 'Push,' It May Be to Get a Mother 'out of the Hospital.'"⁶

Such images have spurred a half-dozen pieces of legislation in Congress as well as adoption of limits by five states and consideration of legislation by at least six others.

The federal measures include the following:

- The text of H.Con.Res. 79, introduced by Reps. Bernard Sanders (I-Vt.), Peter A. DeFazio (D-Ore.), and George Miller (D-Calif.), was attached to H.R. 2127—the Departments of Labor, Health and Human Services, and Education appropriations bill—prior to its August 1995 passage by the House. The resolution expresses the sense of Congress that DHHS' Maternal and Child Health Bureau collaborate with other organizations to encourage studies on postpartum stay; that decisions on postpartum stay be left to doctors and patients; and that hospitals, health insurers, health service organizations, and health plans abide by ACOG and AAP 48- and 96-hour guidelines.
- H.R. 1936, introduced by Miller and 20 cosponsors, would apply the 48- and 96-hour limits to Federal Employee Health Benefit Plan contracts.
- H.R. 1948, introduced by Miller, and S. 969, introduced by Sens. Bill Bradley (D-N.J.), Nancy Kassebaum (R-Kans.), and John D. Rockefeller IV (D-W.Va.), are companion House-Senate bills that would require health plans to provide coverage for inpatient care in a health care facility to new moms and babies for at least the 48- and 96-hour periods after delivery if such care is deemed medically necessary by the attending physician or is requested by the mother. H.R. 1968, introduced by Rep. Gerald B. H. Solomon (R-N.Y.), is identical to H.R. 1948/S. 969.
- H.R. 1950, introduced by Rep. Frank Pallone Jr. (D-N.J.), is identical to H.R. 1948/S. 969, with the exception that it would change the effective date from immediately upon enactment to a year after enactment.
- H.R. 1955, introduced by DeFazio and 22 cosponsors, would amend the Employee Retirement Income Security Act of 1974 (ERISA) to apply the 48- and 96-hour limits to health plans subject to ERISA. It would permit shorter stays if postpartum care meets medical criteria recommended by ACOG and AAP.
- H.R. 1970, introduced by Rep. Robert G. Torricelli (D-N.J.), would require insurers to cover 48- and 96-hour postdelivery stays and would provide for civil monetary penalties if they did not.

Several states have adopted provisions that limit health plans (other than those that are self-insured and thereby protected by ERISA). The states include the following:

- Maryland—Legislation (S.B. 677 and H.B. 888) was enacted May 25, 1995, applying the 48- and 96-hour ACOG-AAP guidelines to HMOs. If a newborn meets the ACOG-AAP medical stability criteria and the HMO authorizes one home visit for newborn screening, the HMO may authorize a shorter stay.
- New Jersey—Legislation (A.B. 2224) became law on June 28, 1995, prohibiting individual and group health contracts from limiting coverage to less than the 48- and 96-hour stays recommended by ACOG and AAP. The limits can be waived for plans that provide postdelivery home care (at least three home visits) unless the mother requests the full stay or it is deemed medically necessary by the attending physician.
- North Carolina—Legislation (Chapter 345, G.S. 58-3-170) went into effect October 1, 1995, that requires organizations providing health plans to follow the 48- and 96-hour limits.
- Massachusetts—A bill (S. 2057) that will go into effect on March 1, 1996, was signed into law November 28, 1995, to impose the 48- and 96-hour limits on all health plans except those that are self-insured.
- New Mexico—A state commission adopted a rule November 30, 1995, establishing minimum 48- and 96-hour limits, as well as coverage for longer stays if medically necessary and for two to three home visits.⁷

California, Colorado, Delaware, Illinois, New York, Pennsylvania, and Rhode Island all have bills pending to place minimum time limits on postpartum stays. Those in California, Delaware, Illinois, and Pennsylvania follow the ACOG-AAP recommendations. California's provides flexibility for a medical group of treating physicians to apply its own guidelines. Colorado's reinforces physician autonomy (a treating physician would not have to request authority for continued coverage beyond the 48- and 96-hour periods). New York's would follow the 48-hour guideline for vaginal deliveries and set 220 hours for caesareans. Rhode Island's legislature scaled back its bill to call for a special legislative commission to report findings and recommendations by April 3, 1996. Although the Kentucky legislature had a bill on

its docket last summer that would have set voluntary coverage of 72 hours for postpartum care, it did not consider it; legislation is expected to be reintroduced during the body's 1996 session.⁸

Because the state provisions are limited in purview, the federal legislators who are sponsoring legislation contend that postpartum stay should be a federal matter. State provisions do not apply to coverage for all mothers within their borders. They do not extend, for instance, to health policies written in other states (for instance, residents of New Jersey who have coverage through New York or Pennsylvania employers). They also do not extend to self-insured employers who are regulated under ERISA. Extension under ERISA would require an exemption, which is not part of coverage legislation now pending in Congress.

PRACTITIONER, PLAN, AND HOSPITAL PERSPECTIVES

As reflected in their testimony on H.R. 1948/S. 969 and other statements, ACOG and AAP have backed legislative approaches. So has the AMA, although it would like three additions: a prohibition on monetary incentives for new mothers to leave the hospital before the minimum time limits, a ban on managed care plans' penalizing participating physicians who do not release patients within the limits, and expansion of the legislation to self-insured plans. Supportive of state actions, it thinks a federal approach more timely.⁹

The ACNM, on the other hand, has opposed the legislation, because it is against "any arbitrary time limits on inpatient care." The college also objects to the legislation's lack of recognition of "the legal scope of practice of providers other than physicians."¹⁰

The Group Health Association of America (GHAA) also is against the legislation, because it focuses "on *where* care is provided" rather than "*what* care is appropriate and *how* it can best be provided for a variety of women." Objecting to the establishment of "an inflexible statutory standard for an exact number of hours for a hospital maternity stay," the association points to the need for "integration of prenatal, hospital, and postpartum care" to allow "clinicians to identify which components of care traditionally provided in the hospital can be accomplished more appropriately in other settings, both before and after childbirth." It indicates that HMOs use prenatal education, maternal and infant integrated care plans, breast-feeding support services, and postpartum home visits to achieve comprehensiveness.¹¹

These approaches are used by organizations such as Harvard Community Health Plan (HCHP), Kaiser Permanente, and U.S. Healthcare. HCHP has a program to reduce postpartum stays to 24 to 36 hours (subject both to guidelines and discharging clinicians) that includes prenatal classes, home visits by nurses, and consultations with lactation specialists. Half of women who give birth under the plan (two-thirds of those with vaginal deliveries) leave the hospital 24 to 36 hours after delivery and most of the new mothers have home visits. The newborn readmission rate is 1.3 percent within 7 days of age, the same as before the program was instituted. According to a member satisfaction survey, 87 percent of women with a 24-hour stay were satisfied or very satisfied with their care.¹²

Kaiser Permanente has maternal and infant outcome guidelines that allow for "individual decisions based on the needs of each patient." The average postdelivery stay for an uncomplicated vaginal delivery is 24 to 36 hours. Kaiser stresses prenatal care beginning in the first trimester. It also emphasizes certain postpartum services: confirmation, prior to discharge, of an appointment with a physician (for initiation of infant immunizations and follow-up tests); home visits by nurses; and assistance with breast-feeding and other nutritional problems plus well baby care, as appropriate.¹³

Patient satisfaction surveys indicate that 91 percent of new mothers in Kaiser's Northeast Region (Connecticut, western Massachusetts, and Westchester County in New York) were very satisfied or satisfied with their experience. In Ohio, members and physicians in a Maternity and Newborn Home Visit Program provided a 99.8 percent approval rating. In Sacramento, 65 percent of respondents said that the discharge time was appropriate, while 20 percent complained that it did not occur early enough.¹⁴

At an October 1995 meeting of the National Perinatal Information Center on short-stay hospitalization, Arthur Cohen, M.D., U.S. Healthcare's corporate medical director for women's health, stressed that managed care plans must use approaches that spend health dollars widely. Saying that inpatient maternity is a "significant revenue center," he indicated that the goal is to decrease cost while maintaining quality of care. Questioning how it is possible to cover all payers through legislation, he stated that a great deal of clinical experience and discussion, education, and program development and evaluation stands behind his organization's maternity and pediatric programs.

Cohen described a U.S. Healthcare program that had covered 35,601 deliveries since 1993. Of that number, 24,691 deliveries resulted in postpartum stays of 24 to 48 hours. Of the 35,601, 0.46 percent of the mothers were readmitted to the hospital within 30 days of delivery, as were 0.88 percent of the babies (most often for jaundice). Prior to 1993, the readmission rates were higher, 0.79 percent and 1.03 percent, respectively.

For their part, some hospitals are jumping into the postpartum stay debate by offering a free night to prospective mothers, sort of a "stay one night, get the second free" lure to increase utilization. Others, according to the American Hospital Association (AHA), are offering special early-discharge programs that incorporate home visits for follow-up care: Doylestown Hospital's "Baby Bracelets Program" (Pennsylvania), Fairfax Hospital's "Home Tomorrow Program" (Virginia), Intermountain Health Care System's "Short-Stay Maternity Care" (Utah), and Kapi'olani Medical Center for Women and Children's "Stork Express Program" (Hawaii).¹⁵

INFLUENCE OF RESEARCH DATA

Through the leadership of DHHS' Maternal and Child Health Bureau (MCHB)—with contributions from the National Perinatal Information Center and medical school and HMO researchers—available research on the effects of short postpartum stay has been collected and examined at national conferences over the last year or so. The research, however, is inconclusive relative to adverse effects of short postpartum stay. Questions about the availability, accuracy, and validity of data on such stays abound in the literature that has been compiled.

An MCHB conference held March 31 through April 1, 1995, resulted in a summary document, *Early Hospital Discharge: Impact on Newborn Screening*,¹⁶ that cited various studies. Because researchers have been most concerned with newborn conditions that "rely on the accumulation of a specific metabolite for their detection," they have concentrated in early-discharge surveys on PKU, homocystinuria, and maple syrup urine disease rather than on conditions such as sickle cell disease, cystic fibrosis, and muscular dystrophy that "rely on the quantitative measurement of specific enzymes."

The Council of Regional Networks for Genetic Services (CORN) has compiled state and territorial newborn screening data since 1987. Its report on second testing of newborns for certain disorders (required by

certain states in part due to early discharge) raises concerns about this focus. CORN's "review of national PKU statistics for 1987" found "only 2 cases of PKU detected of 536,689 infants screened by a second test in 13 states" and "no cases of PKU for 618,075 infants screened a second time in 1988." Contending that it would have cost over \$7 million to detect a single case of PKU through second screening, researchers raised questions about, but gave no recommendations on, the cost effectiveness of such a policy.

California is generally recognized as having the most extensive newborn screening experience and emphasizing technological innovation in screening methods. Data from the California Newborn Screening Program on detection of PKU showed that, of more than 7 million newborns screened (some less than 24 hours), one case was missed. A comparison of data both from Massachusetts and a national survey of newborn screening programs indicated that 90 percent of states recommend collection of second specimens for PKU screening within two weeks of age (50 percent of states say "day two" and 30 percent state "one week"). Its conclusion was equivocal, however: "In the long run, current early-discharge practices may prove to be short sighted for health insurers and others involved if these practices cause some newborns with disorders to go undetected during the optimal treatment period."

In Maryland, according to the MCHB document, postpartum stay declined from 2.29 to 1.78 from 1990 to 1992. During the same period, the number of incomplete and missing metabolic screening samples from newborns rose from 12 percent to 29 percent, according to the Newborn Screening Program of Maryland. A survey of 36 Maryland hospitals and 12 HMOs showed that 10 of the hospitals as well as 10 of the HMOs had scheduled appointments for newborn care with designated providers prior to discharge.

Several studies on maternal and newborn hospitalization had mixed results. Paula Braveman and other researchers compiled information for MCHB on maternal and infant outcomes relative to discharge with and without follow-up services, postpartum home visiting, and rehospitalization. Few in number, most outdated, and some deemed not statistically valid due to sample size, the studies offered conflicting results.

Two studies released in 1995 indicated increased risk for newborns discharged within 48 hours of birth. A study conducted by Judith E. Frank, M.D., at Dartmouth-Hitchcock Medical Center on 15,000 infants discharged in 1993 from 26 New Hampshire

hospitals showed that of 3,500 infants discharged early, "the percentage of readmissions for the early discharge group was 1.16 percent (compared to 1.09 percent of those discharged after 48 hours), and 2.04 percent of the early discharge group were seen in the emergency room (compared to 1.17 percent of those discharged after 48 hours)."¹⁷ However, early discharge was demonstrated to be cost-effective: "the cost saving from early discharge in New Hampshire was \$7.26 million dollars in 1993," according to New Hampshire Hospital data. Frank concluded: "The key to insuring both cost effectiveness and optimal care for mothers and infants sent home at less than two days of life should include appropriate home care by trained health professionals."¹⁸

HCIA, Inc., of Baltimore looked at babies delivered by caesarean section. The data base for the study—one-fourth of all childbirth discharges in the United States in 1993—was drawn from more than 10 million discharges from public and proprietary hospitals, as well as individual and group hospital information.¹⁹ Of those caesarean-delivered babies who stayed in the hospital for only 24 hours, the hospital readmission rate was 4.3 percent, generally due to infections acquired during birth or conditions related to preterm birth. Study investigator David Foster, Ph.D., said, however, that "it's still cheaper for hospitals to discharge infants early and go ahead and allow the 4.3 percent to be readmitted."

Cost effectiveness seems to depend on effective follow-up programs, generally through defined care plans incorporating home visits, lactation support, and subsequent newborn screening. As Richard Marshall, M.D., of the Harvard Community Health Plan indicated at the October 1995 National Perinatal Information Center conference, the goal is to achieve cost effectiveness while improving quality of care, often by providing support to new mothers at home. Stressing the importance of individual criteria, he said that teenage mothers without support systems, non-English-speaking immigrants, diabetic moms, mothers with no or difficult access to emergency care, and mothers with psychosocial and/or substance abuse problems pose special challenges to early-discharge goals.

THE FORUM SESSION

This Forum session will focus on several key questions:

- Why have the House and Senate and state legislatures become involved in coverage for postpartum stay?

- Is postpartum stay primarily a coverage issue? A practice issue? A continuum of care issue?
- What implications does mandated postpartum coverage have for Medicaid managed care programs?
- What are the implications of ERISA for federal and state legislative efforts to define postpartum stay coverage? If mandated coverage leaves out women and infants covered by self-insured plans, how effective can it be? Also, what is the impact of coverage gaps affecting women and infants in plans that cross state lines?
- Is physician autonomy an issue? How much autonomy do physicians have in determining postpartum stay? Do physicians in managed care arrangements have less autonomy in determining length of stay than those who are not? Does—or can—legislation reinforce or hinder physician autonomy in governing practice patterns?
- What is the role of organized medicine's practice guidelines relative to managed care plans' outcomes strategies and governmental entities' legislative and regulatory provisions?
- Does the postpartum stay issue represent rebellion by physicians and nurses, as well as consumers, against managed care? Is legislation to define coverage a first step in setting limits on managed care plans' practices?
- What is the position of employers, both those who are self-insured and those who are not, on mandating postpartum stay?
- How effective are programs that combine short postpartum stays with home visits and other supportive services? How do such programs address concerns raised by medical societies (especially ACOG and AAP) and consumers?
- What is the role of research in influencing the debate on postpartum stay? What attempts are being made to bring together managed care plans' studies and surveys with those of government and academia on the postpartum stay issue?
- What is the role of the press in shaping postpartum stay as a consumer and legislative issue?

David E. Gagnon, M.P.H., executive director of the National Perinatal Information Center, will open the session with an overview of health policy issues centered on postpartum stay. A former president of the National Perinatal Association and a founding member of the AHA Section for Maternal and Child

Health, he has 25 years' experience in health care, having been a hospital administrator, perinatal care leader, and author of numerous publications on perinatal issues.

William Oh, M.D., chair of the American Academy of Pediatrics' Committee on Fetus and Newborn in 1994 and 1995, will discuss the ACOG/AAP guidelines and physician practice and autonomy issues relative to postpartum stay. He practices in Providence, where he is Sylvia Kay Hassenfeld Professor of Pediatrics and chairman of the Department of Pediatrics at Brown University School of Medicine. He also is pediatrician-in-chief at Rhode Island Hospital and medical director of Hasbro Children's Hospital.

Dean A. Rosen, J.D., will examine legislative approaches (emphasizing federal initiatives) to coverage for postpartum stay. He is the health policy coordinator and majority counsel to the Senate Labor and Human Resources Committee, which he previously served as minority counsel. He also was labor and judiciary counsel to Sen. Dave Durenberger (R-Minn.). Before he joined the Senate, he was associated with the law firm of Dow, Lohnes & Albertson.

Arnold W. Cohen, M.D., will address concerns of managed care relative to postpartum stay. Corporate medical director for women's health care at U.S. Healthcare, he also is a clinical professor of obstetrics and gynecology (OB/gyn) at Jefferson Medical College. A prolific writer of articles, abstracts, and books in his field, he was the director of both obstetrics and maternal-fetal medicine at the Hospital of the University of Pennsylvania before he joined U.S. Healthcare. He has participated extensively in OB/gyn specialty committee activities.

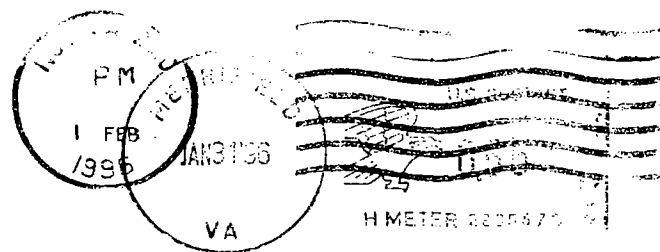
Judith E. Frank, M.D., associate professor of pediatrics at Dartmouth Medical School and chief of the Division of Neonatology at Dartmouth-Hitchcock Medical Center, will explore the significance of research to postpartum stay policy. She came to Dartmouth in 1974 as an assistant professor of maternal and child health. Earlier, she held several posts at Vanderbilt Clinic, Columbia College of Physicians and Surgeons. Active in research and policy issues, she is co-director of the Vermont-New Hampshire Perinatal Program.

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issue-Excerpts from ACOG & AAP's
Guidelines for Perinatal Care
referenced in our statement

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POSTPARTUM AND FOLLOW-UP CARE ■

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.

During the postpartum hospital stay, health care personnel can provide the mother with professional assistance when she is most likely to be uncomfortable and can help her to anticipate how she may feel once she is home. The new mother may be unsure of the normal physical changes that occur after delivery and of her ability to care for the newborn. The mother should be evaluated when she is with her infant(s) to identify problems she is having so that appropriate instructions with education can be provided prior to discharge. Prenatal instructions given to prepare the family for the infant's care at home should also be reinforced.

Both in-hospital and community agencies may assist the family. Information on public and private groups that give assistance and circumstances under which these organizations may be asked for assistance should be available in the hospital. Various sources may include the following:

- The in-hospital social service department should be an integral part of the interdisciplinary effort to coordinate hospital and discharge activities, to obtain public or private assistance, and to render psychosocial support.
- Members of the Visiting Nurses Association may be available to visit the home to assess the parents' child-rearing skills, the home environment, maternal emotional stability, and infant status and development. Under the physician's direction, these nurses may administer drugs or provide other types of therapy.
- Certain groups may be available to lend support and provide education on special activities (eg, breast-feeding).

Discharge

Prior to discharge a discussion should be held between the physician or another health care provider and the mother (and father, if possible) about

any expected perinatal problems and ways to cope with them. Plans for future and immediate care, as well as instructions to follow in the event of an emergency or complication, should be discussed.

Maternal Considerations

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

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

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

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

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

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

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

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

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

Early Infant Discharge and Follow-up

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

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

- Hemoglobin or hematocrit and blood glucose determinations as clinically indicated
- Screening tests required by law

- Initial hepatitis B vaccine should be administered.

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

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

High-Risk Infants

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

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

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LEVEL 1 - 1 OF 2 STORIES

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May 5, 1995

SECTION: Vol. 44 ; No. 17 ; Pg. 335; ISSN: 0149-2195

LENGTH: 1323 words

HEADLINE: Trends in length of stay for hospital deliveries - United States,
1970-1992.

BODY:

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 .

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 dagger , other private insurance, Medicaid, and self-paying) in 1977. From 1977 through 1992, the average length

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of stay decreased for these payment groups; decreases ranged from 35% to 38% for vaginal deliveries and from 32% to 47% for cesarean deliveries.

* Numbers from other racial/ethnic groups were too small for reliable analysis. dagger use of trade names and commercial sources is for identification only and does not imply endorsement by the Public Health Service of the U.S. Department of Health and Human Services.

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 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.

Morbidity and Mortality Weekly Report, May 5, 1995

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2. Morbidity and Mortality Weekly Report, May 5, 1995, Vol. 44 ; No. 17 ; Pg. 335; ISSN: 0149-2195, 1323 words, Trends in length of stay for hospital deliveries - United States, 1970-1992., IAC 16950892
3. Morbidity and Mortality Weekly Report, May 5, 1995, Vol. 44 ; No. 17 ; Pg. 337; ISSN: 0149-2195, 1363 words, Deaths from melanoma - United States. 1973-1992., IAC 16950894
4. Morbidity and Mortality Weekly Report, May 5, 1995, Vol. 44 ; No. 17 ; Pg. 347; ISSN: 0149-2195, 2252 words, Reptile-associated salmonellosis - selected states, 1974-1995; includes related article on preventing transmission from reptiles to humans, IAC 16950896
5. Morbidity and Mortality Weekly Report, May 5, 1995, Vol. 44 ; No. 17 ; Pg. 351; ISSN: 0149-2195, 99 words, Monthly immunization table., IAC 16950898

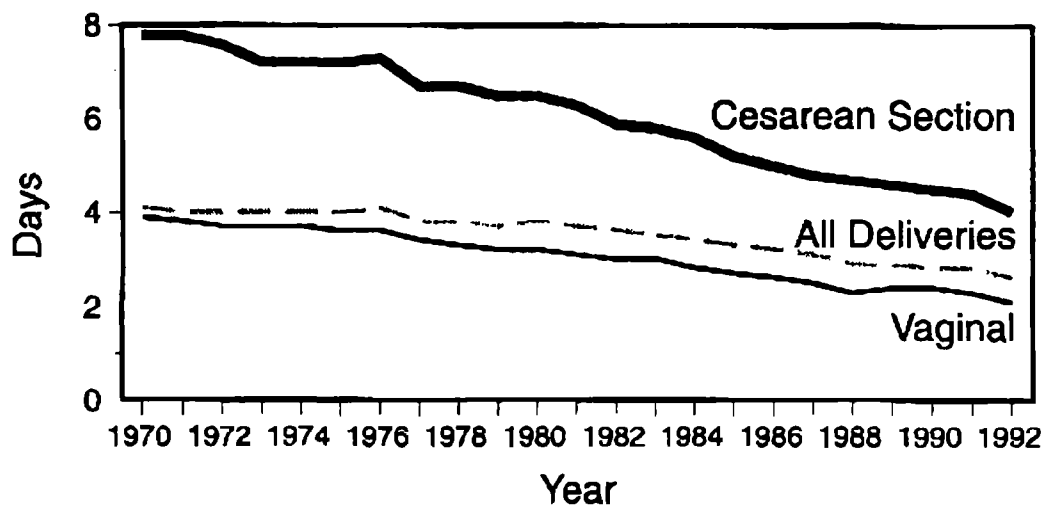
Trends in Length of Stay for Hospital Deliveries — United States, 1970–1992

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



Early Discharge: Outcomes of Primiparas and Their Infants

SISTER CORINNE M. LEMMER, RN, MS

The effects of early hospital discharge on maternal and infant outcomes were studied by interviewing 21 primiparas choosing early discharge and 21 primiparas with hospital stays longer than 24 hours. Other than supervision of infants for jaundice, conditions requiring medical intervention were not linked to time of discharge. No significant differences occurred in intensity of concerns at one week postpartum. The most intense concerns of primiparas, regardless of length of stay, focused on maternal body image, infant care and behavior, and recognition of signs of illness. Women choosing early discharge had more social support at home following discharge. These findings support the need for greater nursing intervention during the puerperal period and for further research evaluating early discharge programs.

During the past decade, a significant trend has been a shorter length of hospital stay for postpartum mothers. As increasing numbers of women choose early discharge, nurses are concerned as to whether or not early hospital discharge is appropriate for all women, especially primiparas, and whether or not postpartal teaching is effective and directed towards the real needs of new parents.

Studies conducted during the mid-1970s and 1980s showed that early discharge was relatively safe for the majority of low-risk women,¹⁻⁵ that consumers were satisfied with early discharge,^{1,2,4,5} and that early discharge was economically feasible for institutions and parents.^{2,4-6} Although many of the women in these studies were of mixed parity, little attention was paid to the outcomes of primiparas as a select group or to the psychosocial experiences of the women. In the early discharge programs described, nurses in expanded roles were often actively in-

involved, both prenatally and postpartally, in clinics, hospitals, birthing centers, and homes. These nurses provided screening, education, and anticipatory guidance to those women opting for early discharge.

Studies of new mothers during the puerperal period have revealed physical, social, and emotional concerns.⁹⁻¹⁷ Items of concern most often identified in these studies focused on the infant—feeding practices, physical care, crying, behavior, and normal growth and development—and the mother—fatigue, loss of sleep, and loss of time to be alone or with one's spouse. Primiparas were shown to have a greater number of concerns than multiparas.¹⁶⁻¹⁸

PURPOSE

A study was conducted to identify the impact early discharge has on the outcomes of primiparas and their infants. A hypothesis was tested to see if a significant difference would occur between the morbid-ity rates of healthy primiparas and their healthy term infants discharged within 24 hours of delivery and

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Table 1. Criteria For Participation in Study

Primiparas	Infants
Gravida 1, abortion 0	38–41 weeks' gestation
No history of infertility	2500–4500 g
20 years of age or older	Documented normal physical exam
Vaginal delivery	Stable temperature
Temperature less than 38.0°C	Demonstrated ability to feed (i.e., suck and swallow mechanisms intact)
No postpartal hemorrhage	
Blood pressure less than 140/90 mmHg	
Able to read and speak English	

the morbidity rates of healthy primiparas and their healthy term infants discharged more than 24 hours after delivery. The following research questions were posed: 1) are the postpartum concerns of primiparas discharged within 24 hours of delivery and the postpartum concerns of primiparas choosing later discharge different? and 2) why do women choose early discharge?

Conceptual Framework

The developmental tasks concept provides a frame of reference for the study. A review of the nursing literature^{17,19–24} delineates five main developmental tasks that women undertake in the transition to parenthood: 1) physical restoration; 2) integration of the pregnancy, labor, and delivery experiences; 3) relinquishment of expectations about the fantasized child, and acceptance of the real child; 4) assumption of the care-taking role; and 5) redefinition of relationships within the family. The main concerns new mothers experience are related to these developmental tasks.

Definition of Terms

Terms used in this study are defined as follows.

- Early hospital discharge refers to release from the hospital within 24 hours of delivery.
- Maternal and infant outcomes are defined as the states of physiologic and psychosocial well-being measured during the puerperal period, six to eight days after delivery.
- Morbidity is defined as the incidence of physiologic conditions requiring medical supervision or intervention, as obtained through a history and physical assessment of mothers and infants.
- Concerns refers to worries, questions, and focuses interest or intense preoccupation related to the postpartal period. Concerns are classified in categories

relating to self, infant, father of the infant, family unit, and community.

METHODS

Sample

The study sample was chosen from the population of healthy primiparas who elected to deliver at a large metropolitan hospital in a southwestern city between September 15 and December 15, 1984, and their healthy term infants. All mother-infant dyads were required to meet study criteria before hospital discharge (Table 1).

Twenty-one of 35 eligible primiparas choosing early discharge and their infants comprised the short-stay group. Convenience sampling was used to select a comparison group of 21 primiparas who delivered during the same time period who chose to stay in hospital longer than 24 hours after delivery. This long-stay group was composed of the first 21 women who met eligibility criteria and agreed to participate in the study.

Procedure

Women were either met in the hospital before discharge or contacted by telephone in their homes. These women were asked to participate in a study seeking information on how new mothers and their infants get along after going home from the hospital. A home visit was made six to eight days after delivery. At this time, study questionnaires were completed and assessments of maternal and infant well-being were conducted through interviews with mothers, using health-history forms developed for use in the study. Any abnormal findings were followed-up by physical examination. One week postpartum was chosen as the point of data collection because earlier research had used one of the data collection instruments within this time interval.¹¹ All data were collected by the investigator, a graduate student in a perinatal clinical nursing specialty program.

Instruments and Analysis

Infant and maternal physical assessment forms were developed by the investigator based on standard postpartal and infant assessment formats. Normal parameters for each item in the review of systems were established. Face validity of the instruments was ascertained by submitting the forms to two maternal-child clinical nurse specialists. Responses to the review of systems were recorded as

Table 2. Age and Years of Education

	Short-Stay Group (N = 21)			Long-Stay Group (N = 21)			t	p
	Range	Mean	SD	Range	Mean	SD		
Age	20-32	23.81	3.25	20-35	25.95	4.39	1.75	NS
Education	12-17	13.62	1.69	9-17	14.24	1.97	1.06	NS

SD: standard deviation.

normal or abnormal, and the number of abnormal findings was summed for each subject.

A questionnaire was devised to elicit demographic data and information about social support, prenatal education, reasons for choice of length of stay, and follow-up services received after discharge. Independent *t*-tests and chi-square analyses were used to determine any significant differences in observations between groups.

A maternal concerns questionnaire* was completed by the subjects to test differences between groups in concerns at the time of data collection.¹¹ This 46-item instrument had been previously used to test changes in concerns of primiparas from the third postpartum day to one week after discharge. The tool was divided into categories of physical concerns relating to self (10 items); emotional concerns about self (8 items); concerns relating to the infant (11 items); concerns relating to the infant's father (6 items); concerns relating to the family unit (4 items); and concerns relating to the community (7 items). Internal consistency for the tool was demonstrated in the earlier study by a Cronbach's alpha coefficient of .97.²⁵ Intensity of concerns was determined by asking women to rank each item of concern as *no*, *little*, *moderate*, or *much* concern. In both long-stay and short-stay groups, total scores of all items of concern were calculated. An independent *t*-test was used to detect any difference between mean scores of the two groups.

RESULTS

Length of stay ranged from 12 to 24 hours for the short-stay group and 36 to 80 hours for the long-stay group. Seven women in the short-stay group were discharged at 12 hours postpartum; 14 went home between 21 and 24 hours postpartum. The median length of stay for the long-stay group was 48.4 hours.

Both groups were similar with respect to age, edu-

cation, marital status, race, insurance coverage method of infant feeding, and attendance at childbirth education classes (Tables 2 and 3). The majority of women were employed outside the home during their pregnancy. For both groups, median family income was between \$20,000 and \$24,999, and ranged from less than \$8,000 to greater than \$30,000.[†]

Medical Outcome

Analysis of maternal physical assessments demonstrated no significant difference between groups with respect to the number of women reporting complications (Table 4). Of the seven conditions requiring medical intervention among the 42 women, none

† Data on family income was collected by having women select a range of income rather than a specific number. Therefore, *t*-tests were not done.

Table 3. Race, Marital Status, Insurance Coverage, Attendance at Prenatal Education Classes, Method of Feeding Infant

	Short-Stay Group (N = 21)	Long-Stay Group (N = 21)	χ^2	p
	Frequency	Frequency		
Race				
Caucasian	21	20		
Hispanic	0	1		
Marital status				
Married	21	20		
Not married	0	1		
Had insurance for coverage of stay	14	19	2.26	NS
Attended prenatal education classes	20	17	.91	NS
Method of feeding				
Breastfeeding	20	21		
Bottle	1	0		

* Establishment of consistency of the maternal concerns tool was waived by the author's thesis committee.

Table 4. Morbidity Among Women

Complications	Short-Stay Group (N = 3)	Long-Stay Group (N = 4)
Urinary tract infection	—	2
Postpartum hemorrhage	—	—
Retained placental fragments, day 6)	1	—
Abdominal pain, possible thrombophlebitis	1	—
Failed milk production	1	—
Fungal breast infection	—	1
Pain, lower quadrant	—	—
Pain, unknown etiology	—	1
Totals	3	4

$\chi^2 = .16; p > .05; NS.$

could be directly attributed to time of discharge. Fourteen women in the long-stay group reported feelings of fatigue during the first week after delivery. This compares with seven women in the short-stay group, a finding which approaches significance ($\chi^2 = 3.43, p = .064$).

Chi-square analysis of the number of infants with complications revealed a significant difference between the two groups (Table 5). Seven of the 21 infants in the short-stay group required serum bilirubin determinations on an outpatient basis as compared with one infant in the long-stay group. This was a significant difference ($\chi^2 = 3.86, p < .05$). Phototherapy was initiated in four cases.

Fourteen women in the short-stay group and nine women in the long-stay group contacted their infants' health-care providers with questions regarding their infants' health (Table 6). Items in the list of maternal ques-

Table 5. Morbidity Among Infants

Complications	Short-Stay Group (N = 9)	Long-Stay Group (N = 3)
Jaundice	7	1
Supervision only	3	—
Supervision + treatment	4	1
Inadequate milk supply requiring change in feeding	1	1
Ear infection	1	—
Hypothermia	—	1
Lymph node enlargement (groin)	—	1
Totals	9	4

$\chi^2 = 4.2; p < .05.$

Table 6. Reasons Given by Mothers for Contacting Infants' Health-Care Providers

Reason	Short-Stay Group (N = 14)	Long-Stay Group (N = 9)	Total (N = 23)
Jaundice	7	1	8
Feeding questions	4	1	5
Crying	1	3	4
Cord care	1	1	2
Normal number wet diapers	1	—	1
Normal consistency of stools	1	—	1
Ear infection	1	—	1
Question about side effect of maternal medication in milk	1	—	1
Uric acid stains on diaper	—	1	1
Vaginal discharge of female infant	—	1	1
Hypothermia	—	1	1
Possible upper respiratory infection	—	1	1
Choking/cyanotic episode	—	1	1
Totals	17	11	28

tions that are clearly abnormal states (i.e., jaundice, ear infection, abnormal temperature) were removed from the table. The remaining questions deal with the ability to distinguish what is normal infant health and behavior from what is abnormal. Women contacted their health-care providers less frequently with questions about their own health (Table 7).

Maternal Concerns

When mean scores for the total 46 items of concern were compared, no significant difference between

Table 7. Reasons Given by Women for Contacting Maternal Health-Care Provider

Reason	Short-Stay Group (N = 4)	Long-Stay Group (N = 6)	Total (N = 10)
Urinary tract infection	—	2	2
Pain medication refill	—	2	2
Constipation	—	2	2
Postpartum hemorrhage	1	—	1
Possible thrombophlebitis	1	—	1
Fungal breast infection	—	1	1
Left lower quadrant pain	—	1	1
Failed milk production	1	—	1
Hemorrhoidal discomfort	1	—	1
Totals	4	8	12

groups was obtained. Of greatest intensity to women in both groups were concerns relating to the infant and to the physical needs of the mother (Table 8). More than half of the women in both groups expressed moderate or much concern about being a good mother, recognizing signs of illness in their infants, return of their figures to normal, and exercise. Women in both groups expressed many questions about breastfeeding at the time of the interview and this is reflected in their concerns about infant feeding and breast soreness. Fewer women expressed intense concerns relating to items pertaining to relationships with their husbands, the family unit, and the community. Focus of concerns regarding work often centered on finding suitable child care services.

Factors Motivating Choice of Early Discharge

All subjects in the study knew that discharge from the hospital at less than 24 hours was an option. Reasons most frequently identified by women in the short-stay group for choosing early discharge included comfort, financial concerns, and the recognition that a healthy mother and infant were as safe at home as in the hospital. In contrast, women in the long-stay group listed concern for the mother's health and recovery, the need for rest, and recognition of the need to become acquainted with and learn about their first infants as the reasons for opting for a longer hospital stay.

Other Findings

When asked to identify if help in the home was available following discharge, all but one woman reported at least one source of support. Women in the short-stay group reported more sources of support, specifically from their husbands, mothers, and mothers-in-law (Table 9).

DISCUSSION

Findings of this study supported those reported in the literature that early discharge is medically safe for low-risk, middle-class women and their infants. This study indicated that early discharge does not have adverse effects in terms of outcomes for primiparas nor does early discharge have a great effect on the intensity of mothers' concerns at one week postpartum.

One of the concerns regarding the advisability of early discharge was that pathologic conditions manifested in the second or third day of life may go undetected. When infants were discharged within 24 hours of birth, the usual screening for jaundice by visual inspection or use of reflectance photometers

Table 8. Concerns of Greatest Intensity for at Least 11 or More Subjects

Item of Concern	Short-Stay Group (N = 21) (Frequency)	Long-Stay Group (N = 21) (Frequency)	Total (N = 42) (Frequency)
Category: Self			
Food you eat	8	8	16
Exercise habits	10	12	22
Return of figure to normal	12	13	25
Breast soreness	6	5	11
Being a good mother	13	12	25
Category: Infant			
Normal growth and development	7	8	15
Infant feeding practices	12	8	20
Physical care	10	9	19
Interpreting infant's behavior	8	8	16
Recognizing signs of illness	12	13	25
Safety	8	8	16
Category: Father of infant			
Finding time to be alone together	4	8	12
Sexual relations	6	5	11
Family planning (birth control)	5	6	11
Category: Family unit			
Managing the demands of household	6	8	14
Finances	8	8	16
Category: Community			
Concerns regarding work	7	7	14

Table 9. Individuals Providing Support in the Home Following Discharge

	Short-Stay Group (N = 21)	Long-Stay Group (N = 20)
Husband	16	13
Mother	16	13
Mother-in-law	5	3
Sister	1	2
Friend	1	2

is not possible; nor was it possible to use the frequent practice of offering additional fluids to hasten excretion of bilirubin. In prior studies,^{1,2,4} routine postpartum examination of infants in the home by nurses was part of the early discharge program. These examinations included assessment for jaundice. Most of the pediatricians providing care to the short-stay infants in this study requested that the infants be seen in a clinic setting on the second or third day of life for a physical examination. The frequent monitoring of bilirubin levels of short-stay infants in this study reflects a cautious approach to management by the medical community.

Would the problems of inadequate maternal milk supply and the frequent maternal contact with physicians have been circumvented or reduced had appropriate nursing guidance and counseling been available to the women after discharge? No women in the study reported home visits after discharge; none attended postpartal education sessions other than that routinely provided by the hospital before discharge; and only four women in each group received follow-up phone calls by their physicians.

The frequent contact with physicians, by the women in both groups, reflected the efforts of women to accomplish specific developmental tasks during the early postpartal period. These tasks included the need to identify behavioral cues, become familiar and comfortable with the newborn's bodily functions, and provide appropriate nurturing care. Questions women asked were mirrored in the items that were identified as being of more intense concern (Table 8). The frequent contact may also have represented the need of the women to validate their mothering skills. Adams,⁹ Carlson,²⁰ and Mercer²² have previously emphasized mothers' needs for verbal encouragement. Sumner and Fritsch¹⁶ have reported that the reason for early postpartal phone calls from women was not for specific information, but more to receive assurance that the mothers were doing the right thing.

Items of greatest concern to primiparas in this study corresponded with those of prior research.⁹⁻¹⁷ All noted a persistence of intense (moderate to much) concern about physiologic changes following childbirth and about infant behavior, and less (no to little) intense concern regarding the infant's father, family, and community.¹¹ More than half the women in the study reported concerns regarding maternal body image and exercise. These findings supported the theory that adaptation to changes in body appearance is one of the components of the developmental task of physical restoration.^{17,22}

Choice of length of stay depended on whether the home or the hospital was perceived as the better

environment to meet comfort, recovery, and learning needs. Other factors influencing which environment was perceived as the better place to spend the early puerperal period included financial concerns, social support available in the home, past experience with the health-care system, and individual perceptions of what constituted the normal childbirth and postpartal experience. The less frequent report of fatigue in the short-stay group may have reflected the fact that these women had more help following discharge and were not subject to hospital routines.

IMPLICATIONS FOR NURSING

Although findings suggest that early discharge is indeed safe for most healthy, middle-class primiparas, this study reemphasizes the need for greater nursing intervention as families progress through the developmental tasks of the puerperal period. Postpartum services that provide information, reinforce prior learning, and affirm the mothering role need to be developed and expanded.

The early postpartum period is recognized as a poor time for extensive patient teaching due to the mother's priority needs for rest and bodily comfort.^{17,19} Early discharge also precludes extensive patient teaching. Therefore, teaching must be individualized and based on the unique needs of the woman. PredischARGE assessments of mother and infant should be planned as opportunities for teaching women to distinguish normal from abnormal conditions. Written information on signs of illness, community resources, and care provider phone numbers should be made available. Follow-up phone calls, home visiting services, postpartum hot lines, and early parenting classes that focus on infant behavior, growth and development, feeding practices, and parenting skills need to be developed. Contacts need to be made within the second day after discharge as this is the time when maternal physical discomforts are greatest and when first responsibility for total care of the infant rests with the parents.

Easing the transition into the parenting role needs to be started prenatally, particularly for women anticipating early discharge. Anticipatory guidance about maternal physiologic and emotional changes should be provided using the developmental tasks of the puerperal period as a guide during clinic visits. Eliciting women's perceptions of the postpartal period and providing realistic information about changes that may occur may lessen intensity of later concerns. Assessment of the type and amount of social support that will be available after discharge should become routine.

CONCLUSION

Although evidence suggests that the prenatal period is not an optimal time for learning about the postpartal period and infant care, women who choose early discharge may be more open to learning prenatally because they recognize the limited time available for professionally directed learning in the hospital. A unit of content which reviews newborn behavior and characteristics in addition to infant care and feeding skills should be included in prenatal education curricula.

Suggestions for further research into the outcomes of early discharge include replication of the study with populations of women at risk due to inadequate social support, unavailability of prenatal or parenting classes, and unusual emotional or physiologic needs (e.g., adolescents, low-income groups, and single parent families).

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(letters continued from page 226)

tionally provided the supportive care to such clients. Again, the frontline nurse has a real role to play in the detection of abuse, and when further professional assistance is needed this nurse should consider first consulting with nurse experts within the profession.

Our thanks to this reader for her thoughtful response. Such critiques will foster nursings' role in the area of women's health.

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