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Judy K. Lask

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THE IMPACT OF OFFERING A FINANCIAL INCENTIVE
TO MOTHERS OPTING FOR AN
EARLY DISCHARGE

by

Judy K. Lask

A thesis
submitted in partial fulfillment
of the requirements for the degree of
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APPROVAL PAGE

We approve the thesis of Judy K. Lask.

Kenneth W. Griswold, Ed.D. 4/10/90
Research Advisor Date

Raymond W. Schuff 4/27/90
Second Reader Date

[Signature] 4/27/90
P.M.A. Director/Representative Date

ABSTRACT

THE IMPACT OF OFFERING A FINANCIAL INCENTIVE TO MOTHERS OPTING FOR AN EARLY DISCHARGE PROGRAM

The purposes of this this study were to (a) determine the willingness of maternity patients to participate in an early discharge program, (b) determine why patients would or would not participate, and (c) determine if a financial incentive would have any impact on their decision.

The subjects of the study were pregnant women currently enrolled in prenatal and LaMaze classes at Rockford Memorial Hospital in Rockford, Illinois who were planning to deliver at Rockford Memorial Hospital.

The researcher read aloud to the subjects the definitions of the components of an early discharge program. The researcher then distributed a questionnaire and asked the subjects to complete it. The survey contained demographic

data, questions regarding willingness to participate in an early discharge program, reasons why the subjects would or would not participate, and if a financial incentive would or would not affect their choice.

Major findings indicated that 50% of this convenience sample indicated an interest in an early discharge program. The remaining 50% indicated concern for their safety and their infant's safety as the major reasons for not wanting to participate.

Additional findings were that the cost of hospitalization was a concern as 63 out of 95 subjects indicated interest in an early discharge program if a financial incentive was offered. Lack of knowledge about infant care by the mother decreased the desirability of an early discharge program.

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CHAPTER 1

Purpose

The purpose of this study was to explore the question, would maternity patients be willing to use an early discharge program in place of the traditional length of stay after having a baby? If there was a willingness on the part of patients to use an early discharge program, then the researcher would conduct a feasibility study, which would include program development and operational cost.

The health care industry, like other businesses, is operating in an environment of increasing consumer demands, cost containment, and increasing competition. The implications for today's manager includes maintaining an appreciation of the consumers' demands through early identification of nationwide trends; developing programs to market competitively; and exercising cost containment practices. The advent of utilization review, a declining birth rate, and a more educated consumer population better able to evaluate services in order to choose between providers indicate the hospitals that survive will be those that identified the trends and are willing to change accordingly (Loubeau, 1984).

Problem

There is considerable professional and public concern over the dramatic rise in the cost of providing health care. Hospital charges for having a baby increased 49% from 1973 to 1983 (Lubic, 1983). Although this rise in cost has occurred nationwide, larger hospitals have experienced significantly higher and more rapidly increasing rates. In many states of the country, including Michigan and Illinois, insurance companies were refusing to pay for the second post partum day (second day after delivery) after a normal delivery (Sandrick, 1984). This change in reimbursement policy is a significant trend of which managers in the health care industry must be aware.

DeVries (1983) conservatively estimates that 60% of all births occur normally. Theoretically, this population would be eligible to participate in early discharge programs. The potential savings that early discharge programs offer to both the hospital and patient has been addressed in the literature over the past decade (Hickey, 1977, McIntosh, 1984, Patterson, 1987). Several early postpartum discharge demonstration programs have been developed to control over-crowding in hospitals, to offer inadequately insured patients low-cost care, or to control costs in health maintenance organizations (Patterson, 1987).

In many metropolitan areas throughout the United States, free standing birth centers (a facility for giving birth that is not physically attached to a hospital and where the stay is less than twenty-four hours) are emerging. These centers are directly competing for the same consumer population. This change has introduced a new competitor in the market place which managers in the health care industry must monitor.

Attitudes about birth have shifted from an illness to a wellness orientation. Changes in medical care, social attitudes, prenatal education, and theories of parent-infant interaction have influenced the attitudes and beliefs of postpartum women (Patterson, 1987). These changes reflect not only a reorganization of parental roles and responsibilities, but also about childbirth practices. Not long ago childbirth was viewed as an event which simply happened, not an event in which both parents or other family members participated.

Health care providers are encountering many parents who are no longer content to remain passive during the preparation and process of birthing. Stolte and Meyers (1987) described today's maternity services consumer as more educated and more assertive, knowing what to expect, having a better understanding of what is happening to them, and being more aware of their own rights.

Because of the changes in patient characteristics, many couples are frustrated by the regimented, sterile, highly technical and impersonal environment of the hospital setting. They prefer their home since it provides a comfortable and personal environment in which they are in control. The medical community, on the other hand, has reservations about early discharge. Even though only three percent of low-risk births have any complications (Scupholme, Allan & Robertson, (1986), no physicians in Rockford, Illinois were willing to participate in an early discharge program because no formal program has been developed. If low-risk patients could deliver in a hospital and participate in an early discharge program, the early discharge program could provide a successful compromise among consumers, the medical community, and the hospital.

The desire of insurance companies to reduce cost and selectively pay for services forces hospitals to be unique and innovative. The above factors, along with the desire of the consumer of maternity care services, indicates that the timing may be right for hospital administration to investigate the feasibility of developing a formal early discharge program.

Scope of the Research

The Perinatal Network Coordinator at Rockford Memorial Hospital conducted the study. The researcher utilized all resources that were available at Rockford Memorial Hospital and the University of Illinois College of Medicine in Rockford, Illinois. The marketing department of Rockford Memorial Hospital and the researcher's advisor helped develop the measurement tool and determined the most effective way to distribute the tool.

The measurement tool developed by the researcher was an eleven question survey. The demographic data obtained by the survey could be evaluated for its marketing value. The survey also included direct questions about using an early discharge program. Subjects checked reasons for using or not using such a program. Lastly, subjects indicated if they would consider participating in an early discharge program if a financial incentive were offered.

The focus of the research was on the subject's interest in using an early discharge program. The study group consisted of prenatal class participants for the months of March, April, and May 1989. This group involved both first time parents and those couples having repeat pregnancies. It also included single parents. The subjects represented a broad range of social-economic backgrounds.

The researcher explained to the participants the definition of an early discharge program. The researcher also explained what follow-up care and options were available within the program and the perceived cost benefit of the program. Subjects also learned the nature and purpose of the survey which was to identify their willingness to use an early discharge program based on their current knowledge base about early discharge programs. At this time also, the subjects received verbal assurance of confidentiality and anonymity.

After imparting this knowledge to the participants, the subjects completed the survey.

Theoretical Framework

The researcher employed two theoretical frameworks for the study. The first was family centered maternity care. The second was the concept of cost containment.

In 1978, the Interprofessional Task Force on Health Care of Women and Children issued a joint statement entitled "The Development of Family-Centered Maternity/Newborn Care." This task force consisted of representatives from the American College of Nurse-Midwives, the American Nurses' Association, the Nurses' Association of the American College of Obstetricians, and the American Academy of Pediatrics. Representatives from these groups collaborated and agreed

upon the following definition of family-centered/newborn care:

Family centered maternity/newborn care can be defined as the delivery of safe, quality healthcare while recognizing, focusing on, and adapting to both physical and psychological needs of the client-patient, the family, and the newly born. The emphasis is on the provision of maternity/newborn health-care which fosters family unity while maintaining physical safety (Interprofessional Task Force on Health Care of Women and Children, 1978, p.2)

The joint statement also advocated the provision of such services as :

1. Childbirth classes for the entire family;
2. Continuing education for maternity staff including information about current childbirth trends;
3. A more liberal definition of family to include other supportive persons important to the mother;
4. Development of birthing options;
5. Development of the option of early discharge of mother and infant with appropriate follow-up visits to assess early postpartum progress.

This professional statement of the Task Force reflected increased awareness of consumer demands and changing patient characteristics and values regarding maternity care. Childbearing couples are more knowledgeable and concerned consumers as a result of the prepared childbirth movement, the women's health movement, and the rise of consumer consciousness (Patterson & Peterson, 1980).

In 1977 the National Chamber Foundation conducted a study. The purpose was to determine strategies for containing the country's escalating health care costs. The premise of the study was that businesses must take a more active role in the health care of the nation. It is imperative that they become purchasers, not just payers of health services (Chamber, 1977). As a result of this study, businesses have formed coalitions for health actions. Such coalitions are placing increasing pressure on health care facilities to reduce health care costs and continue to provide quality care. Health care industries striving to implement cost savings in their own member establishments may find that these coalitions offer an excellent opportunity to communicate the economy of early discharge programs.

Keeping business informed about early discharge programs is as important as building the same awareness among insurance companies. Perhaps even more so, because

business ultimately determines employee benefit packages. Business contracts with insurance companies to cover reimbursement according to the negotiated and specified terms. Business and industry, in effect, determine both the availability and rate of reimbursement.

Operational Definitions

1. Early discharge: Dismissal from the hospital within twenty-four hours after giving birth.
2. Patient: Pregnant women in the child-bearing age who are enrolled in the March, April and May prenatal and LaMaze classes at Rockford Memorial Hospital.
3. Child-bearing age: Women between the ages of 14 and 40.
4. Follow-up: mother and infant assessment provided in the home by a licensed registered nurse; a telephone call to the home by a licensed registered nurse; or examined by the mother's and infant's physician within twenty-four to seventy-two hours after discharge.

Chapter 2

Review of Related Literature

This chapter includes research literature which is related to the study. The opening section presents an overview of literature relating to family-centered care and consumer demands. Section two focuses on maternal-fetal outcomes. The final section explores the cost effectiveness of early discharge programs.

Family-Centered Care and Consumer Demand

Several decades ago childbirth was a family affair that for the most part the family controlled. Because the pregnant women delivered at home, family members surrounded her from the time that she began labor throughout the puerperium (six weeks after delivery). Since the mother remained in her own home, the father and siblings had the freedom to spend an almost unlimited amount of time with the mother and new baby. Family contact with the infant and delivered mother began moments after birth. Often the father was present at birth of the infant.

As the United States became more industrialized, hospitalization for labor and delivery became more commonplace, especially in urban areas. Often after delivery in the late nineteenth century newborns remained with their mother. Hammock-like cribs were placed

at the foot of the bed, where with some help from the nurse, the mother could tend her infant (Lieberman, 1976). Because wards were often noisy and crowded, and some women were too ill to care for their infant, hospitals began to develop a night nursery similar to the one at the Boston Lying-in Hospital of 1898. This remedy proved very satisfactory; many physicians and nurses were of the opinion that newborns should remain in a nursery at all times to maintain the quiet and tidiness of the ward (Lieberman, 1976).

In the early twentieth century, a more realistic need for nurseries emerged. Communicable diseases, such as epidemic diarrhea, scarlet fever, and dysteria, caused a large number of infant and maternal deaths. The need for separate care as a control mechanism for preventing the spread of infection became the essential reason for nursery care of infants (Lieberman, 1976).

By the 1940's, hospital deliveries had steadily increased with a concomitant decrease in maternal and infant death. The newborn nursery and thus the separation of mother and child, became a firmly entrenched practice. This practice introduced an era of rigid schedules, formula feedings, and strict asepsis (prevention of infection).

As parents began to question the necessity of rigid rules and routines of the hospital, health care professionals and social scientists began analyzing the effects of those practices on family relationships and on individual family members (Lubic, 1975).

Dr. Grantly Dick-Reed of England influenced the attitude changes of health professionals in the early 1940's. His 1944 book, Childbirth Without Fear introduced the concept of natural childbirth to the United States. This approach to childbearing offered a more humanistic approach which included educational classes devised to give expectant parents knowledge about pregnancy and newly-developed breathing and relaxation techniques for the mother preparing for labor. Fathers entered the delivery area. At the same time Dr. Dick-Reed was experimenting in England, Fernan LaMaze began to develop his methods of nonmedicated childbirth to encourage the expectant couple to work together on breathing and dissociation (relaxation) techniques in the labor and delivery room.

Since the early 1970's, attention has focused on uniting the family during the birthing process. A study conducted by Klaus, Jerauld, and Kreger in 1972 indicated that this critical period of separation of mother and infant from the father not only delays paternal attachment to the infant, but also effects the father's behavior toward the child over a much longer time.

Peterson and Mehl (1978) supported the concept of early contact. They found that the most significant variable predicting variance of parent attachment was the length of separation of parents and infants. The authors concluded that less separation resulted in more parental attachment.

The Effects of Childbirth on Men

Although the literature is extensive in its reference to its effects of pregnancy and childbirth on women, it yields little about the effects of this phenomena on men and even less on the family as an entity. Nursing literature relating to the participant father has been sparse. Most studies are anthropological or sociological in nature, and observational rather than experimental. For example, although Tanzer (1968) did not study husbands directly, she found that husbands that wanted to and did participate during labor and delivery, had positive feelings about having done so. Men may have more interest in and more need to play a role in childbirth than realized. The evolving social structure of middle-class America redefined and emphasized the participant role of the expectant father and new father (Jessner, Wright & Foy, 1970).

The concept of couvade was also evidence of the male identification with childbirth. Couvade is the observance of certain rituals and behaviors of fathers during childbirth such as coaching his wife during contractions or participating in relaxation techniques during the labor process. This phenomenon, according to Coleman (1969), helped a father to not only play an important role in pregnancy and childbirth, but also helped him to make the transition to fatherhood in front of his wife and society. Coleman also reported that men who participated in the childbirth with their wife had a means for coping with the intense feelings associated with birth.

Robert Bradley (1974), an obstetrician and proponent of husband-coached childbirth, reported that women who delivered in unfamiliar surroundings and without the support of their family had a significant rise in their stress level. The rise in stress could have a negative impact on labor. The concept of a homelike atmosphere in a warm setting with the support of loved ones appeared to have a stress reduction effect, thereby reducing the length of labor (Shannon-Babitz, 1979).

Researchers seemed to support the idea that we are now living in a time when informed consumers can make real choices about the kinds of health care which most satisfactorily meets their needs (Farley, 1986).

Child-bearing in the 1980's

Childbearing couples have changed markedly over the past decade. They want to be part of the health care team, to have professionals do their care with them, not for them. The mere fact that they are expressing this need instead of just accepting what is available is also a change. Dinglay (1979) stated that hospitals have to become much more sensitive to the needs of families, even going so far as to explore alternatives to hospital delivery.

Studying the trends of today's childbearing couples, we notice that the size of the family is decreasing. As the size of the family decreases, the expectation of the birth experience increases. In 1984 Gallup conducted a poll for Levi Strauss as part of a market analysis for maternity care and found that 79% of fathers were attending births (Lubic, 1986).

The goals of parents are frequently more complex than just a positive physical outcome. They assume that childbirth will result in the birth of a healthy baby to a mother who experiences minimal physical trauma. This assumption is their minimal expectation (Countryman, 1982).

Many prospective parents have participated in childbirth education classes and are well aware of childbirth options. They are actively seeking physicians who will give them exactly the kind of support and experience they have learned about, believe in, and plan for.

Contemporary parents view childbirth as a normal function in their lives, not as an acute illness or a debilitating disease. An increasing number of childbearing couples view the hospital setting negatively. They are looking for psychological not mechanical support; and for the human touch, not the heavy hand of technology. (Allgaier, 1978).

Parental choices in childbirth vary. Some couples want a longer hospital stay, based on their concerns for the mother's health and recovery, the need for rest, and their inherent belief that a longer stay will provide the necessary time to become acquainted with and learn about their infant. At the other extreme, are those couples who believe they are quite capable of handling this phenomenon completely on their own. The vast majority however, appear to be at various points between the two extremes.

In addition to the apparent dichotomy of choice, two opposing trends are evolving in maternity service. On one hand, most hospitals are providing some form of family-centered care. However, concurrently, medical intervention, often highly specialized and technical, has

been increasingly interjected into the normal labor and delivery process.

Couples who have participated in a variety of educational programs to prepare themselves for pregnancy, childbirth, breast feeding, and infant care, generally are unwilling to accept much of the medical intervention without question or a struggle. Medical intervention such as mandatory electronic fetal monitoring has been a significant factor in their seeking alternatives to the current "traditional" hospital stay.

Current Perspectives on Childbirth

Three important movements that have changed the face of maternity care in the last two decades. These movements are the natural childbirth movement, the feminist movement and the consumer movement. The natural childbirth movement is not new to the medical profession or the consumer of maternity services. However, this movement gained strength and momentum in the 1970s. Wilmuth (1975) contended that while the major focus of prepared childbirth has been to increase women's control over their emotions and actions in labor, it has had another positive outcome - providing a sense of control in interpersonal relationships between the parent and care providers.

A woman can share in the decisions of labor and delivery and maintain a sense of autonomy and self sufficiency, thereby increasing her satisfaction with her childbirth experience. Organizations such as the International Childbirth Education Association (ICEA), encouraged the input of lay persons as consumers in American childbirth practices. As a result, organizations such as this has increased the public's knowledge of natural childbirth practices and outcomes.

Similar ideas concerning power and decision making rights have grown out of the feminist philosophy. The idea of women regaining control over their bodies and rehumanizing the birth experience have been prominent themes of the Women's Movement. The area in which women are being less patient with our current systems of care delivery is in childbearing (Lubic, 1975.)

As a result of these movements, the obstetrical practices and maternity services of facilities in this country were increasingly the targets of consumerism. In addition, pregnant clients began to demonstrate economic power by "shopping" for the facility that would provide the support and services that they were seeking, thus influencing the availability of alternatives.

In addition to the aforementioned movements, lay people were starting to find pathways to a higher level of wellness during the transition to parenthood without the assistance of health care professionals. This phenomena is associated with the consumer movement. Cobb (1976) made an excellent case for the importance of social support as a moderator of life stress throughout the life cycle. Cobb cited studies that had examined the effects of social support on hospitalization of children bereavement, complications of pregnancy and so forth, all of which showed that there is some protective effect exerted by a high level of social support during times of high stress. These studies supported the belief that social support could lessen the impact of the crisis component of adjusting to a new infant. As a result, consumer support groups such as LaMaze and LeLeche were found to increase self-esteem and coping ability, increase the belief of one's ability to parent, and recognize the normality of one's problems and concerns (Cronenwett, 1980).

Early Discharge

During the introduction of early discharge programs as an alternative to childbirth experience, issues pertaining to maternal and newborn outcomes, patient satisfaction and economic feasibility for patients and

institutions were raised. Studies conducted by Avery, (1982), Mehl, Peterson, Sololwsky, & Whitt, (1976), and Schupholme, (1981) showed that early discharge was relatively safe for the majority of low-risk women and that consumers were satisfied with early discharge. Norr and Nacion (1987) conducted the most in depth study regarding maternal outcomes by reviewing all publication data of early discharge programs between 1960 and 1986. According to their review, less than two percent of mothers participating in early discharge programs had to be readmitted to the hospital after discharge due to postpartum complications.

The literature review of newborn outcomes in relation to early discharge was also favorable. Britton & Britton (1984) studied newborns of a middle-class population. Of the 1,583 infants studied, eleven (0.7%) had problems other than jaundiced that required hospitalization after discharge. An inner city study conducted by Schupholme, (1981) also concluded that early discharge was safe for infants born to that population segment as well. Results from a study conducted by Power, Wolf & Van Coeverden De Groot (1980) also indicated that infants and mothers discharged early were at no disadvantage but noted that careful selection of patients for early discharge is essential.

The previous cited literature and that of Norr and Nacion (1987) supported the researcher's belief that positive maternal and newborn outcomes result from the careful selection and screening of candidates who are allowed to participate in early discharge programs. Two key criteria utilized in this process is self-selection and risk assessment. Self-selection addresses those women who chose their care provider and place of birth and had a willingness to participate in an early discharge program. According to Barieffi, (1982) women choosing alternatives to traditional care expected to have a normal delivery and a healthy baby.

The second element, risk assessment, is essential for a successful early discharge program. The literature indicates that most early discharge programs are currently serving a "low-risk" population. Population characteristics of the "low-risk" population indicate that these women and families are from the middle-class or upper middle class. They are likely to be healthy, have adequate economic resources and housing, and easy access to immediate and routine health care.

In the general routine of today's obstetrical care practice, risk assessment is conducted a minimum of three times as was it conducted in the study by Power, Wolf, Van Coeverden, & DeGroot (1980). In their study, the first time the patient evaluation was conducted was during the patient's initial prenatal visit. Risk criteria ascertained

during this visit determined the patient's initial eligibility to the program. The second time was during the patient's third trimester to determine that nothing had changed during the course of the pregnancy. The final patient evaluation occurred at the initial time of the onset of labor. By following this established risk assessment triage, it is believed that maternal and newborn outcomes are likely to remain positive and that pregnant women and their offspring will receive the appropriate level of care.

Norr and Nacion, (1987) further concluded in their study that infants were rehospitalized more often than their mothers with an average percent rate of four to seven percent. The variability in the readmission rates reflected the differences in the definition and treatment of hyperbilirubinemia (jaundice). Only one early discharge program discussed infant mortality. Hellman et al. (1962) reported four deaths of infants discharged early. Based on the results of the studies that have been conducted on maternal and neonatal outcomes involved in early discharge programs, the researcher believes that the consumer and health professionals can reasonably assure candidates that early discharge programs are a safe alternative to "traditional" hospital stay after delivery.

Positive maternal and infant outcomes are predictable if one couples self-selection with careful screening of program participants.

Cost Effectiveness

The researcher examined cost effectiveness from both the health care and the consumer perspectives. Studies conducted by Yanover, Jones, & Miller (1976), Schupholme, (1981) McIntosh, (1984), Regan (1984) and Jansson (1985) favorably supported the economic impact that early discharge programs had on the consumer and institutions offering this program as an alternative to traditional hospital stay. Schupholme, (1981) cited a reduction in the cost of hospitalization in excess of \$500.00 per patient.

Farley, (1984) conducted one of the most extensive studies regarding cost analysis in which seventy birthing centers participated. Each center supplied charges from the hospital that they used as a transfer facility for those patients requiring hospitalization. Farley demonstrated that the average hospital charge was \$3,015 compared to \$1,406 for the birthing center. This difference amounted to \$1,069 less per delivery in the use of a birthing center. That means that if 50% of American women anticipating a normal pregnancy and birth used a birth center, there would be approximately a \$2.5 billion savings to those who provide maternity care benefits or insurance.

In relation to hospital cost effectiveness, little information was found. Mc Intosh (1984) conducted a study in one hospital in Red Deer City, Alberta, Canada to examine whether the early discharge program offered at that institution reduced length of stay and hospital costs. McIntosh concluded that an early discharge program has the potential to reduce postpartum length of stay without increasing the total hospital bill.

The New York Business Group on Health is a coalition of approximately 140 organizations and businesses providing employee benefits. The major concern of the business groups is the availability, quality and affordability of health care. The driving factor of the organization of the coalition was the escalation of health care costs (Warsaw, 1985). Warsaw (1975) indicated that the rate of increase was about 12.5 % a year, with a projected increase in cost of 14.1 % by the year 1990. In addition, he identified the most common cause of hospitalization as obstetrically related.

This knowledge gives consumers and insurance companies a new focus of interest in cost. Birthing centers have only recently developed in the 1980s and according to Cannoodt, (1982) are serving less than one-half of one percent of American women annually.

Considering the previous mentioned savings that birthing centers are providing third party payers and consumers, hospital's must recognize that a longer hospital stay may become economically prohibitive and should begin now to plan for safe, early discharge programs.

Roberman, (1987) frankly addressed the point that the largest financial burden generally is not borne by the consumer but by the government and third party payers. If early discharge programs develop and proliferate without the involvement of both the government and third party payers, a health care system may develop which divides patients along public and private lines of management. Considering the potential financial impact that this would have on the nation's government hospitals, some already bordering on brink of financial crisis, a shift in the obstetric patient mix could result in more hospitals closures.

Current Health Care Issues and Recommendations

The previous literature indicates that in the past two decades, early discharge programs have been developed in both private and public institutions. Recognizing that competition for the health-care dollar is keen in this era of escalating hospital costs and expenditures, it is imperative that hospitals recognize that the "traditional" length of stay may become prohibitive for some of their

patients and begin now to plan for safe, early discharge programs.

Like most hospitals nationwide, Rockford Memorial Hospital has experienced the impact of reduced length of patient stay created by the Diagnostic Related Groupings (DRG's) and the pressures of third party payers. Particular to the area of obstetrics, the average length of stay at Rockford Memorial Hospital has decreased from four to 2.2 days. Although the length of stay has decreased, the system of obstetrical health care delivery has changed very little. The reduced length of stay not only decreased the period of time the mother has to recover from the delivery of her infant but also decreased the amount of time health professionals have available to meet the psychological and social needs of the family. The increased pressure perceived by health professionals to meet these needs increases their workload especially in light of the nursing shortage that currently exists nationwide and at Rockford Memorial Hospital.

The foregoing literature indicated that the consumer is seeking an alternative to the traditional obstetrical health care system, and that financial support for longer lengths of stay has diminished. It has also been addressed that resources available to provide patient care has reduced. In light of the changes that have occurred in

obstetrical health care delivery, Rockford Memorial Hospital must begin to evaluate to its current obstetrical care system and to make changes accordingly. It appears that now may be the time to consider developing a formal early discharge program.

Chapter 3

Methodology

The purpose of this study was to investigate the willingness of maternity patients to participate in an early discharge program. The information obtained from this study was studied for its marketing purposes to determine why participants would or would not use such a program. In this chapter the researcher outlines the methodology used to achieve this purpose.

Research Design

This study was non-experimental in nature and used a survey design (Polit & Hungler, 1987). The intent of the survey was to obtain information from the population regarding preference, distribution and interrelations of characteristics within the sample population. The target population received a survey in the form of a questionnaire.

Setting

The setting of this study was a 435 bed hospital in Rockford, Illinois. Data collection was for the months of April, May, and June 1989 on all couples who attended prenatal and Lamaze classes at the hospital. The average number of deliveries at this facility ranged between 200-225 per month. Approximately seventy-five percent of patients

who delivered in the hospital attended prenatal or Lamaze classes. The clients served by this non-profit hospital were predominately middle-class.

Population/Sample

The target population for this study were women enrolled in the hospital prenatal and Lamaze programs. The women were to be between the ages of 14-40 and scheduled for delivery at the hospital. One hundred women met the criteria for inclusion in the population and consented to participate in the study.

Informed Consent

The researcher submitted the proposal for this study to the hospital's Vice-President of Clinical Affairs and the Marketing Director. They approved the proposal in November, 1988. The researcher's advisor approved the proposal in December, 1988. Subjects learned the purpose of the research and were assured by the researcher of both anonymity and confidentiality. The subjects were instructed by the researcher not to indicate their identity on the survey. In addition, the researcher assured the subjects that the surveys would be destroyed upon completion of the research project. The subjects did not sign a consent form. The willingness of the participants to complete and return the survey was implied consent.

Instrumentation

The researcher developed the Short Term Maternity Stay Survey (see Appendix A). The instrument is an eleven item questionnaire. The intent of the survey was to gather demographic information and attitudes toward participating in an early discharge program and identify the components of such a program most appealing to the participants.

The Director of Marketing and the researcher's advisor reviewed the initial instrument and made minor changes. The result of their review was the questionnaire found in Appendix B. This review established the content validity of the survey.

The first seven items of the survey were demographic items. Information requested included the age and marital status of the participants, number of pregnancies and indicators regarding socio-economic status.

Question eight focused on the subject's willingness to participate in an early discharge program. The subjects chose between definitely use, probably use, definitely not use and probably not use. The subjects then responded in questions nine and 10 to a list of reasons why they made their choice. They checked all the reasons that applied and added any reasons not already included on the check list. Lastly, in question 11 subjects indicated whether or not they would participate in an early discharge program if a financial incentive were offered.

Procedures for Data Collection

The prenatal/Lamaze class instructor informed the class that the researcher would be attending the class to ask the members to participate in the project. Upon arrival the researcher explained the purpose of the study to the class participants. The researcher reviewed the concept of an early discharge program. This review included a systematic explanation of the following information: the definition of early discharge, how eligibility would be determined, who would be the care providers involved, the anticipated cost savings of the program based on literature findings, and the three most frequently used methods of follow-up described in the literature which included telephone calls, a nurse visit, or an early visit to the mother's and infant's physician which occurred usually within twenty-four to seventy-two hours after discharge from the hospital. The researcher then distributed the surveys and asked the class to complete it. The subjects were reassured of confidentiality of the survey and the fact that participation was completely voluntary. The researcher collected all of the respondent's surveys as class participants left to go on tour of the hospital's obstetrical department.

Data Analysis

The researcher analyzed the data obtained from the Short Term Maternity Stay Survey for its relationships. Descriptive statistics provided a summarization of the characteristics of the sample. The researcher also analyzed relationships between the demographic data and willingness to use or not use an early discharge program. The statistical test used was chi-square with $p < .05$.

Limitations

The researcher selected a non-random sample because of its practicality and economy. The sample size was limited to women enrolled in pre-natal and Lamaze classes at the hospital. This type of sampling increased the probability of bias.

The first bias identified by the researcher involved the number of subjects participating in the study were experiencing their first pregnancy. The researcher theorized that the more pregnancies a woman experiences; the more comfortable she becomes caring for herself and the infant. This could have a favorable impact on her willingness to participate in an early discharge program.

The second bias noted by the researcher was the over representation of the caucasian race. The results of the survey may have been different if a larger number of minorities were represented.

The researcher believed, with the exception of the two identified biases, that the sampling is a representation of the community. By utilizing the results of the survey the researcher should be able to identify attitudes and program components desired by those women who will be delivering at the hospital.

CHAPTER 4

Analysis of the Data

In this chapter, the researcher describes the results of the data analysis. The chapter includes a description of the subjects who participated in the project, as well as comparisons of those who would probably, definitely, probably or definitely not participate in an early discharge program. The impact of offering a financial incentive is also examined.

Description of the Sample

The subjects for this study were self-selected in terms of their enrollment in prenatal classes and volunteering to participate in the project. The source of the subjects were women participating in the March, April, and May prenatal class at Rockford Memorial Hospital. A total of 100 subjects participated in the study. The researcher performed a frequency distribution on the demographic data of the sample and obtained the following relative frequency percents.

Three percent of the women were under age 18, 16% were 18-23, 45% were 24-29 years of age, 28% were 30-35, 9% were 36-40, and 1% was over 40 years of age.

Subjects provided their marital status. Nine percent of the women were single; 82% were married; 6% were divorced/separated; and 3% were widowed.

For 65% of the women this pregnancy was their first. Twenty percent were experiencing their second pregnancy, 11% their third, 3% their fourth, and 1% more than four pregnancies.

The sample included 15% black women, 71% caucasian and 6% Hispanic. The remaining 3% listed "other" for their race.

The occupation of the subjects included 15% blue collar workers, 21% clerical, 12% professional, and 31% as housewife. Twenty percent indicated "other" for occupation but did not specify their area of work. One subject did not choose to answer this question.

Seven percent had incomes of less than \$10,000 per year, 28% earned \$11,000-\$20,000 per year, and 31% earned \$21,000-30,000 annually. Subjects with annual incomes of \$31,000-40,000 represented 23% of the group, and 10% earned \$41,000-50,000. One subject chose not to answer this question.

The educational level of the participating subjects included 12% who had not completed high school, and 47% who listed their highest degree as a high school diploma. Thirty-eight percent had postsecondary education, and 1% indicated receiving a professional school education. Two percent of the survey population did not answer this question.

Findings Pertaining to the Problem Statement

Table 1 shows the degree of willingness of potential patients to participate in an early discharge program.

Table 1

WILLINGNESS TO PARTICIPATE IN AN EARLY DISCHARGE PROGRAM

<u>DEGREE OF WILLINGNESS</u>	<u>FREQUENCY</u>	<u>RELATIVE FREQUENCY PERCENT</u>	<u>CUMULATIVE PERCENT</u>
Definitely would use	2	2	2
Probably would use	48	48	50.5
Probably would not use	41	41	91.9
Definitely would not use	8	8	100.0
Valid Cases = 99 Missing Cases = 1			

By utilizing a frequency distribution, the researcher tried to first determine the spread of the sample population.

Secondly, the researcher tried to identify if any particular area of concentration existed either favorably or unfavorably towards participating in an early discharge program.

Fifty out of 100 definitely or probably would participate in an early discharge program. Seventy-six percent wanted more control over their care. Twenty-three percent indicated that they had either no or limited insurance coverage and 12% indicated that the cost of hospitalization was a concern. Twenty-seven percent indicated they wanted more control over their infant's care. Six percent listed "other" as reasons to participate in an early discharge program. Of this six percent, four listed reasons related to wanting to return as soon as possible to the "comforts" of their home. The remaining two indicated the lack of a caring attitude previously experienced while hospitalized for previous pregnancies.

Findings Related to Those Not Willing to Participate in an Early Discharge Program

Forty-nine subjects indicated they would definitely not or probably not participate in an early discharge program of those unfavorable to such a program. Nineteen percent were concerned about either their safety or the safety of the infant. Fourteen percent indicated they did not want early discharge; another 27% expressed concern about how to care for the infant. Eight-two percent indicated they had adequate insurance coverage and the cost of hospitalization was not a concern. Six percent checked "other", indicating that they had concerns about breast-feeding.

Cross Tabulation Findings

Chi square was computed as a test of significance. Chi square is a statistical test for determining whether an obtained distribution differs significantly from the theoretical or expected distribution and thus may attribute to the operation of factors other than chance. A complete print out of computer generated computations of each of the variables including cross tabulation can be found in Appendix B. The distribution revealed at a significance level of $p < .05$ a significant statistical difference between the subjects who would participate in an early discharge program and the subjects who would not participate in an early discharge program ($p = .0005$). The cross tabulation demonstrated trending by the various categories (Tables 5-7).

Table 2WILLINGNESS TO PARTICIPATE IN AN EARLY DISCHARGE PROGRAM

<u>AGE</u>	<u># of Respondents Participate</u>	<u># of Respondents Not Participate</u>
Under 23	13	4
24 - 29	39	6
30 and over	12	26

TABLE 3WILLINGNESS TO PARTICIPATE BASED ON NUMBER OF PREGNANCIES

<u># of Pregnancies</u>	<u># of Respondents to Participate</u>	<u># of Respondents Not to Participate</u>
1	51	14
2	11	9
3 or more	3	12

The 24-29 age group is the most likely to participate in an early discharge program; those women experiencing their first pregnancy appeared to favor participating in an early discharge program.

TABLE 4WILLINGNESS TO PARTICIPATE BASED ON EMPLOYMENT

<u>Employment</u>	<u># of Respondents to Participate</u>	<u># of Respondents Not to Participate</u>
Employed outside the home	57	11
Housewife	14	27

Women who were employed outside the home were more likely to want to participate in an early discharge program. Housewives were less likely to participate in an early discharge program.

TABLE 5WILLINGNESS TO PARTICIPATE BASED ON INCOME

<u>Annual Income</u>	<u># of Respondents to Participate</u>	<u># of Respondents Not to Participate</u>
Less than \$10,000	4	3
\$11,000 - \$20,000	15	13
\$21,000 - \$30,000	5	26
\$31,000 and over	26	7

The higher income family, \$31,000 and over, were more likely to want to participate in an early discharge program.

TABLE 6

WILLINGNESS TO PARTICIPATE BASED ON MARITAL STATUS

<u>Marital Status</u>	<u># of Respondents to Participate</u>	<u># of Respondents Not to Participate</u>
Not Married *	11	7
Married	43	48

*Not married includes single, separated, divorced & widowed

Marital status did not appear to impact on the willingness of the participants to participate in an early discharge program.

TABLE 7

WILLINGNESS TO PARTICIPATE BASED ON EDUCATION

<u>Education</u>	<u># of Respondents to Participate</u>	<u># of Respondents Not to Participate</u>
Grade/High School	24	32
College/Professional School	36	8

The higher the educational level of the respondents, the more likely they are to want to participate in an early discharge program.

CHAPTER 5

Discussion and Recommendations

This chapter is a discussion of the findings of the data analysis and includes the researcher's recommendations.

Discussion

The concept of early discharge by a childbearing couple is relatively new. One of the most widely recognized trends in obstetrics has been the dramatic change in the level of family participation in pregnancy and childbirth. Ten years ago, the presence of the father in the delivery room was rare. In the 1980's most fathers attend the birth of their child. It is estimated that husbands attend 80% to 85% of spontaneous deliveries (Countryman, 1982). In addition, parents are wanting to share the birthing experience with other family members evidenced by the increasing number of hospitals designating at least one delivery room as a "family birthing room" where siblings and other "significant" family members are allowed to witness and share in the birthing experience.

A second trend of which health care managers and marketing departments must be aware is the desire of women to have more control over their care. Fifty one out of 100 subjects indicated that being able to have more control over their care and/or their infant's care were major reasons for participating in an early discharge program.

The informed consumer is very real in the field of obstetrics. The researcher, employed by a hospital, has frequently responded to telephone calls from consumers inquiring about the hospital's obstetrical birthing options and services. The hospital that listens and responds to the requests of the consumer and patient will better position itself in the competitive market of obstetrics.

It is equally important to learn why women are unwilling to participate in an early discharge program. This study showed that of the eight women who indicated they definitely would not participate in early discharge, all indicated that concern for their own safety or their infant's safety was the major reason not to participate.

From a marketing perspective, it is very valuable to identify the number that are neither for or against early discharge. Often this segment of the population has not received enough information to form an opinion about early discharge programs; or have not had the need or been motivated to seek the services of such a program. From this study, 89 of the 100 subjects indicated they probably would/would not participate in an early discharge program.

Forty-eight of the above 89 subjects indicated they probably would participate in an early discharge program.

The major reason was to have more control over their own care and their infant's care. The second leading reason centered around the concern of insurance coverage.

Of the 48 subjects, 37 indicated they would probably participate in an early discharge program if a financial incentive were offered.

Forty-one subjects indicated they probably would not participate in an early discharge program. Their major reason focused on their concern of being able to care for their infant. The second leading reason indicated their concern for the infant's safety. The third reason centered around good insurance coverage and cost not being a significant factor. Of particular interest is that out of the 41 subjects, 12 (29%) indicated they would participate in an early discharge program if a financial incentive were offered.

The findings of this portion of the research project suggest that hospitals need to develop alternatives to the current methods for meeting the patient's physical, emotional and educational needs of the new mother if an early discharge program is to be successfully implemented. In addition, subjects of this portion of the study indicated an sense of impending changes in third party reimbursement.

As the pressure increases to reduce health care costs, the researcher believes that insurance companies in the midwest will begin to change maternity benefits for cost-containment similar to those who have successfully developed and demonstrated cost-containment programs on the west and east coasts. When this occurs, it is anticipated that obstetrical practice patterns will be similar nationwide resulting in a nationwide trend toward shorter lengths of stay (Sandrick, 1984).

Conclusions

Based on the findings of the data analysis, the researcher made the following conclusions:

1. At this time there is a desire by women to participate in an early discharge program.
2. There are certain categories of women who are more willing to participate in an early discharge program. These women can be identified by age, number of pregnancies, employment, and income.
3. Concern for safety of the mother and infant is the major reason for not wanting to participate in early discharge.

4. Insurance coverage and cost of hospitalization is not an overwhelming concern at this time. The researcher concludes however that subjects are sensing probable changes in maternity benefits evidenced by their probable willingness to participate in an early discharge program if a financial incentive were offered.

Recommendations and Further Research

Based on the findings and conclusions of this study, the researcher makes the following recommendations:

1. A larger population be studied to ascertain if this sample is truly representative of the general population served by Rockford Memorial Hospital. This sample should include other pregnant women than those attending prenatal classes at Rockford Memorial Hospital.
2. Patient education programs should be re-evaluated and when appropriate, changed, to better meet the needs of the patient.
3. Hospital administration and insurance companies should communicate to determine the feasibility of offering a financial incentive to patients electing to participate in an early discharge program.

4. The hospital should investigate program development and operational costs of establishing an early discharge program.
5. Hospital management should communicate with other institutions who have successfully implemented an early discharge program to develop a better understanding of the concept.

It is difficult to predict the changes that will occur in health care delivery. However, it is clear that those hospitals most likely to succeed will be those who have researched and developed cost-effective patient care services. The literature has shown that short term maternity stay can be safe for patients and successful in reducing the cost of hospitalization. Rockford Memorial Hospital has successfully gained the community's recognition as a leader of promoting and providing "high-tech" quality care. Based on its reputation, it is the researcher's belief that it can compliment its reputation by developing "high-touch" obstetrical services sensitive to the needs of both the patient's and third party reimbursers' needs. The market for the obstetrical patient is highly competitive. To capture and maintain it, requires hospitals to be visionary in their planning.

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APPENDIX A

EARLY DISCHARGE PROGRAM SURVEY

1. AGE

- A. Under 18..._____ D. 30 - 35..._____
- B. 18 - 23..._____ E. 36 - 40..._____
- C. 24 - 29..._____ F. over 40..._____

2. MARITAL STATUS

- A. Single_____ C. Divorced/Separated_____
- B. Married_____ D. Widowed_____

3. NUMBER OF PREGNANCIES

- 0_____ 3_____
- 1_____ 4_____
- 2_____ over 4_____

4. RACE

- Caucasian_____ Black_____
- Hispanic_____ Other_____

5. OCCUPATION

- A. Blue Collar (Manufacturing)_____ D. Clerical_____
- B. Professional _____ F. Other_____
- C. Housewife_____

6. ANNUAL INCOME

- A. Less than 10,000_____ D. 31,000-40,000_____
- B. 11,000 - 20,000_____ E. 41,000-50,000_____
- C. 21,000 - 30,000_____ F. over 50,000_____

7. Please Circle the last year of education completed.

Grade School								High School				College				Professional			
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20+

8. If available, would you participate in an early discharge program?

- A. Definitely_____ C. Definitely Not_____
- B. Probably_____ D. Probably Not_____

(Skip to Question 9)

(Skip to Question 10)

9. If your answer to question 8 was Definitely or Probably, which of the following are reasons (check all that apply)

- A. Have no insurance coverage_____
- B. Have limited insurance coverage_____
- C. Want to go home as soon as possible after delivery_____
- D. Want more control over my care_____
- E. Want more control over my infant's care_____
- F. Cost of Hospitalization is a concern_____
- G. Other(please specify)_____
-

10. If your answer to Question 8 was Definitely Not or Probably Not, which of the following are reasons (check all that apply)

- A. Have adequate insurance_____
 - B. Don't want to go home within 24 hours after delivery_____
 - C. Cost of hospitalization is not a concern_____
 - D. Concern about knowing how to care for my baby_____
 - E. Concern for my safety and the baby's safety_____
 - F. Other (please specify)_____
-

11. If a financial incentive were offered, would you participate in an early discharge program?

yes_____

no_____

APPENDIX B

TABULATIONS OF VARIABLES

V01		AGE				
VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL	
UNDER 18	1	3	3.0	3.0	3.0	
18 - 23	2	14	14.0	14.0	17.0	
24 - 29	3	45	45.0	45.0	62.0	
30 - 40	4	28	28.0	28.0	90.0	
36 - 40	5	9	9.0	9.0	99.0	
OVER 40	6	1	1.0	1.0	100.0	
TOTAL		100	100.0	100.0		
MEAN	3.290	STD ERR	.096	MEDIAN	3.000	
MODE	3.000	STD DEV	.957	VARIANCE	.915	
VALID CASES	100	MISSING CASES		0		

V02		MARITAL STATUS				
VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL	
SINGLE	1	9	9.0	9.0	9.0	
MARRIED	2	82	82.0	82.0	91.0	
DIVORCED/SEP	3	6	6.0	6.0	97.0	
WIDOWED	4	3	3.0	3.0	100.0	
TOTAL		100	100.0	100.0		
MEAN	2.030	STD ERR	.052	MEDIAN	2.000	
MODE	2.000	STD DEV	.521	VARIANCE	.272	
VALID CASES	100	MISSING CASES		0		

V03 PREGNANCIES

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
ONE	2	65	65.0	65.0	65.0
TWO	3	20	20.0	20.0	85.0
THREE	4	11	11.0	11.0	96.0
FOUR	5	3	3.0	3.0	99.0
OVER 4	6	1	1.0	1.0	100.0
TOTAL		100	100.0	100.0	

MEAD	2.550	STD ERR	.088	MEDIAN	2.000
MODE	2.000	STD DEV	.880	VARIANCE	.775

VALID CASES	100	MISSING CASES	0
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V04 RACE

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
CAUCASIAN	2	71	71.0	65.0	65.0
HISPANIC	3	6	6.0	20.0	85.0
BLACK	4	15	15.0	11.0	96.0
OTHER	5	3	3.0	3.0	99.0
	6	5	5.0	1.0	100.0
TOTAL		100	100.0	100.0	

MEAD	1.474	STD ERR	.090	MEDIAN	1.000
MODE	1.000	STD DEV	.873	VARIANCE	.763

VALID CASES	95	MISSING CASES	5
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V05 OCCUPATION

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
BLUE COLLAR	1	15	15.0	15.2	15.2
PROFESSIONAL	2	12	12.0	12.1	27.3
HOUSEWIFE	3	31	31.0	31.3	58.6
CLERICAL	4	21	21.0	21.2	79.8
OTHER	5	20	20.0	20.2	100.0
	9	1	1.0	MISSING	
TOTAL		100	100.0	100.0	

MEAD	3.192	STD ERR	.132	MEDIAN	3.000
MODE	3.000	STD DEV	1.315	VARIANCE	1.728

VALID CASES 99 MISSING CASES 1

V06 INCOME

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
LESS THAN 10,000	1	7	7.0	7.1	7.1
11,000 - 20,000	2	28	28.0	28.3	35.4
21,000 - 30,000	3	31	31.3	31.3	66.7
41,000 - 50,000	4	23	23.2	23.2	89.9
OVER 50,000	5	10	10.1	10.1	100.0
	9	1	1.0	MISSING	
TOTAL		100	100.0	100.0	

MEAD	1.474	STD ERR	.090	MEDIAN	1.000
MODE	1.000	STD DEV	.873	VARIANCE	.763

VALID CASES 95 MISSING CASES 5

V07 YEARS EDUCATION

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
	9	2	2.0	2.0	2.0
	10	7	7.0	7.1	9.2
	11	3	3.0	3.1	12.2
HIGH SCHOOL	12	47	47.0	48.0	60.2
	13	7	7.0	7.1	67.3
	14	16	16.0	16.4	83.7
	15	7	7.0	7.1	90.8
COLLEGE GRAD	16	8	8.0	8.2	99.0
POST GRAD	18	1	1.0	1.0	100.0
	99	2	2.0	MISSING	
TOTAL		100	100.0	100.0	

MEAN	12.765	STD ERR	.175	MEDIAN	12.000
MODE	12.000	STD DEV	1.728	VARIANCE	2.986

VALID CASES	98	MISSING CASES	2
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V08 PARTICIPATE IN PROGRAM

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
DEFINITELY	1	2	2.0	2.0	2.0
PROBABLY	2	48	48.0	48.5	50.5
DEFINITELY NOT	3	8	8.0	8.1	58.6
PROBABLY NOT	4	41	41.0	41.4	100.0
	9	1	1.0	MISSING	
TOTAL		100	100.0	100.0	

MEAD	2.889	STD ERR	.099	MEDIAN	2.000
MODE	2.000	STD DEV	.989	VARIANCE	.977

VALID CASES 99 MISSING CASES 1

V09 NO INSURANCE

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	95	95.0	95.0	95.0
IS A REASON	1	5	5.0	5.0	100.0
TOTAL		100	100.0	100.0	

MEAD	.050	STD ERR	.000	MEDIAN	.000
MODE	.000	STD DEV	.219	VARIANCE	.048

VALID CASES 100 MISSING CASES 0

V10 LIMITED INSURANCE

VALUE LABEL	VALUE	FREQUE	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	82	82.0	82.0	82.0
IS A REASON	1	18	18.0	18.0	100.0
TOTAL		100	100.0	100.0	
MEAD	.180	STD ERR	.039	MEDIAN	.000
MODE	.000	STD DEV	.386	VARIANCE	.149
VALID CASES	100	MISSING CASES			0

V11 HOME ASAP

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	88	88.0	88.0	88.0
IS A REASON	1	12	12.0	12.0	100.0
TOTAL		100	100.0	100.0	
MEAD	.120	STD ERR	.033	MEDIAN	.000
MODE	.000	STD DEV	.327	VARIANCE	.107
VALID CASES	100	MISSING CASES			0

V12 CONTROL OVER MY CARE

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	76	76.0	76.0	76.0
IS A REASON	1	27	24.0	24.0	100.0
TOTAL		100	100.0	100.0	
MEAD	.240	STD ERR	.043	MEDIAN	.000
MODE	.000	STD DEV	.429	VARIANCE	.048
VALID CASES	100	MISSING CASES			0

V13 CONTROL OVER MY INFANT CARE

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	73	73.0	73.0	73.0
IS A REASON	1	27	27.0	27.0	100.0
TOTAL		100	100.0	100.0	
MEAD	.270	STD ERR	.045	MEDIAN	.000
MODE	.000	STD DEV	.446	VARIANCE	.199
VALID CASES	100	MISSING CASES			0

V14 CONCERN-COST OF HOSPITAL

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	88	88.0	88.0	88.0
IS A REASON	1	12	12.0	12.0	100.0
TOTAL		100	100.0	100.0	
MEAD	.120	STD ERR	.033	MEDIAN	.000
MODE	.000	STD DEV	.327	VARIANCE	.107
VALID CASES	100	MISSING CASES			0

V15		OTHER				VALID	CUMM
VALUE LABEL	VALUE	FREQ	PERCENT	PERCENT	PERCENT	TOTAL	
IS NOT A REASON	0	94	94.0	94.0	94.0	94.0	
IS A REASON	1	6	6.0	6.0	6.0	100.0	
TOTAL			100	100.0	100.0		
MEAD	.140	STD ERR	.035	MEDIAN	.000		
MODE	.000	STD DEV	.349	VARIANCE	.122		
VALID CASES	100	MISSING CASES	0				

NOT PARTICIPATING IN PROGRAM

V16 ADEQUATE INSURANCE

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	82	82.0	82.0	82.0
IS A REASON	1	18	18.0	18.0	100.0
TOTAL		100	100.0	100.0	

MEAD	.180	STD ERR	.039	MEDIAN	.000
MODE	.000	STD DEV	.386	VARIANCE	.149

VALID CASES	100	MISSING CASES	0
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V17 HOME AFTER 24 HOURS

VALUE LABEL	VALUE	FREQUE	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	86	86.0	86.0	86.0
IS A REASON	1	14	14.0	14.0	100.0
TOTAL		100	100.0	100.0	

MEAD	.140	STD ERR	.035	MEDIAN	.000
MODE	.000	STD DEV	.349	VARIANCE	.122

VALID CASES	100	MISSING CASES	0
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V18 NOT CONCERNED-COST OF HOSPITAL

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	95	95.0	95.0	95.0
IS A REASON	1	5	5.0	5.0	100.0
TOTAL		100	100.0	100.0	

MEAD	.050	STD ERR	.022	MEDIAN	.000
MODE	.000	STD DEV	.219	VARIANCE	.048

VALID CASES	100	MISSING CASES	0
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NOT PARTICIPATING IN PROGRAM

V19 CONCERN-HOW TO CARE FOR BABY

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	73	73.0	73.0	73.0
IS A REASON	1	27	27.0	27.0	100.0
TOTAL		100	100.0	100.0	
MEAD	.270	STD ERR	.045	MEDIAN	.000
MODE	.000	STD DEV	.446	VARIANCE	.199
VALID CASES	100	MISSING CASES			0

V20 CONCERN-MINE AND BABY SAFETY

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	81	81.0	81.0	81.0
IS A REASON	1	19	19.0	19.0	100.0
TOTAL		100	100.0	100.0	
MEAD	.190	STD ERR	.039	MEDIAN	.000
MODE	.000	STD DEV	.394	VARIANCE	.155
VALID CASES	100	MISSING CASES			0

V21 OTHER

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
IS NOT A REASON	0	96	96.0	96.0	96.0
IS A REASON	1	4	4.0	4.0	100.0
TOTAL		100	100.0	100.0	

MEAD	.040	STD ERR	.049	MEDIAN	.000
MODE	.000	STD DEV	.197	VARIANCE	.039

VALID CASES	100	MISSING CASES	0
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V22 PARTICIPATE-FINANCIAL INCENTIVE

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
YES	1	63	63.0	66.3	66.3
NO	2	32	32.0	33.7	100.0
	9	5	5.0	MISSING	
TOTAL		100	100.0	100.0	

MEAD	1.337	STD ERR	.049	MEDIAN	1.000
MODE	.000	STD DEV	.446	VARIANCE	.199

VALID CASES	100	MISSING CASES	0
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V23 SCHOOL

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
SOME HIGH SCHOOL	2	12	12.0	12.2	12.2
HIGH SCHOOL GRAD	3	47	47.0	48.0	50.2
SOME COLLEGE	4	30	30.0	30.6	90.8
COLLEGE GRAD	5	8	8.0	8.2	99.0
POST GRAD STUDIES	6	1	1.0	1.0	100.0
		2	2.0	MISSING	
TOTAL		100	100.0	100.0	

MEAN	3.378	STD ERR	.085	MEDIAN	3.000
MODE	3.000	STD DEV	.844	VARIANCE	.712

VALID CASES	98	MISSING CASES	2
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V24 EARLY DISCHARGE

VALUE LABEL	VALUE	FREQ	PERCENT	VALID PERCENT	CUMM TOTAL
DEFINITELY/PROBAB:	1	5	50.0	50.5	50.5
DEFINITELY/NOT PR:	2	49	49.0	49.5	100.0
		1	1.0	MISSING	
TOTAL		100	100.0	100.0	

MEAN	1.495	STD ERR	.051	MEDIAN	1.000
MODE	1.000	STD DEV	.503	VARIANCE	.253

VALID CASES	99	MISSING CASES	1
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CROSSTABULATION: V08

V22	COUNT		NO	ROW TOTAL
	ROW PCT	YES		
	COL PCT	1		
V08	TOT PCT			
DEFINITELY		1 100.0 1.6 1.1		1 1.1
PROBABLY	2	47 100.0 75.8 50.0		47 50.0
DEFINITELY NOT	3		7 100.0 21.9 7.4	7 7.4
PROBABLY NOT	4	14 35.9 22.6 14.9	25 64.1 78.1 26.6	39 41.5
COLUMN TOTAL		66 66.0	32 34.0	94 100.0

CHI-SQUA	D.F.	SIGNIFICANCE	MIN E.F.	CELLS WITH E.F.<5
54.03153	3	.0000	.340	4 OF 8 (50.0%)

NUMBER OF MISSING OBSERVATIONS = 6

CROSSTABULATION: V08

		COUNT	YES	NO	ROW TOTAL
V22		ROW PCT			
		COL PCT			
		TOT PCT	1		
EDP					
		1	48		48
DEFINITELY/PROBA			100.0		51.1
			77.4		
			51.1		
DEF/NOT PROBA					
		2.00	14	32	46
DEF/NOT PROBA			30.4	69.6	48.9
			22.6	100.0	
			14.9	34.0	
=====					
COLUMN			62	32	94
TOTAL			66.0	34.0	100.0

CHI-SQUA	D.F.	SIGNIFICANCE	MIN E.F.	CELLS WITH E.F.<5
54.03153	1	.0000	15.660	NONE
50.62553	1	.0000	(BEFORE YATES CORRECTION)	

NUMBER OF MISSING OBSERVATIONS = 6