

POLICY STATEMENT

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Fetus and Newborn

Hospital Stay for Healthy Term Newborns

ABSTRACT. Decisions regarding the length of hospital stays for newborns and their mothers became driven by financial reimbursement from third-party payers in the 1990s. The Newborns' and Mothers' Health Protection Act of 1996 and a report from the Secretary's Advisory Committee on Infant Mortality acknowledge the importance of physician assessment in determining the timing of each newborn's discharge. The pediatrician's primary role is to ensure the health and well-being of the newborn in the context of the family. It is within this context that this revised statement addresses the short hospital stay (<48 hours after birth) for healthy term newborns. *Pediatrics* 2004;113:1434–1436; newborn, hospital, discharge.

BACKGROUND

Early newborn discharge began as a consumer-initiated movement and as an alternative to home delivery in the 1980s. In the 1990s, it became driven by third-party payers refusing payment for hospital stays extending beyond 24 hours after an uncomplicated vaginal delivery.¹ Congress responded by signing into law the Newborns' and Mothers' Health Protection Act of 1996,² which prohibited payers from restricting benefits for hospital stays to <48 hours for a vaginal delivery or <96 hours after birth by cesarean section. The act, however, did not prohibit earlier discharge of a mother and her newborn if she and her attending health care professional are in agreement that it is appropriate. Reports of recent experience with early discharge have documented both problems and successful programs.^{3–8} The Secretary's Advisory Committee on Infant Mortality recently published its recommendations from a preliminary report to Congress. The report emphasized that "the goal of postnatal and postpartum care should be good health and well-being, not only the prevention of rare and catastrophic events."⁹

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The hospital stay of the mother-infant 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 infant at home. Many cardio-

pulmonary problems related to the transition from an intrauterine to an extrauterine environment usually become apparent during the first 12 hours after birth.¹⁰ However, detection of jaundice,¹¹ ductal-dependent cardiac lesions,^{12,13} gastrointestinal obstruction,¹⁴ and other problems¹⁵ may require a longer period of observation by skilled and experienced health care professionals. Furthermore, the length of stay should be based on the unique characteristics of each mother-infant dyad, including the health of the mother, the health and stability of the infant, the ability and confidence of the mother to care for her infant, the adequacy of support systems at home, and access to appropriate follow-up care.^{16,17} All efforts should be made to keep mothers and infants together to promote simultaneous discharge.

RECOMMENDATIONS

It is recommended that the following minimum criteria be met before any newborn discharge. It is unlikely that fulfillment of these criteria and conditions can be accomplished in <48 hours. If discharge is considered before 48 hours, it should be limited to infants who are of singleton birth between 38 and 42 weeks' gestation, who are of birth weight appropriate for gestational age, and who meet other discharge criteria as follows:

1. The antepartum, intrapartum, and postpartum courses for mother and infant are uncomplicated.
2. Delivery is vaginal.
3. The infant's vital signs are documented as being within normal ranges and stable for the last 12 hours preceding discharge, including a respiratory rate below 60 per minute, a heart rate of 100 to 160 beats per minute,¹⁸ and axillary temperature of 36.5°C to 37.4°C (97.7°F to 99.3°F),^{19,20} measured properly in an open crib with appropriate clothing.
4. The infant has urinated and passed at least 1 stool spontaneously.
5. The infant has completed at least 2 successful feedings, with documentation that the infant is able to coordinate sucking, swallowing, and breathing while feeding.
6. Physical examination reveals no abnormalities that require continued hospitalization.
7. There is no evidence of excessive bleeding at the circumcision site for at least 2 hours.
8. The clinical significance of jaundice, if present before discharge, has been determined, and ap-

- appropriate management and/or follow-up plans have been put in place.^{21,22}
9. The mother's knowledge, ability, and confidence to provide adequate care for her infant are documented by the fact that she has received training and demonstrated competency regarding:
 - Breastfeeding or bottle feeding (the breastfeeding mother and infant should be assessed by trained staff regarding breastfeeding position, latch-on, and adequacy of swallowing)
 - Appropriate urination and defecation frequency for the infant
 - Cord, skin, and genital care for infant
 - Ability to recognize signs of illness and common infant problems, particularly jaundice
 - Proper infant safety (eg, proper use of a car safety seat and supine positioning for sleeping)
 10. Family members or other support persons, including health care professionals such as the family pediatrician or his or her designees, who are familiar with newborn care and knowledgeable about lactation and the recognition of jaundice and dehydration are available to the mother and her infant after discharge.
 11. Maternal and infant blood test results are available and have been reviewed, including:
 - Maternal syphilis and hepatitis B surface antigen status
 - Cord or infant blood-type and direct Coombs test results, as clinically indicated²²
 - Screening tests performed in accordance with state regulations, including screening for human immunodeficiency virus infection²³
 12. Initial hepatitis B vaccine is administered as indicated by the infant's risk status and according to the current immunization schedule.²⁴
 13. Hearing screening has been completed per hospital protocol and state regulations.²⁵
 14. Family, environmental, and social risk factors have been assessed. These risk factors may include but are not limited to:
 - Untreated parental substance abuse or positive urine toxicology results in the mother or newborn
 - History of child abuse or neglect
 - Mental illness in a parent who is in the home
 - Lack of social support, particularly for single, first-time mothers
 - No fixed home
 - History of untreated domestic violence, particularly during this pregnancy
 - Adolescent mother, particularly if other conditions above apply

When these or other risk factors are identified, discharge should be delayed until they are resolved or a plan to safeguard the infant is in place.
 15. Barriers to adequate follow-up care for the newborn such as lack of transportation to medical care services, lack of easy access to telephone communication, and non-English-speaking parents have been assessed and, wherever possible, assistance has been given the family to make suitable arrangements to address them.

16. A physician-directed source of continuing medical care for the mother and the infant is identified. For newborns discharged <48 hours after delivery, a definitive appointment has been made for the infant to be examined within 48 hours of discharge. It is essential that all infants having a short hospital stay be examined by experienced health care professionals. If this cannot be ensured, discharge should be deferred until a mechanism for follow-up evaluation is identified. The follow-up visit can take place in a home or clinic setting as long as the health care professionals examining the infant are competent in newborn assessment and the results of the follow-up visit are reported to the infant's physician or his or her designees on the day of the visit.^{26,27}

The purpose of the follow-up visit is to:

- Weigh the infant; assess the infant'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 obtain historical evidence of adequate urination and defecation patterns for the infant
- Assess quality of mother-infant interaction and details of infant behavior
- Reinforce maternal or family education in infant care, particularly regarding infant feeding
- Review the outstanding results of laboratory tests performed before discharge
- Perform screening tests in accordance with state regulations and other tests that are clinically indicated, such as serum bilirubin
- Verify the plan for health care maintenance, including a method for obtaining emergency services, preventive care and immunizations, periodic evaluations and physical examinations, and necessary screenings

The follow-up visit should be considered an independent service to be reimbursed as a separate package and not as part of a global fee for maternity-newborn labor and delivery services.

CONCLUSIONS

The fact that a short hospital stay (<48 hours after birth) 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 discharge should be the decision of the physician caring for the infant and should not be based on arbitrary policy established by third-party payers. Local institution of these guidelines is best accomplished through the collaborative efforts of all parties concerned. Institutions should develop guidelines through their professional staff in collaboration with appropriate community agencies, including third-party payers, to establish hospital-stay programs for healthy term infants that implement these recommendations. State

and local public health agencies also should be involved in the oversight of existing hospital-stay programs for quality assurance and monitoring. Additional research results from the Pediatric Research in Office Settings network study of the various issues of care of newborns and their mothers in the early postnatal weeks, including postdischarge follow-up, are anticipated to provide additional understanding of safe and appropriate practices.²⁸

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REFERENCES

- Hospital stays continue 10-year decline. *Am J Public Health*. 1992;82:54–
- Bradley W. Newborns' and Mothers' Health Protection Act of 1996. *Pub L No.* 104-204
- Welt SI, Cole JS, Myers MS, Sholes DM Jr, Jelovsek FR. Feasibility of postpartum rapid hospital discharge: a study from a community hospital population. *Am J Perinatol*. 1993;10:384–387
- Soskolne EI, Schumacher R, Fyock C, Young ML, Schork A. The effect of early discharge and other factors on readmission rates of newborns. *Arch Pediatr Adolesc Med*. 1996;150:373–379
- Danielsen B, Castles AG, Damberg CL, Gould JB. Newborn discharge timing and readmissions: California, 1992–1995. *Pediatrics*. 2000;106:31–39
- Malkin JD, Garber S, Broder MS, Keeler E. Infant mortality and early postpartum discharge. *Obstet Gynecol*. 2000;96:183–188
- Liu LL, Clemens CJ, Shay DK, Davis RL, Novack AH. The safety of newborn early discharge: the Washington State experience. *JAMA*. 1997;278:293–298

- Braveman P, Egarter S, Pearl M, Marchi K, Miller C. Problems associated with early discharge of newborn infants. Early discharge of newborns and mothers: a critical review of the literature. *Pediatrics*. 1995;96:716–726
- Eaton AP. Early postpartum discharge: recommendations from a preliminary report to Congress. *Pediatrics*. 2001;107:400–403
- Desmond MM, Rudolph AJ, Phitaksphairawan P. The transitional care nursery: a mechanism for preventive medicine in the newborn. *Pediatr Clin North Am*. 1966;13:651–668
- American Academy of Pediatrics, Provisional Committee on Quality Improvement and Subcommittee on Hyperbilirubinemia. Practice parameter: management of hyperbilirubinemia in the healthy term newborn. *Pediatrics*. 1994;94:558–565
- Gentile R, Stevenson G, Dooley T, Franklin D, Kawabori I, Pearlman A. Pulsed Doppler echocardiographic determination of time of ductal closure in normal newborn infants. *J Pediatr*. 1981;98:443–448
- Lambert EC, Canent RV, Hohn AR. Congenital cardiac anomalies in the newborn. A review of conditions causing death or severe distress in the first month of life. *Pediatrics*. 1966;37:343–351
- Lister J, Irving IM, eds. *Neonatal Surgery*. 3rd ed. London, England: Butterworths; 1990
- Jackson GL, Kennedy KA, Sendelbach DM, et al. Problem identification in apparently well neonates: implications for early discharge. *Clin Pediatr (Phila)*. 2000;39:581–590
- Britton JR, Baker A, Spino C, Bernstein HH. Postpartum discharge preferences of pediatricians: results from a national survey. *Pediatrics*. 2002;110:53–60
- Bernstein HH, Spino C, Baker A, Slora EJ, Touloukian CL, McCormick MC. Postpartum discharge: do varying perceptions of readiness impact health outcomes? *Ambul Pediatr*. 2002;2:388–395
- Southall DP, Richards J, Mitchell P, Brown DJ, Johnston PG, Shinebourne EA. Study of cardiac rhythm in healthy newborn infants. *Br Heart J*. 1980;43:14–20
- Eoff MJ, Meier RS, Miller C. Temperature measurement in infants. *Nurs Res*. 1974;23:457–460
- Mayfield SR, Bhatia J, Nakamura KT, Rios GR, Bell EF. Temperature measurement in term and preterm neonates. *J Pediatr*. 1984;104:271–275
- Bhutani VK, Johnson L, Sivieri EM. Predictive ability of a predischARGE hour-specific serum bilirubin for subsequent significant hyperbilirubinemia in healthy term and near-term newborns. *Pediatrics*. 1999;103:6–14
- American Academy of Pediatrics, Subcommittee on Neonatal Hyperbilirubinemia. Neonatal jaundice and kernicterus. *Pediatrics*. 2001;108:763–765
- American Academy of Pediatrics, American College of Obstetricians and Gynecologists. Human immunodeficiency virus screening. *Pediatrics*. 1999;104:128
- American Academy of Pediatrics, Committee on Infectious Diseases, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, American Academy of Family Physicians. Recommended childhood and adolescent immunization schedule—United States, January–June 2004. *Pediatrics*. 2004;113:142–147
- American Academy of Pediatrics, Task Force on Newborn and Infant Hearing. Newborn and infant hearing loss: detection and intervention. *Pediatrics*. 1999;103:527–530
- Nelson VR. The effect of newborn early discharge follow-up program on pediatric urgent care utilization. *J Pediatr Health Care*. 1999;13:58–61
- Escobar GJ, Braveman PA, Ackerson L, et al. A randomized comparison of home visits and hospital-based group follow-up visits after early postpartum discharge. *Pediatrics*. 2001;108:719–727
- American Academy of Pediatrics. PROS LAND Study. Available at: www.aap.org/pros/landmain.htm. Accessed February 24, 2004

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