

# When Medicine and Politics Collide: Early Newborn Discharge

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Early newborn discharge, which is defined as a hospital stay of 24 hours or less for newborn infants after an uncomplicated vaginal delivery, has become increasingly common practice in the past several years. The unprecedented attention paid to this issue during the past year by numerous state legislatures followed a press release by the American College of Obstetrics and Gynecology (ACOG) in early May 1995, which suggested that early discharge might be responsible for increasing rates of neonatal hospitalization. Minimum 48-hour length of stay legislation has so far been enacted in New Jersey, Maryland, and North Carolina, and similar proposals are being considered in at least 10 other states. In Maryland managed care organizations have been permitted to offer either an extra hospital day beyond the standard 24 hours or pay for an early home nursing visit that includes newborn metabolic screening. This offer is in line with the *Guidelines for Perinatal Care*,<sup>1</sup> issued jointly by the ACOG and the American Academy of Pediatrics (AAP), which allows for discharge within 24 hours when no complications are encountered and when certain other criteria are met. The AAP recently refined this policy in October 1995<sup>2</sup> citing 16 conditions that need to be met before discharge. These conditions range from the completion of at least two successful feedings and newborn stooling and urination to a documented ability of the new mother to care for the baby.

This issue has elicited a spate of comments in the past year from such diverse groups as the Group Health Association of America, a trade organization of diverse health maintenance organizations (HMOs)<sup>3</sup> and *U.S. News and World Report*<sup>4</sup>

and *The New York Times*.<sup>5</sup> The HMO industry clearly perceives such legislation as anti-managed care, while proponents of these legislative initiatives view them as necessary guarantees to maternal and newborn health. Between these extremes are numerous managed care plans that have incorporated early home visit contacts (within the first 24 to 48 hours after discharge) to postpartum women if requested by their maternity care provider or to selected women designated high-risk by the plan itself. Recently Kaiser Permanente's Northern California Region has initiated a prospective multiyear study of maternal and infant outcomes after early hospital discharge.

Advocates for such guaranteed length of stay cite medical risks (neonatal jaundice, infection, feeding problems, etc.), problems for the mother and infant that might go undetected with early discharge. Other concerns raised include potentially lost opportunities for genetic testing (phenylketonuria, neonatal hypothyroidism), early immunizations (hepatitis B), and maternal education (breast-feeding, routine child care). The perceived loss of control of medical decision making from physicians to cost-conscious policies of third party payers could also be at the root of this discord.

Studies of early discharge with or without postpartum home visiting have previously yielded conflicting results. These studies have been limited by inadequate statistical power, inconsistent definitions of early discharge, lack of an appropriate comparison group, and findings that are not generalizable to different settings or populations.<sup>6</sup> In this context, the study of Braveman et al<sup>7</sup> in this issue of the *Journal* is a particularly timely and important contribution to the medical literature and to health care policy makers. Health care utilization for low-risk newborns after early hospital discharge was tracked by acute care visits, rehospitalization, and well-baby visits during the first few months of life. Low-risk newborns who received a package intervention con-

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sisting of a single nurse home visit and several nurse-initiated telephone calls were compared with those not receiving such an intervention. Given the limitations inherent in a retrospective study design, the authors found a statistically significant reduction in acute-care visits by 14 days and a nonsignificant reduction in such visits and missed well-baby visits among the intervention group through 2 months after birth. The very small number of rehospitalizations prohibited a valid analysis of this outcome.

All family physicians and other maternity care providers want assurances that the health of newborns and their mothers will not be compromised in this new age of managed care. As a family physician and a new medical director of a managed care health plan, I have found it apparent that the goals of managed care are in fact congruent with these desires. Lost in all the rhetoric, however, is that the lack of evidence correlating longer maternal-child lengths of hospital stay with better short- or long-term outcomes should serve as an impetus for us all to reexamine our practices surrounding maternity care. Family physicians, who uniquely straddle the life cycle fence in providing care to expectant mothers, infants, and newly created families, are in an ideal position to study and influence such practices.

Criticism of early newborn discharge revolves around several medical and nonmedical issues. Braveman et al<sup>7</sup> cite the "vulnerable early postpartum period," when medical complications are most likely to occur. The use of postpartum hospital care to teach or reinforce maternal-infant bonding, routine infant care, breast-feeding, and family planning or to assess postpartum depression and family involvement is also frequently mentioned. What is omitted is that postpartum medical complications for mother or baby are exceedingly infrequent events. The number of women who wish to return to their own home soon after birth, who do not wish to "medicalize" an otherwise normal life event, are often overlooked. The actual time hospital nursing personnel spend in direct contact with new mothers providing the teaching and reinforcement that has clear value has never been studied. The content of this teaching and the ability of new mothers and families to become truly engaged in the learning process in the immediate postpartum period have never been assessed.

Clearly there are solutions to this medical-political conflict. First, managed care could contract for case rates for vaginal and cesarean births that are independent of length of stay. Such a contract, of course, would shift the burden of utilization risk to hospitals and physicians. The focal point of the debate would change, but the issue itself would not go away. Second, as in Maryland, managed care could pay for the less costly option after a 24-hour stay and make the mother responsible for any costs beyond this minimum. Third, greater use of the interventions described by Braveman et al<sup>7</sup> might well have a demonstrable impact on the health of mothers and infants in the early postpartum period. Fourth, managed care might well have to develop greater flexibility in dealing with this issue. Here, communication between the maternity care provider and the medical director of the health plan is critical. Admittedly, this communication is dependent on the individual plan and the personalities involved. Finally, family physicians supported by managed care could invest greater attention and resources to incorporating more of the education of newly emerging families into their prenatal education programs. The appropriate time to first learn about infant care, lactation, maternal-infant bonding, and early childhood development is during the prenatal period—not during the early postpartum period.

When scientific evidence is lacking and anecdotal experience predominates, legislating hospital lengths of stay for any condition is a bad precedent despite the best of intentions. It reflects poor communication and a lack of cooperation between practicing physicians and managed care constituencies that need each other if each is to accomplish their individual goals. Such legislative alternatives stymie innovative approaches to improving health care and truly serve no one. Braveman et al<sup>7</sup> should be commended for helping to move this contentious discussion to more rigorous examination of current practice and, I hope, to point the way toward a constructive solution.

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## The DSM-IV-PC: Toward Improving Management of Mental Disorders in Primary Care

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Mental disorders are common in primary care, occurring in 20 percent to 39 percent of patients seen.<sup>1-4</sup> In fact, more patients with mental disorders are seen by primary care physicians than by mental health care providers.<sup>5</sup> Mental disorders result in substantial patient suffering, disability, and health care costs.<sup>6-9</sup> Despite their wide occurrence and importance, mental disorders are frequently not recognized by primary care physicians.<sup>1,2,10,11</sup> Even when they are aware of the symptoms of a mental disorder, primary care physicians rarely make an accurate diagnosis.<sup>12</sup>

There are many reasons why mental disorders are not accurately diagnosed by primary care physicians. These reasons include inadequate knowledge of the diagnostic criteria, lack of time during the medical visit, and primary care physi-

cians' doubts about the clinical utility of psychiatric diagnoses and their own ability to manage these types of problems effectively once they have been diagnosed.<sup>13,14</sup>

The *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Primary Care Version* (DSM-IV-PC) was developed to address some of the obstacles to the accurate diagnosis of mental disorders by primary care physicians. It is one eighth the size of the DSM-IV and is therefore much more concise and easier to read than the DSM-IV. This reduction in size has been accomplished largely by focusing on disorders that are most relevant to primary care. The DSM-IV-PC is also easier to use than the DSM-IV because it is organized around nine algorithms and supportive text that enable the primary care physician to go efficiently from symptoms to diagnoses.

A paper in this issue of the *Journal*, written by 2 of the principal architects of the DSM-IV-PC, describes its development and organization.<sup>15</sup> The authors recognize that the DSM-IV-PC is a work in progress and that the manual will need to be revised as more data are obtained about mental disorders in the primary care setting. The development of the DSM-IV-PC, nonetheless, represents an important step toward improving primary care physicians' ability to recognize and treat mental disorders effectively. It is likely to be of most benefit as a tool for training students and residents. Whether or not primary care physicians will take the time to review it and follow its algorithms when a mental disorder is suspected remains to be seen.

The development of the DSM-IV-PC should be viewed in the context of other efforts to improve the diagnosis and treatment of mental disorders in the primary care setting. Two diagnostic systems have recently been developed to help primary care physicians make diagnoses of common mental disorders consistent with DSM-IV.<sup>4,16,17</sup> Both PRIME-MD and the Symptom-Driven Diagnostic System for Primary Care (SDDS-PC) are two-stage processes for detecting and diagnosing mental disorders. The stages consist of a screening questionnaire followed by a structured physician interview with those patients who meet the criteria for a possible mental disorder. Both systems have been well validated in the primary care setting. These systems take the work done on the DSM-IV-PC to the next level by providing tools both to

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