REGION OF OTTAWA-CARLETON | REPORT
RÉGION D'OTTAWA-CARLETON | RAPPORT

Our File/N/Réf. 03-07-98-0050
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DATE 19 November 1998

TO/DEST. Community Services Committee

FROM/EXP. Committee Co-ordinator

SUBJECT/OBJET **EARLY POST PARTUM DISCHARGE POSITION PAPER**

REPORT RECOMMENDATION

For Committee discussion.

BACKGROUND

The Committee Chair, Councillor A. Munter, has requested that the above-cited document from the Ontario Public Health Association Child Health Workgroup, dated November 1998, be referred to the Committee for discussion.

The report is issued separately, and is respectfully submitted.

Approved by
M. J. Beauregard

Early Post Partum Discharge Position Paper

Ontario Public Health Association
Child Health Workgroup

November, 1998

Ontario Public Health Association

(OPHA)

EARLY POST PARTUM DISCHARGE POSITION PAPER

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The mission of the Ontario Public Health Association (OPHA) is "working to strengthen the impact of people who are active in community and public health throughout Ontario".

Ontario Public Health Association
(OPHA)

EARLY POST PARTUM DISCHARGE POSITION PAPER

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Supporting Documents for the Early Postpartum Discharge Paper are available from Nolly at OPHA:

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INTRODUCTION

Recent Ontario data suggest that a reduction in hospital stay following childbirth (from 4.5 to 2.7 days) is associated with increased newborn hospital readmissions for jaundice and dehydration (Lee et al., 1995). The American Medical Association (1995) cites similar findings in Dartmouth, where the Medical Center found a 50% increase in the readmission rate and a 70% increased risk of visits to the emergency room among infants discharged within 48 hours of birth.

Canada has lagged far behind the United States in enacting legislation which will protect postpartum women and newborn infants. The Ontario Public Health Association (OPHA) has demonstrated a commitment to addressing and advocating for child health issues and is well-positioned to play a leadership role in this area.[1] The commitment to promoting healthy transitions for new families is integral to the concept of healthy, caring communities. However, at the present time there are wide variations in services available, inconsistent levels of funding allocated to this population, barriers to accessing services, and no clear mandate for system-wide planning of services.

The purpose of the position paper is to address the issue of early postpartum discharge (EPPD) by: providing a review of the literature, reports and policy guidelines; presenting results of a survey of services within Ontario health unit regions conducted by the OPHA Child Health Workgroup; and making policy recommendations.

LITERATURE REVIEW

The research evidence on early postpartum discharge remains equivocal. Voluntary participation EPPD programs with stringent eligibility criteria and a nurse home visiting post-discharge, has been shown to be safe for mothers and infants (James et al., 1987). However, a recent critical review of the research suggests that there is no clear evidence supporting the safety, efficacy, and effectiveness of routine EPPD programs (Braveman et al., 1995). These authors assert that studies related to early discharge are limited by: methodological flaws, small sample size, and the use of select, low-risk populations. Another review completed by Britton et al. (1994) identified major methodological flaws and bias with all studies reviewed. They suggest that no conclusions be drawn from the literature and that the current practice of using clinical judgement to determine time of discharge be endorsed.

a) Infant Issues:

Fox & Kanarek (1995) examined readmission rates for healthy infants discharged early but did not find any significant difference in relation to length of postpartum hospital stay. Pittard and Geddes (1988) also concluded that there was no significant difference in hospital readmission for infants discharged moderately early (26-36 hours) compared to

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[1] At the 1997 OPHA Annual general meeting a resolution was passed on early postpartum discharge.

those with extended hospitalizations (48-136 hours). However, Carty & Bradley (1990) have documented an increased number of infants with jaundice, cord infections, and respiratory difficulties when their mothers were discharged between 12 - 48 hours, although overall morbidity was low. Pascale et al. (1995) observed a significant increase in the number of breast-fed newborn infants readmitted with hyperbilirubinemia, sepsis, and dehydration.

Although most early discharge programs are targeted at low-risk populations, some studies have examined programs for vulnerable groups. Margolis et al. (1997) identify that vulnerable women (e.g. low-income, low education) chose to go home early more often than do less vulnerable groups. Conrad et al. (1989) found that when babies of low-income women discharged at <48 hours, had readmission rates of 2.3% versus 0.89% when their mothers were discharged at >48 hours. Other authors suggest that low-income women have significant maternal and infant morbidity regardless of length of postpartum stay (Norr et al., 1988).

Three newly-published American studies present conflicting results. Liu et al. (1997) conducted a population-based study of over 310,000 live births in the State of Washington from 1991 to 1994. Early postpartum discharge was associated with an increased risk of newborn readmission for jaundice, dehydration, and sepsis. Infants born to primigravidas, mothers less than 18 years of age, and mothers with premature rupture of membranes were at increased risk for readmission. In a study during the same time period, Edmonson et al. (1997) studied newborns readmitted to hospital for feeding problems in the state of Wisconsin. Babies born to mothers who were: breast-feeding, primiparas, single, low educated (< grade 12), or on social assistance, were at increased risk of readmission. However, early postpartum discharge was <u>not</u> associated with newborn readmission. A case control study in Michigan, reviewing charts of infants readmitted to hospital within the first 14 days of life found that discharge within 72 hours postpartum significantly increases the risk of readmission for hyperbilirubinemia. There was no difference in readmission rates for babies discharged at ≤ 48 hours and those discharged at <72 hours (Maisels & Kring, 1998).

b) Maternal Issues:

Research on maternal issues also presents contradictory findings. Pediatricians have expressed concern that when mothers are discharged home early, lactation is often not well established, and as a result breast-feeding rates have declined (Charles and Prytowsky, 1995). However, other authors have found no difference or even improved breast-feeding rates associated with early discharge (Waldenstrom et al., 1987; Schuurmans and Stewart, 1996; Quinn et al., 1997). Beck et al. (1992) found no increased risk of postpartum depression with shorter length of stay (24-48 hours). However, Hickey et al. (1997) found double the incidence of postpartum depression in women going home early, although they define EPPD as <72 hours.

Recent research is beginning to address the impact of EPPD on the timing of postpartum teaching. New mothers who are discharged at less than 48 hours postpartum have many unmet teaching needs, particularly related to infant feeding and recognizing infant illness (Fishbein & Burggraf, 1998). A study conducted in Hamilton, Ontario identifies the availability of 24 hour telephone advice as the most important (76% of respondents) post-

discharge service that women want when going home early (< 48 hours). Other important community supports include daily nurse home visits (60%) and home making (59%) (Rush & Valaitis, 1992).

Other researchers, while not specifically assessing teaching needs related to EPPD, suggest that topics related to the immediate physical health needs of both mother and baby are most important, particularly for first time mothers (Beger & Cook, 1998). In Waterloo Region, Ontario, an evaluation of Public Health Nurses' postpartum services identified most commonly expressed concerns of new mothers as breastfeeding (90%), physical care of the baby (60%), baby behaviour (60%), and becoming a new parent (59%) (Powell et al, 1998).

c) Summary of the literature:
Most research on EPPD has been conducted in the United States where populations may differ in sociodemographic risk factors. Geographic variations and economic factors likely influence the results. The applicability of these research findings to Canada is uncertain. Studies frequently use very different intervention models and information on post-discharge services is often lacking. As overall newborn readmission rates are low, many study samples do not have the statistical power to detect significant differences. To- date, no population-based studies have been conducted at a provincial or national level to examine the trends and variations in infant readmissions in Canada.

In the literature reviewed, definitions of early discharge vary from 12 to 72 hours, making it difficult to compare results. Current research evidence which examines the impact of reduced length of stay is equivocal, particularly for women and infants from diverse populations and economic backgrounds. Given the variability of information, it is a challenge to plan coordinated postpartum programs and to develop responsive health care policies. In keeping with the recommendation made by Britton et al. (1994), the Canadian Pediatric Society (1995) and the Society of Obstetricians and Gynaecologists of Canada (1996) have issued policy statements in favour of flexible length of stay with careful assessment, preparation, and community follow-up.

POLICY STATEMENTS AND OTHER GUIDELINES

Although the evidence to guide policy development is equivocal with respect to EPPD, a variety of organizations at the regional, provincial and national level have developed policy statements in the 1990s. These statements are summarized in the ***Supporting Document for the Early Post Partum Discharge Paper*** **available through OPHA**. Over time, guidelines and recommendations have become more specific in nature.

Initial reports make recommendations with respect to the timing of services. In 1993, the recommendation that community services be available 7 days per week and support especially for breastfeeding be available 24 hours, was made in the report from the Early Discharge Project (Ministry of Health, 1993). In March 1996, the Perinatal Committee of Eastern Ontario suggested that contact with the family should be made within 24 hours and arrangements made for a physical examination within 48 hours if discharge was at or less

than 48 hours (Perinatal Committee of Eastern Ontario, 1996). This was similar to the National Breastfeeding Guidelines (Canadian Institute of Child Health, 1996).

The Joint Statement of the Canadian Paediatric Society and the Society of Obstetricians and Gynaecologists of Canada (CPS/SOGC) in December 1996 specified that the mother and baby be evaluated within 48 hours of discharge. The CPS/SOGC Joint Statement has been endorsed by the Registered Nurses Association of Ontario (Registered Nurses Association of Ontario, 1997), the Azzopardi Coroner's Inquest (Office of the Chief Coroner, Ontario, April 1997), and the Metropolitan Toronto District Health Council (1997).

There is general agreement that the mother/baby evaluation should be provided by a health care professional. The CPS/SOGC suggests "a physician or other qualified professional with training and experience in maternal/infant care"(p.1283). The CPS/SOGC further specify that a 12 to 24 hour stay is acceptable " ...provided the mother and baby are well, the mother can care for her baby and there is community nursing follow-up in the home"(p.1284). The Metropolitan Toronto District Health Council (MTDHC) suggests "a professional (i.e., nurse) who is skilled in postpartum (both physical and psychosocial) and breastfeeding assessment and teaching"(p.17).

The CPS/SOGC Joint Statement and the MTDHC recommendations specify that this assessment should be carried out in a home visit. The RNAO Statement does not specify the location although they do endorse the CPS/SOGC Joint Policy Statement. The Azzopardi Coroner's Inquest emphasizes that the evaluation be "in person" and recommends "a physician, Public Health Nurse, Breastfeeding Out-Patient Clinic, or other arrangement which ensures that a qualified professional examines the baby and the breastfeeding".[2] There is general agreement that a follow-up examination of the newborn by a physician should take place within 7 to 10 days of the birth (although the MTDHC recommends 5 to 7 days).

The MTDHC [1997] recommends mothers be "provided with the tools to empower themselves on matters relating to their care and that of their baby"..."there should be one standard *Maternal /Newborn Passport* which is given to the mother as her record of information, on the birth and her baby, which she can carry with her on visits to her primary care providers." The Azzopardi Inquest recommended "that upon discharge a detailed record go home with the client so that the mother and those doing the follow up would have access to the information"(p. 2).

The Ontario Mandatory Health Programs and Services Guidelines (MHPSG) (1997) do not explicitly address the immediate postpartum period however they do have a standard to promote and support breastfeeding. The MHPSG (1997) standard for promoting and supporting breastfeeding directs health units to ensure provision of "telephone consultation to breast feeding mothers" (p.32,) but does not specify the provider. The MHPSG, in the

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[2] In response to the release of the Coroner's report and based on the Guelph inquest recommendations, the OPHA Child Health Workgroup developed a background article for media release. This was circulated to all Ontario health units and District Health Councils in 1997.

Standard that "ensures provision of services to breastfeeding mothers," suggests " training of peer educators to act as breastfeeding advocates and to provide in home support" (32). This does not correspond to the Inquest recommendations or CPS/ SOGC guidelines. The Azzopardi Inquest recommendations state specifically "that information provided to mothers of newborn infants make it clear that volunteer organizations which provide support to breastfeeding mothers are not a substitute for professional health care advice or assessment" (p.3) and further "evaluations over the telephone should be discouraged because of the potential for miscommunication" (p.1) and "that anyone giving phone advice about breastfeeding be adequately qualified in breastfeeding"(p.3) .

The United States has led the way in mandating early discharge and there has been a significant recent change in policy direction enacted at the federal level. The Newborns' and Mothers' Health Protection Act of 1996, provides standards for a minimum length of postpartum stay and assessment of each women and infant. Several individual states have subsequently passed their own legislation based on the principles of this act.

Newborns' and Mothers' Health Protection Act of 1996 (USA)

(1) The length of post-delivery inpatient care should be based on the unique characteristics of each mother and her newborn child, taking into consideration 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 the access of the mother and infant to appropriate follow-up health care; and

(2) The timing of the discharge of a mother and her newborn child from the hospital should be made by the attending provider in consultation with the mother.

http:\www.arentfox.com/telemed/telemed.7q.html

Summary of policy statements:
Even though the research literature is incomplete and equivocal, positions are being advocated by various professional organizations in the province of Ontario. Guidelines address formal discharge criteria for mother and baby; when, where, and by whom the first infant assessment should be carried out; timing of the first well-baby visit; communication amongst health care providers; and support for breastfeeding. A variety of formal guidelines and recommendations have been written but at this time they have not been acted upon in a systematic way. Despite professional guidelines, there are no structures in place to ensure implementation and compliance.

POSTPARTUM SURVEY RESULTS

The OPHA Child Health Workgroup conducted a survey concerning the length of hospital stay, factors affecting length of stay, and community services available to women in the perinatal and immediate post-partum period. This survey was faxed to all health unit regions in the province of Ontario in February of 1998. Managers responsible for Family Health Programs were asked to complete the questionnaire or to forward it to an appropriate person in their area for completion. Information was received from 41 of the 42 regions, yielding a 98% response rate. The one missing health unit did reply but was

unable to complete the survey or supply the requested information.

Length of Postpartum Hospital Stay (LOS):
There was a great deal of variation in LOS amongst health unit regions and even between hospitals in the same region. LOS for vaginal deliveries varied from 24 hours, predominantly in large urban centres, to 4 to 5 days in smaller rural communities. Commonly, hospitals discharged at 48 hours (45%), 24-48 hours (17%), or 48-72 hours (13%). Moreover, the length of stay for caesarean deliveries ranged from 48 hours, again in a large urban Centre, to 5 days in smaller rural communities (see Tables 1 and 2).

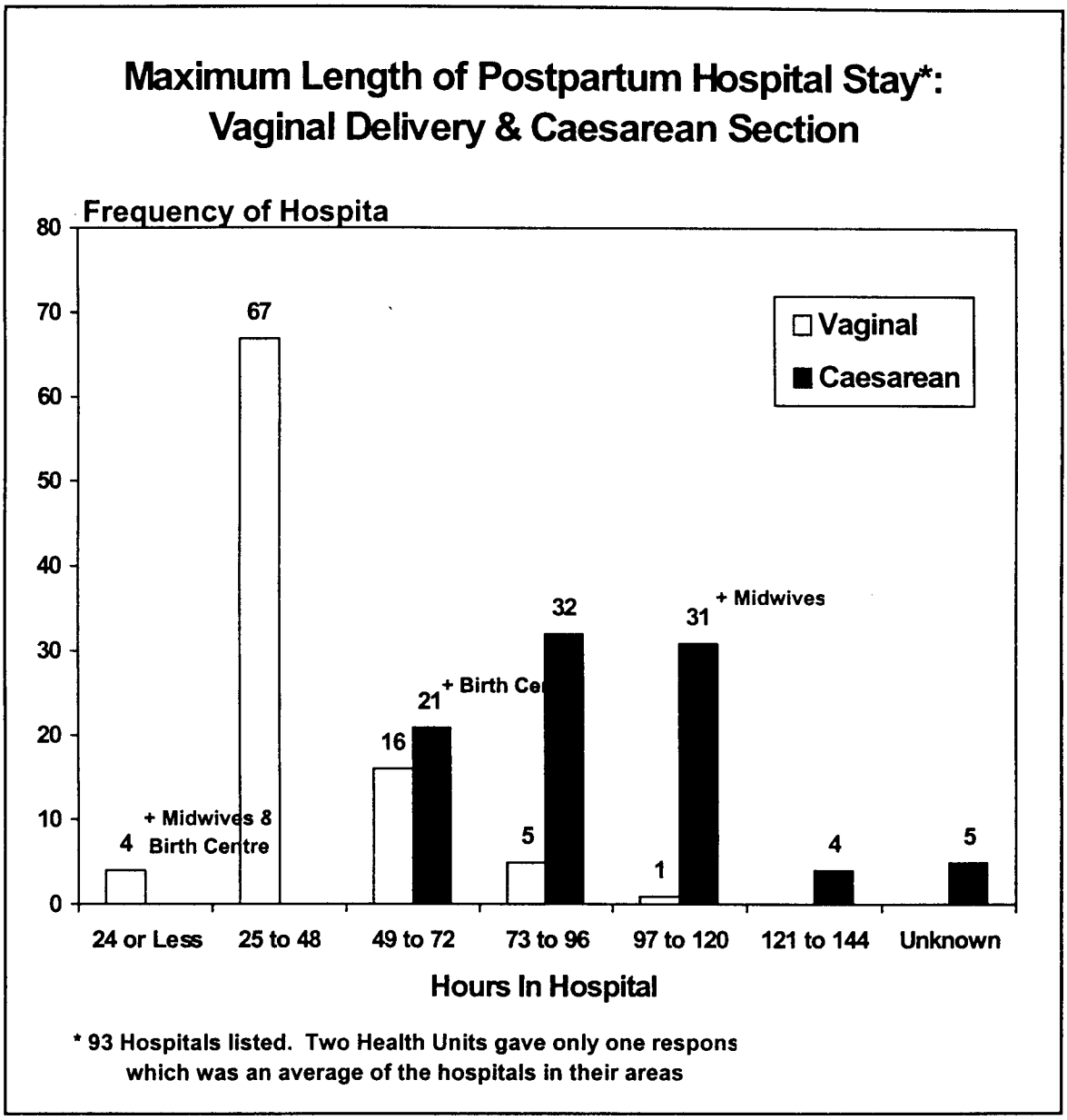
Table 1: Length of Postpartum Hospital Stay:

Vaginal Delivery	Number of Hospitals
3-4 hours	midwives
24 hours	4 + Birth Centre
24-36 hours	3
24-48 hours	16
24-72 hours	1
36 hours	1
36-48 hours	5
48 hours	42
48-72 hours	12
48-96 hours	1
72 hours	3
72-96 hours	4
120 hours	1
Total # hospitals [1]	93
Birth Centre	1
Midwives	1

Caesarean Section	Number of Hospitals
2-3 days	6 + Birth Centre
2-5 days	2
3 days	15
3-4 days	16
3-5 days	5 + midwives
4 days	16
4-5 days	23
4-6 days	4
5 days	1
no info given	5
Total # hospitals [1]	93
Birth Centre	1
Midwives	1

[1] Two health units gave only one response which was an average of the hospitals in their areas.

Figure 1: Maximum Length of Postpartum Hospital Stay: Vaginal Delivery & Caesarean Section



Factors Affecting Length of Postpartum Stay:

Health unit regions were asked to identify all factors affecting length of postpartum stay. The following factors were cited by health unit regions as affecting hospital discharge: breastfeeding (87.8%), social situations (85.4%), maternal skill and knowledge (75.6%), home support issues (65.9%), maternal age (51.2%), weather (41.5%) and transportation (36.6%).

Community Services:

Health unit regions were asked to identify if the following postpartum services are currently being provided in their regions.

Table 2: Community Service[1] Provided by Agencies in Health Unit Regions

	By agency:	# Responses	Weekday only	Weekend only	Weekday and Weekend	Not Provided
Telephone Line	Health Unit	40	31 (77.5%)	0	3 (7.5%)	6 (15%)
	Hospitals [2, 3]	40	0	1 (2.5%)	30 (75%)	9 (22.5%)
	CCAC [4]	40	0	0	6 (15%)	34 (85%)
	Other	39	5 (12.8%)	2 (5.1%)	7 (17.9%)	25 (64.1%)
Lactation Clinics	Health Unit	40	17 (42.5%)	0	2 (5%)	21 (52.5%)
	Hospitals	40	17 (42.5%)	1 (2.5%)	7 (17.5%)	15 (37.5%)
	CCAC	40	0	0	1 (2.5%)	39 (97.5%)
	Other	39	4 (10.3%)	0	2 (5.1%)	33 (84.6%)
Postpartum Clinics	Health Unit	40	10 (25%)	0	0	30 (75%)
	Hospitals	40	8 (20%)	1 (2.5%)	5 (12.5%)	26 (65%)
	CCAC	40	0	0	1 (2.5%)	39 (97.5%)
	Other	40	3 (7.5%)	0	1 (2.5%)	36 (90%)
Home Visiting	Health Unit	40	32 (80%)	0	6 (15%)	2 (5%)
	Hospitals	40	2 (5%)	0	3 (7.5%)	35 (87.5%
	CCAC	40	3 (7.5%)	1 (2.5%)	24 (60%)	12 (30%)
	Other	38	4 (10.5%)	0	9 (23.7%)	25 (65.8%)

1 The questionnaire also asked about homemaking and group services. The data for those two variables did not always reflect the immediate postpartum period so this information is not presented in the chart. A more complete analysis of variations within health unit regions is available from the Child Health Workgroup.

2 Many health unit regions have more than one hospital. Services provided by hospitals counted only once per region.

3 Respondents commented that staff were not always formally assigned to hospital telephone lines and thus the availability of information provided by some hospitals is inconsistent.

4 CCAC = Community Care Access Centre

Summary of postpartum survey:

The results of the survey indicate that postpartum services available to women vary widely across the province. CCACs provide home visiting service to a subset of postpartum women, predominantly those requiring medical intervention, for example, caesarian section dressing changes. It is uncertain from the results of the survey, how many CCAC's provide other services for families in the postnatal period.

Most regions have telephone lines, however, only three health units provide weekend service. Telephone information lines were provided on weekdays by 31 (77.5%) of health units. This is in keeping with the MHPSG (1997). Hospitals provide most of the telephone information services on weekends. This is a concern given the comments of the respondents about inconsistent staffing provision for phone lines within hospitals. Many regions have phone lines provided by more than one organization. We do not know from the questionnaires if these lines are provided in a collaborative manner and/or if information provided is consistent.

Despite policy documents which recommend early breastfeeding assessment, lactation clinics are available sporadically, and often not available on weekends. Only two health units offer lactation clinics on weekends. Postpartum clinics are even less available than lactation clinics both during the weekend and on weekdays. No health units offer weekend postpartum clinics.

Almost all health units offer weekday home visiting (95%) but only 15% offer weekend service. Many CCACs also do not provide weekend coverage which raises concerns with regard to accessibility of service to women experiencing breastfeeding problems when other access issues exist (e.g. transportation, child care, physical discomfort, lack of supports).

The results of this survey demonstrate the wide variability in both the type and the availability of services in the different health unit regions. They also clearly indicate the lack of services available to new families on weekends in many regions. Respondents were asked for changes expected in the current services provided in their regions as a result of the down loading of Public Health to the municipalities. Twenty-eight respondents (68%) commented on concerns about funding cuts and the ability to meet the demand for services and/or respond to the needs of families during the post-partum period. These respondents commented on past cuts to Public Health funding and the lay-offs of Public Health Nurses which jeopardized the delivery of these services. The Healthy Babies, Healthy Children Program (HBHC) was mentioned by nine respondents (22%). Comments reflect concerns about the under funding of this initiative and that this program only serves those at highest risk, leaving many families unserved. And even though HBHC has since received increased funding this program does not address the need in the early postpartum discharge period..

UNIQUE PROGRAMS:

Many health unit regions have developed a variety of creative initiatives in response to early post partum discharge. The following are examples of a few of these initiatives.

Baby's First Week Home

A unique partnership with Toronto Public Health and Toronto East General Hospital exists. Birth referrals are faxed to the Health Department by the hospital staff. From there, a telephone assessment is done by a Public Health Nurse within 24 hours. Based on the assessment, the client will either have a home visit by a Public Health Nurse or be referred to a Well Baby Clinic which is staffed 7 days/week. Two days the clinic runs out of the Health Department, 5 days out of the Hospital. There is no exchange of monies for this program. What is unique about this program is its true partnership within the community to service postpartum families. (Contact: Linda Shortt (416) 469-8566)

Mother Baby Support Program

St. Joseph's Health Centre, Community Health Centres, St. Elizabeth Health Care, and Toronto Public Health collaborated in response to reduction in hospital stay to 24 hours. In this program, the hospital purchases the home visiting service within 24 hours post discharge, from various agencies, depending on client address. If a client is followed by a community health centre, the client will continue to be followed up by that centre. This service is for all women regardless of parity. The hospital pays for the first home visit and will pay for a second visit if needed. After this, Toronto Public Health will visit for as long as indicated. This community based initiative is unique in that they share community resources to provide early postpartum care. They have worked on protocols for ensuring consistency and standards among care providers. Evaluation is underway.
(Contact: Marylou Walker (416) 392-0898)

A Regional Approach

Grand River and Cambridge Memorial hospitals in Waterloo region provide post discharge clinics for mothers discharged within 24 hours of delivery. An appointment is made prior to discharge. At 72 hours post birth a Registered Nurse and/or /Lactation Consultant assesses infant feeding, weight, hydration, jaundice, bonding, and the general health of baby and mother. Referrals are made to appropriate community supports as needed. Families are encouraged to see their physician within 7-10 days. In addition, parents may contact the New Mother Support Services for breastfeeding support at Grand River Hospital until the infant is one month old. Several community organizations provide home support to new families. Midwives continue to provide postnatal follow up for their clients.

Public Health Nurses, from the Waterloo Region Community Health Department assess the family in the hospital and work collaboratively to ensure that community support is in place prior to discharge home. Mothers are provided with information on how to access resources once home. Public health follow up may involve telephone consultation or home visiting. Parents may also call the Healthy Children InfoLine for information or support.

Community Breastfeeding Support sites and rural Family Wellness sites offer professional assessment and peer support throughout the region during the week. Both hospitals provide breastfeeding support on the weekend as well as during the week. [Contact: Margaret Weidmark (519) 883-2002 Ex. 5351].

CONCLUSION

Current research evidence which examines the impact of reduced length of postpartum stay is equivocal. Given the variability of information, it is a challenge to plan coordinated postpartum programs and to develop responsive health care policies. Although numerous policy statements and professional guidelines have been written, there is no mechanism to ensure implementation or compliance. The provincial survey conducted by OPHA Child Health Workgroup identified that:

- there is variation in length of postpartum stay (3-120 hours)

➛ factors such as breastfeeding status, social situations, maternal skill and knowledge, home support, maternal age, weather and transportation affect length of stay

➛ there is wide variation in both the types and the availability of services (particularly weekends).

Flexible, responsive services that respect individual needs are an integral component of any community-based postpartum program. Because of the limited resources available to agencies and institutions, attempts must be made to ensure that those families at increased risk for poor health outcomes be appropriately supported in the community. Public health can display leadership at a provincial level through advocacy and healthy public policy efforts, using population health promotion expertise.

New families who are socially or economically disadvantaged are more likely to experience barriers in accessing services. These families are also more likely to have adverse health outcomes. Targeting resources to these mothers and their infants will have a positive impact by reducing inequities in health outcomes.

Integration of community and acute care maternal/infant health services is key to ensuring that the needs of all new mothers are met within the community. No one agency or service in isolation can meet the needs of this population in our community. However, by working together, in partnership with the community, support for new mothers can be strengthened and enhanced. This spirit of co-operation in promoting and protecting the health of our community's new mothers and their babies, will promote their optimal health.

RECOMMENDATIONS

As the research to date is equivocal, there is an urgent need to conduct population-based research to examine trends and variations in newborn readmission in Ontario as well as at a national level. This will assist in determining what programs should be offered to which women under what circumstances. Even though the research literature is incomplete and equivocal, various organizations in the province of Ontario have developed policy statements and practice guidelines. The following recommendations are made based on the literature reviewed in this paper, existing policy documents, the Child Health Workgroup survey and in keeping with current professional guidelines.

At the provincial level, a policy agenda should be developed which includes[3]:

- A minimum standard of programs and services for new mothers in Ontario

[3] The midwifery model of care is consistent with many of these recommendations.

- Professional organizations and key community stakeholders working should work together to promote and protect the health of new mothers and their babies
- A requirement and standard in the Ontario Mandatory Health Programs and Services Guidelines which addresses early postpartum discharge
- A mechanism to ensure adherence to CPS/SGOC guidelines
- Legislation which provides guidelines for postpartum hospital discharge which are consistent with the United States Newborns' and Mothers' Health Protection Act, 1995
- Postpartum hospital length of stay based on consistent discharge criteria, reflecting individual need
- Development and implementation of a traveling baby record which is consistent across the province

Each local health unit region should:

- Form a local multisectoral planning body which addresses the issues of prenatal and postnatal services in their community
- Address local barriers to accessing service (e.g. transportation, language, child care, hours of service)
- Plan and implement the recommendations from the Azzopardi coroner's inquest
- Ensure that all women be seen by a health care provider (in an office, clinic, or home visit) within 48 hours of hospital discharge
- Ensure that the 48-hour follow-up appointment is arranged prior to hospital discharge
- Ensure that breastfeeding support for women experiencing difficulties is provided seven days a week in their community
- Ensure that new parents be given written information about their baby (e.g. discharge weight) when discharged from hospital

A specific role for the Ontario Public Health Association, to support issues related to Early Post Partum Discharge, is outlined in the resolution submitted to the 1998 Annual General Meeting.

Supporting Documents for the Early Postpartum Discharge Paper are available from Nolly at OPHA: (416) 367-3313
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