Vermont . . .

**Department of Banking, Insurance,
Securities and Health Care Administration**

Insurance Bulletin #114 Revised May 2, 1997

MATERNITY STAYS GUIDELINE

Maternity Coverage Regulation #89-1 applies to all policies of health insurance issued to Vermonters, and generally provides that maternity coverage be a part of all health insurance policies on a non-discriminatory basis. Such coverage is also subject to Bulletin #96, issued on September 27, 1989.

Concerns have been raised by consumers, providers, and legislators that Vermont health insurers may be using utilization review criteria in determining whether to approve or deny health services to their insureds that may require the discharge of new mothers and their newborns from health care facilities shortly after birth, and that the use of such criteria may jeopardize the health of the mothers as well as the newborns if applied against the advice of the health care provider treating the mother. The Legislature has asked the Department to prepare "[g]uidelines for postpartum care" that "shall allow health care providers to determine the appropriate length of postpartum hospital stay based on relevant factors including the complexity of the delivery, whether the delivery was vaginal or caesarian, the clinical condition of the infant and the mother, their social situation and available community support services." P.A. No. 180 (1996 Vt., Adj. Sess.), Sec. 40(a)(2).

The Department has contracted with the Vermont Program for Quality in Health Care, Inc., which issued a set of recommendations for a maternity stays guideline on January 2, 1997. The Commissioner has adopted the recommendations in full, and accordingly expects all health insurers offering maternity coverage in Vermont shall use the attached Maternity Stays Guideline, which are incorporated herein by reference, in deciding when to authorize or deny requested health care services relating to postpartum care.

Please contact Steve Kappel at (802) 828-2900 if you have any questions.

Elizabeth R. Costle, Commissioner

89 Main St., Drawer 20, Montpelier, VT 05620-3101
Banking, Insurance Divisions: (802) 828-3301; Securities Division: (802) 828-3420

Vermont Program for Quality in Health Care
Postpartum Care Guidelines

PREAMBLE

The Maternity Stays Guideline Committee of the Vermont Program for Quality in Health Care was charged by the Vermont Health Care Authority (now the Division of Health Care Administration) with developing "a clinical practice guideline for maternity stays (for mother and newborn) and postpartum care which is agreed upon by practitioners, payers, managed care organizations, and consumers."

The members of the committee have identified sets of criteria for mothers and newborns which should be met prior to hospital discharge. These criteria sets constitute clinical practice guidelines, which can be followed for the vast majority of maternity cases. However, the guidelines are not intended to be all-encompassing, and the committee anticipates that there will be cases in which the best judgment of providers, in consultation with their patients, will dictate deviation from the guidelines.

The following guidelines are based on the needs of families, and not merely on a maximum intended length of hospital stay or cost. The guidelines were developed in this manner because the committee believes there is a lack of documented evidence regarding the appropriate length of hospital stay following the birth of a baby. On the other hand, the committee is striving to be realistic about the need to avoid unnecessary hospitalization and cost and attempted to develop a practical set of criteria which address the essential needs of mothers and babies.

Legislation which mandates coverage for maternity stays of at least 48 hours for a vaginal delivery and 96 hours for a cesarean delivery was recently passed by Congress and signed into law by the President. The committee believes that passage of this mandate does not preempt the need for these guidelines. These guidelines can help assure payers and others that patients are getting high quality care before, during and after their hospital stay. In addition, while the federal legislation creates an entitlement to a minimum hospital stay, the guidelines establish criteria that will help patients and providers determine the most appropriate actual hospital stay, given the specific circumstances and needs of a mother and baby.

These guidelines are designed to accommodate flexible implementation depending on the varying resources in different communities. The committee notes that the prenatal period offers an opportunity to accomplish many of the tasks outlined in the guidelines, though prenatal care does not eliminate the need for high quality subsequent care. It is our hope that use of the guidelines will encourage the provision of more intense prenatal and out-of-hospital postnatal services to complement appropriate in-hospital stays. Hopefully the guidelines will also encourage communities to assess their capacities to serve mothers and newborns and improve as needed. Services in the community needed to support use of the guidelines include but are not limited to lactation consultation, homemaker services, prenatal classes and the availability during the

postpartum period of a maternal and child health nurse or other competent professional to assess the status of both mother and child and respond to their needs if necessary.

Many professional organizations have released position statements on this issue. Among these are the statement on "Hospital Stay For Healthy Term Newborns" released in 1995 by the Committee on Fetus and Newborn of the American Academy of Pediatrics. In that statement, the lack of adequate scientific data to support consensus regarding an optimal post-partum length of stay (in hours) is acknowledged. The VPQHC committee agrees with the AAP statement that "the hospital stay of the mother-newborn dyad should be long enough to allow identification of early problems and to ensure that the family is able and prepared to care for the baby at home." The committee also agrees that "the length of stay should be based on the unique characteristics of each mother-newborn dyad, including the health of the mother, the health and stability of the baby, the ability and confidence of the mother to care for her baby, the adequacy of support systems at home, and access to appropriate follow-up care."

NEWBORN DISCHARGE GUIDELINES

The committee recommends that the following minimum criteria, which have been adapted from the AAP statement, be met prior to newborn discharge. The committee further recommends that the timing of discharge be a collaborative decision among health professionals with direct responsibility for the newborn's care, the newborn's parent(s), and payers. Some newborns with special health care needs due to conditions such as extremely low birth weight or multiple congenital anomalies will need comprehensive care exceeding that which is recommended in this document.

Criteria:

1. The baby's birth weight and gestational age are such that the newborn is expected to make appropriate progress with respect to growth and development in the home environment.

2. The baby's vital signs are documented as being normal and stable preceding discharge, including a respiratory rate that is generally sustained below 60 respirations per minute, a heart rate that is generally sustained between 100 and 160 beats per minute, and an axillary temperature that is generally sustained between 36.1 degrees Centigrade and 37 degrees Centigrade in an open crib with appropriate clothing.

3. The baby has urinated and passed at least one stool, or parent(s) have been instructed in how to monitor these functions.

4. The baby has completed at least two successful feedings, with documentation that the baby is able to coordinate sucking, swallowing, and breathing while feeding. The mother feels confident in being able to feed her baby prior to discharge and/or a lactation consultant will be available at home. Telephone follow-up will be provided by competent practitioners with the ability to assess feeding and the need for further referral until the mother does feel confident.

5. Physical examination reveals no abnormalities that require continued hospitalization. If circumcision is performed prior to discharge, there is no evidence of excessive bleeding at the circumcision site for at least two hours.

6. There is no evidence of significant jaundice at the time of hospital discharge.

7. The following topics have been reviewed by the mother and her care providers. If concern regarding the mother's knowledge, ability and confidence in any of these areas exists, an appropriate follow-up plan is agreed upon by the mother and provider. Telephone follow-up will be provided to reinforce discharge teaching.

   a) Breastfeeding or bottle-feeding. The breastfeeding mother-newborn dyad should be assessed by trained staff regarding nursing position, latch-on, adequacy of swallowing, and mother's knowledge of urine and stool frequency. In cases where the mother intends to breastfeed her newborn, she needs to understand the additional nutritional demands of breastfeeding and necessary precautions regarding consumption of alcohol, prescription medications or other drugs.

   b) Cord, skin, and newborn genital care.

   c) Ability to recognize signs of illness and common newborn problems, particularly jaundice.

   d) Proper use of a car seat.

   e) Positioning for sleeping.

8. Support person(s) (such as primary care providers, the family pediatrician or his/her designees, doulas and home health personnel) familiar with newborn care and competent in lactation training and the recognition of jaundice and dehydration are available to the mother and the baby for the first few days after discharge. There is ongoing health monitoring of the newborn consistent with current medical practice. Family members are available for supportive care.

9. Standard maternal and newborn laboratory data are available and reviewed, including: maternal syphilis, hepatitis B surface antigen, and Group B strep status; cord or newborn blood type and direct coombs test result and any other test result as clinically indicated.

10. Screening tests are performed in accordance with state regulations. If the newborn screen is performed before 24 hours of age, a system for repeating the test must be assured during the follow-up visit.

11. Initial hepatitis B vaccine is administered or plans for its administration have been made.

12. Family, environmental, and social risk factors should be assessed. It is essential that this assessment be performed by a trained maternal-child health practitioner. Risk factors may include but are not limited to: 1) history of parental substance abuse/positive urine toxicology results in the mother or newborn; 2) history of child abuse or neglect; 3) mental illness in a parent who is in the home; 4) lack of social support, particularly for single, first-time mothers; 5) no fixed home; 6) history of untreated domestic violence, particularly during this pregnancy; 7) history of postpartum depression; 8) emotional instability; or; 9) adolescent mother, particularly if other above conditions apply. When these or other risk factors are present, the discharge should be delayed until they are resolved or a plan to safeguard the newborn is in place.

MATERNAL DISCHARGE GUIDELINES

The committee recommends that the following list of criteria be met during the prenatal or post-partum period for all women. The list does not reflect issues specific to newborn's needs although it is intended to generally include the mother's approach to newborn care. To accomplish these tasks, the new mother needs sufficient functional capacity, a home, and a source of income. The list includes basic physical and psychosocial needs. If the patient is at an increased medical or psychosocial risk, special services will be needed. It is intended that the majority of women will be able to meet these criteria.

Extenuating circumstances must be considered in each category of criteria. These circumstances would include any medical, physical, psychosocial, emotional or environmental issue which would affect the woman's ability to meet the criteria. Extenuating circumstances do not necessarily dictate a longer hospital stay, but may indicate the need for supportive postpartum services at home or in the hospital. The list of extenuating circumstances is not all-inclusive but provides examples of instances when additional support and/or services might be necessary. These circumstances demonstrate the need for a multidisciplinary approach to care and that nurses, family members, friends, social workers, and others will have valuable information upon which the physician or provider makes the decision to send a patient home.

These are minimum criteria. If any of the criteria can not be met prior to discharge, then a plan should be in place to meet the criteria within a short period after discharge. A woman's provider(s), in consultation with the woman and her payer, if she is insured, should develop such a plan. The prenatal period offers an opportunity for the expectant mother to learn about her upcoming responsibilities, and for her care givers to identify her unique postpartum needs and begin to put in place whatever accommodations are necessary to optimize her postpartum care.

Criteria:

1. Rest
The patient needs to have had a good rest after the delivery before going home unless she has a home setting that is supportive and amenable to her resting as needed. Extenuating circumstances include other children at home, no partner or one who is not available or no other family support, an unsafe or overcrowded/unsanitary home, a newborn with special needs, or twins/triplets.

2. Ambulation
The patient needs to be able to get out of bed, walk-sit-stand without significant pain. Extenuating circumstances include personal disability, a physical set-up at home that requires frequent climbing or other special difficulty.

3. Diet
The patient needs to be able to eat a regular diet to facilitate recovery and breast milk production. Extenuating circumstances include poor understanding of good nutrition and inability to afford or otherwise obtain food.

4. Physical Recovery
The patient should be knowledgeable of the normal course of recovery and be able to recognize abnormalities. She should be able to perform routine self care. She should have access to professional consultation if she has concerns in these areas.

a) Vital Signs: The patient's vital signs must be within normal limits and stable prior to discharge, and she should understand how to identify fever or symptoms of inadequate blood pressure.
b) Wound Care: The patient needs to understand the proper methods of taking care of either surgical incisions or perineal repair. She may need to be able to take tub or sitz baths. Extenuating circumstances include having unclean well water, not having a tub, and not having time to do this care because of family demands and/or lack of support. The patient should be able to recognize wound infections and other wound abnormalities.
c) Bleeding: The patient should not have excessive vaginal bleeding prior to discharge, and she should be able to determine the signs of hemorrhage.

5. Bladder Care
The patient needs to be able to hydrate well, void adequately or self cath if indicated. Extenuating circumstances include the inability to self-cath if needed or signs of urinary infection.

6. Breast Care and Breast Feeding
The patient is able to take care of her breasts (hand washing, special nipple shields or nipple eversion) and to feed the baby adequately. Extenuating circumstances include physical breast problems or anomalies.

7. Newborn Care

The patient is capable of providing adequate child care (bathing, feeding, etc.). She also needs information about umbilical cord and circumcision care. Extenuating circumstances include inability to understand this information, inability to buy supplies needed, lack of family support or a baby that is colicky or has special needs.

8. Special Needs

There may be special issues to be addressed in the case of an otherwise normal vaginal delivery, including fourth degree laceration, traumatic birth, hemorrhage, fever during labor, protocols for abnormal conditions (such as toxemia or HELLP) and also in the instance where the baby is being given up for adoption. Once the problem is resolved, the patient's needs are again the same as in non-complicated care as listed above.

10. Emotional and Social Support Needs

Family, environmental, and social risk factors should be assessed. It is essential that this assessment be performed by a trained maternal-child health practitioner. Risk factors may include but are not limited to 1) history of parental substance abuse/positive urine toxicology results in the mother or newborn; 2) history of child abuse or neglect; 3) mental illness in a parent who is in the home; 4) lack of social support, particularly for single, first-time mothers; 5) no fixed home; 6) history of domestic violence, particularly during this pregnancy; 7) history of postpartum depression; 8) emotional instability; or 9) adolescent mother, particularly if other above conditions apply. When these or other risk factors are present, the discharge should be delayed until they are resolved or a plan to safeguard the newborn is in place.

CONTINUITY OF CARE FOR MOTHERS AND NEWBORNS

A source of continuing health care for the mother and her baby must be arranged prior to discharge. If this cannot be assured, then discharge should be deferred until a mechanism for follow-up evaluation is arranged. If the baby is not ready for discharge, arrangements must be made for the mother to stay with her newborn. These arrangements would entail a non-hospital level of care for the mother, including overnight accommodations if the mother's presence is medically necessary for the newborn. Professional post-partum support services, if needed, must be arranged.

Access to appropriate care should be continuous for at least the first six postpartum weeks. Continued care may be delivered into the home setting by telephone contact and/or home visits or in the health care provider's place of business. Continued care should encompass all obstetric and pediatric health care including breastfeeding and behavioral health care if needed. The designated health care providers must be knowledgeable, skillful and competent in the care of newborns and new mothers. The frequency and mode of continuing contact and care will be determined on an ongoing basis by the responsible health care provider(s) in conjunction with the family being served.

It is strongly recommended that all newborns discharged from the hospital prior to 24 hours of age be examined by experienced health care providers within 48 hours of discharge. The timing of this examination may vary depending on the uniqueness of each maternal-newborn dyad.

In all cases of discharge of an newborn less than 24 hours of age, some contact with the family should occur within the first 24 hours after discharge, either by phone or visit, and an assessment made at that time regarding the need for and timing of subsequent continued care.

The first follow-up visit can take place in a home or clinic setting, as long as the personnel examining the newborn are competent in newborn assessment and the results of the follow-up visit are reported to the newborn's primary care provider or his/her designees, on the day of the visit.

The purpose of the newborn follow-up visit is to:

1. assess the newborn's general health, hydration, and degree of jaundice; identify any new problems; review feeding pattern and technique, including observation of breastfeeding for adequacy of position, latch-on, and swallowing, and historical evidence of adequate stool or urine patterns;

2. assess quality of parent-newborn interaction and details of newborn behavior;

3. reinforce maternal/family education in newborn care, particularly regarding newborn feeding;

4. review any outstanding results of supplementary laboratory tests performed before discharge;

5. perform screening tests in accordance with state regulations and other tests that are clinically indicated, and;

6. identify a plan for health care maintenance, including a method for obtaining emergency services, preventive care and immunizations, periodic evaluations and physical examinations, and necessary screening.

The purpose of the maternal follow-up visit is to:

1. assess the maternal physiologic recovery following delivery, including adequacy of rest, nutrition and the potential for depression or other emotional problems;

2. assure that a plan is in place for health care maintenance, including a postpartum checkup, knowledge of the signs and symptoms of complications and an emergency plan, and;

3. assess the adequacy of support systems needed for adjustment to parenting and regain and/or maintain physical health.