

"TESTIMONY BY EDWIN F. DAILY, M.D., BEFORE THE COMMITTEE ON WAYS AND MEANS, HOUSE OF REPRESENTATIVES

"(Charts mentioned not printed in RECORD.)

"I am here today in my capacity as the Director of the Maternity, Infant Care-Family Planning Projects of the New York City Department of Health to explain the necessity of continued Federal support of the MIC Project in New York City and similar Projects in 50 cities throughout the United States.

"H.R. 11484, introduced on October 28, 1971 by Congressman Edward Koch, if enacted, will assure continuation of these urgently needed health services for mothers and children.

"New York City has one of the greatest concentrations of low-income families in this country, with more than one-million people receiving public assistance in 1971. As in 1963, they continue to strain the resources of this city, as I believe they do in many other large cities. Before the MIC grants to New York City, there was serious overcrowding of the maternity services in the 15 adequately staffed, tax-supported city hospitals. These hospitals were two or three bus fares away from many families who had no place else to go for maternity care in 1963, so many mothers often got little or no prenatal care.

"In 1963, 40% of the city's residents giving birth were medically indigent; in 1970 this had increased to 50%. In 1963, the incidence of prematurity among general service patients was three times that of the private patients receiving adequate prenatal care and the infant mortality rate of these low or no-income patients was twice as high as that of private patients.

"The New York City MIC program started in 1964 with two maternity clinics in district health centers and has grown each year until now it is operating in 11 Health Department centers in those ghetto areas of the City where the poorest families live. (See map.) The large stars represent clinics providing both maternity and family planning services; the smaller stars where family planning services alone are provided.

"In 1970, 13,000 maternity patients received care in these 11 centers. In 22 Health Department centers family planning services were provided to 35,000 patients. (The graphs attached to my testimony show the growth of the MIC program since 1964.) Medical care is provided by skilled obstetricians or certified nurse-midwives from the staffs of 10 voluntary and 3 municipal hospitals affiliated with the MIC Project. The women are delivered in these hospitals.

"The MIC patients receive total maternity care during pregnancy, at delivery, and postpartum. In addition to obstetricians and certified nurse-midwives, the clinics are staffed with public health nurses, social workers, nutritionists, dentists and the ancillary personnel needed—all under the direction of specialists in the field of maternal and child health. The clinics are operated on the appointment system—broken appointments are promptly followed up. Humane and dignified patient-doctor, patient-nurse relationships are maintained. Consultation or hospitalization for complications is readily available in the affiliated hospitals. Specialized teenage clinic sessions are available to meet the many difficult problems of the young unmarried mothers.

"The MIC program has made great strides in reducing infant mortality in New York City, as evidenced by the following figures. In 1964, when MIC started, the infant mortality rate was 27 per 1000 live births; in 1970, it was 21.6—a decrease of 24%. However, the Mott Haven Health District of the Bronx, where MIC placed two of its largest services, the infant mortality rate has dropped over 50% during these six years! In the adjoining Morrisania Health District, also with MIC services, the rate dropped 30%! Another adjoining Health District—Tremont—without MIC services had an increase in infant mortality during the same six year period.

"The perinatal mortality rate (late fetal and early infant deaths) is lower for MIC delivered women than for all private and nonprivate births in New York City. Considering that the MIC patients live in the poorest areas of the city, many of whom are known to have had inadequate housing and food for most of their lives, this reduction in infant and prenatal mortality rates must be attributed in no small part to the work of the MIC program.

"We talk with every prenatal patient about the importance of preventing unwanted pregnancies by using a birth control method after the baby is born. Before they leave the hospital, our peer-level family planning counselors get them started on a birth control regime of their choosing. Studies have shown that 40% of the children born to low-income families were not wanted by the parents. In

New York City alone, this would mean 25,000 unwanted children are born each year to low-income families. Unwanted children often create serious social and economic problems within the family, especially if there are other children. That is why, at the same time we try to provide good maternity care under MIC, we make every effort to minimize the occurrence of unwanted pregnancies in future years. I am confident these efforts are related to the declining birthrate in New York City. Furthermore, the cost of raising these children educating them and providing health and social services is often a staggering cost to the community. If the MIC and In-Hospital Family Planning program, described in the reprint attached to my testimony, prevents even 10,000 unwanted pregnancies in a year among the 60,000 women to whom we provide post-partum and post-abortion family planning service each year, it will result in a savings of at least \$10 million in tax funds per year—which is three times as much as the annual MIC grants to New York City.

"Mayor John Lindsay, in a recent communication to Secretary Elliott Richardson, stated that 'It appears most unlikely that local funds could be made available to support these lifesaving health programs if the Federal MIC funds are not available after June 30, 1972.'

"The New York City Health and Hospitals Corporation announced in October that, because they have been unable to operate within the budget approved for the Corporation, they plan to reduce through attrition, all staff (except physicians and nurses) in the municipal hospitals by 12%. Inasmuch as the municipal hospitals are already inadequately staffed, this can only have a highly deleterious effect on patient care.

"To abandon the MIC program and return the MIC patients to the overcrowded clinics of inadequately staffed and under-financed municipal hospitals would scatter to the winds all of the advancement made in the delivery of maternity care during the past seven years. Once again, these patients, many of whom face special health hazards, would be subjected to long hours of waiting in the overcrowded clinics of most of the municipal hospitals. There would be a means test and charges which would result in many patients receiving no care.

"The quality of maternity care now available through the MIC board-qualified obstetricians and nurse-midwives, social workers, nutritionists and dentists, and other staff in the MIC clinics would not be available to this population without MIC. Gone would be the warm patient-doctor and patient-nurse relationship never before known to most of the patients before MIC. The MIC clinics convenient to the homes of the patients, now serve one-fifth of all general service patients in the city. 30% of MIC patients are on welfare and 70% are from what have been designated as 'working poor' families. Without MIC or other Federal funding, the MIC maternity clinics in New York City will have to close. Last week, I talked with Dr. Byron Hawks, the MIC director in Little Rock, Arkansas, who told me that if MIC funds are not continued, the low-income women in that city would have to return to 'granny midwives' for maternity care.

"The United States is one of the wealthiest nations in the world. There are funds to support armies, to aid other nations, to subsidize the farmers and yes, even to subsidize the railroads and aircraft industry. Surely funds can be found to finance essential health services for the nation's low-income women. I know your committee is giving consideration to various proposals for financing nationwide health services. I hope that whatever legislation is enacted will assure the financing of specialized high quality maternity and infant care services wherever needed. Since a new nationwide health program cannot be operative for several years, discontinuing MIC would leave an enormous void between 1972 and until a national health program is in full operation.

"I can assure you that tens of thousands of women living in ghetto areas of the cities who have or will benefit from MIC services, will be grateful and relieved if the Congress approves continuation of these desperately needed health services for mothers and their children."

"NEW YORK CITY'S IN-HOSPITAL FAMILY PLANNING PROGRAM

"(By Edwin F. Daily, M.D., Aileen R. Sirey, and Lucille S. Goodlet)

"In May 1970 over 2,800 medically indigent maternity or post-abortion patients in 23 New York City municipal and voluntary hospitals received family planning counseling—and in seven out of 10 cases were initiated on a contraceptive method—before hospital discharge. The counseling is provided on the maternity

wards by 51 family planning counselors specially trained and employed by the Maternity and Infant Care-Family Planning Project (MIC-FP) of the New York City Department of Health. The counselors are themselves mothers; some had been on welfare; all live in the vicinities of the hospitals they serve.

"The In-Hospital Family Planning Program was begun on an experimental basis in July 1969 with maternity patients in three hospitals. The program is expected to reach 4,000 low-income women each month by the end of 1970 and will be extended from the obstetrics and gynecology departments at least to the out-patient departments of the municipal hospitals. Two more municipal, eight voluntary and four state mental hospitals will be added to the program, with counselors assigned to medical, surgical, psychiatric and other services. It is hoped that eventually in-hospital family planning counseling and services can be offered to all of the 140,000 general service patients of child-bearing age who are discharged each year from New York City municipal and voluntary hospitals.

"The major objectives of the new in-hospital program are:

"To offer family planning information and services to large numbers of women of child-bearing age at a time when they are most receptive,

"To create a community system to provide such patient education and service involving the cooperation of the Department of Health and the OB/GYN departments (and eventually other departments) of New York City's municipal and voluntary hospitals,

"To develop an effective method to select and train community women so as to foster a maximum of commitment and initiative, and provide them with sufficient skill and knowledge so that they can work with a minimum of supervision,

"To operate this program at a per patient cost far less than the cost of traditional outreach programs, and

"To augment scarce manpower resources by employing community women and preparing them as family planning counselors, thus channeling much of the program's funding back into the communities that are served.

#### "BACKGROUND

"The MIC-FP project basically provides prenatal care for 12,000 new patients each year in 14 neighborhood centers and hospitals, and family planning services for some 16,000 new patients a year in 28 neighborhood centers.

"Early in 1968 the Department of Health, Education and Welfare invited the New York City Department of Health to submit a plan and budget for an expanded family planning program. The MIC-FP director met with chiefs of obstetrics and gynecology in 12 hospitals then participating in the MIC-FP program to seek their advice. These physicians emphasized the importance of getting family planning help to patients as soon as possible after delivery, since this was the period when motivation to accept contraception was highest. They pointed out that numbers of patients were becoming pregnant between their hospital discharge and post partum visit, and that at least 60 percent of patients never returned for a post partum examination. They also suggested that it would be useful to introduce birth control to postabortal, medical, surgical and psychiatric patients of child-bearing age. Despite the tremendous need for introduction of such services, these physicians said, family planning was a low priority item for busy hospital residents, nurses and social workers. A new type of health worker was needed, they said, recruited from the patients' own communities, and specially trained to educate their neighbors about family planning.

"Initiation of contraceptive counseling and services immediately after parturition had been tried with some success at Cook County Hospital in Chicago and Grady Memorial Hospital in Atlanta. In neither case, however, was the counseling performed by peer group women drawn from the patients' own neighborhoods. (In Chicago, volunteers—predominantly white and middle class—counseled a patient group which was poor and mostly black; in Atlanta nurses provided the counseling.) The In-Hospital Family Planning Program was developed (and endorsed by the OB/GYN chiefs of the 12 hospitals and other key health and family planning leaders in the city) so that family planning counselors would be recruited from the hospital communities, trained by MIC-FP project staff and placed in hospitals which wished to initiate family planning for their patients. The plan and budget (\$137,000 for the first 12 months; it is now

up to \$500,000 a year) was approved by the Department of Health, Education and Welfare (DHEW) Children's Bureau\* in March 1969. By July:

"A core staff of family planning coordinators had been hired in MIC-FP's Division of Community Education to organize recruitment, screening, training and supervision of the family planning counselors. The coordinators are college graduates, some with experience in teaching or the behavioral sciences, and all with a deep interest in the development of family planning services.

"Site visits were made to Grady and Cook County Hospitals to observe the in-hospital family planning programs developed there.

"A seven-week training course for family planning counselors was developed, and an initial group of six women was recruited and training.

#### "DEVELOPING THE PROGRAM IN NEW YORK CITY

"In October 1969 the program was extended to the OB/GYN departments of the nine voluntary and six municipal hospitals then currently participating in MIC-FP projects. Subsequently, agreements to participate in the in-hospital program were signed with a total of 13 municipal and 10 voluntary hospitals with two more municipal, eight more voluntary and four state mental hospitals expected to join the program by the end of 1970.

"(The in-hospital agreement is a formal document signed by the OB/GYN chief of the hospital and the MIC-FP director. The OB/GYN department of the hospital agrees:

"To take charge of the family planning program in the hospital.

"To offer all generally accepted methods of family planning (including IUD, pills, tubal ligation and rhythm),

"To offer family planning services at least to all maternity and abortion patients, before discharge unless there is a medical contraindication,

"To provide family planning services and materials to patients without charge,

"To acquaint all doctors, nurses and nurses' aides working with women of childbearing age in the hospital with the importance of family planning to the health of mother and of future children and to the economy of the family,

"To inform all prenatal patients attending the hospital's OPD service of the importance of family planning and provide appropriate family planning literature,

"To appoint a physician thoroughly familiar with all methods of family planning and the indications and contraindications for various methods, and give him responsibility for medical supervision of the in-hospital and out-patient family planning program.

"To appoint a nurse-midwife or a nurse interested and fully informed about family planning to assume day-by-day supervision of the family planning counselors,

"To instruct all nurses on daytime duty on floors covered by the family planning program about dispensing of pills when this is the method prescribed, and to instruct residents serving these floors about medical approval or disapproval of the methods selected and about insertion of IUDs,

"That patients started on a family planning regimen (other than tubal ligation), will be given a written appointment for their first post discharge family planning visit in a hospital or health department clinic most convenient for the patient; a copy of the appointment slip will be sent to the clinic selected, and a copy sent to the MIC-FP director; and

"That missed return appointments to the family planning clinic will be followed up by one or two telephone calls or letters requesting that another appointment be made.

"The MIC-FP director agrees:

"To employ and train family planning counselors and assign them to participating hospitals on a full- or part-time basis (depending on the average number of discharges per day of patients),

"If the OB/GYN department already has family planning counselors, to reimburse the department for the number of hours each month spent on the in-hospital family planning program,

\*The Childrens Bureau initially directed DHEW's family planning projects grant program, now under the jurisdiction of the National Center for Family Planning Services of the Health Services and Mental Health Administration.

"To pay the OB/GYN department to help defray its added costs: \$4.00 for each inpatient initiated on a family planning regime of pills or diaphragm before discharge; \$6.00 for each patient with an IUD inserted before discharge; \$25.00 for each in-hospital tubal ligation before discharge.

"The per capita reimbursement to the OB/GYN departments averages about \$7.25 per patient who is initiated on a medically prescribed method.

"The role of the counselor is clearly defined: Her duties consist of solely providing family planning information to patients, filling out statistical forms required for reimbursement and seeing to it that a post partum and family planning appointment is arranged for every patient who is initiated on a contraceptive method.

"After the agreement is signed, the MIC-FP's Director of Community Education and Training and one of the family planning coordinators begin a series of informal meetings with key hospital staff to reinforce their awareness of program objectives and their understanding of the role of the family planning counselor, as well as to assist professionals in working through complementary role activities with these new peer counselors. Experience has shown that in some hospitals the program is met hesitantly at first.

"Typical questions raised are: 'Who are these people?' 'What kind of training do they have?' 'How much supervision will they need?' And though never articulated, some staff members' attitudes clearly showed that they felt professionally threatened.

"MIC-FP's coordinator is responsible at each hospital for establishing an atmosphere of cooperation, and assuring staff involved that the family planning counselors will not add to their already heavy responsibilities.

#### "RECRUITMENT OF FAMILY PLANNING COUNSELORS

"Community women are recruited as trainees for the in-hospital program through discussions with such grass-roots agencies as community corporations, Puerto Rican Manpower Development, Planned Parenthood's Community Action Department, the Puerto Rican Guidance Center and the New York State Employment Center. In some cases advertisements are placed in community newspapers.

"No educational qualifications were established for the position of family planning counselor in order fully to utilize the untapped human resources in the community. At the same time some kind of criteria were needed to evaluate candidates so that the program would not be faced with continual turnover of staff into whose training a great deal of money, time and effort has been expended. A screening process was devised whereby groups of seven to 10 applicants are seen by a staff interviewer and observer. The interviewer describes the program, briefly outlines the responsibilities of the family planning counselor and stimulates group discussion on such subjects as local community problems or the applicants' feelings about family planning. Through this group screening process candidates are sought who can discuss "sensitive" topics on a mature level, show tolerance of the opinions of others and can articulate their own thoughts and feelings. Candidates are expected to show an interest in hospital work and need to be able to read and write sufficiently well to handle the statistical forms.

"The interviewer and observer meet after each screening session to discuss each applicant's responses and to select candidates for training. Applicants about whom there is some question are asked back for an individual interview with a different staff member. About one out of five applicants are accepted for training.

"Successful candidates are started in the training program immediately. The salary during the seven weeks of training is \$2.50 per hour, \$3.00 an hour when assigned to a hospital and \$3.50 an hour after six months. The salary is supplemented with full health insurance (a benefit available for the first time to many of these women and their families).

#### "TRAINING

"The training program was developed to provide factual knowledge about family planning, reliable techniques to impart knowledge to patients and an understanding of hospitals and hospital procedures.

"A number of questions about the training program soon became salient:

"What did the trainees already know?

"What would happen to the counselors' ability to relate on a 'peer level' after intensive training?

"If the counselors' education was formal and didactic, wouldn't they relate in the same formal and didactic way to the patients?

"It was decided that a laboratory training experience tailored to each group's particular needs was required to encourage individual initiative.

"The first day of training begins under the direction of a psychologist-counselant.

"Both professional staff and trainees engage, on a first-name basis, in activities designed to break down the barriers to communication. On succeeding days the group discusses the role the counselor will play in the hospital. Out of the questions trainees raise about the job, topics for investigation are formulated about family planning, reproduction, human sexuality and hospitals. In the atmosphere of mutual respect engendered by this laboratory approach to training, life experiences are exchanged without self-consciousness, trainees giving "tell-it-like-it-is" reasons for human behavior, and the coordinators contributing factual knowledge from their own professional experience. Methods and media include lectures, panel discussions, role-playing and problem-solving sessions. On-the-job training experiences at a municipal and voluntary hospital are provided as part of the counselors' seven-week training course.

#### "HOSPITAL EXPERIENCES

"At least two family planning counselors are assigned for each hospital to talk about contraception with the patients and where possible, with their husbands. When the patient is interested in a method, the counselor informs a resident, who prescribes a method after examining the patient. The counselor visits the patient again to explain the details of the method chosen. She completes the statistical form for reimbursement and makes a post partum-family planning appointment for four to six weeks after the patient is discharged. About one in five patients have received their prenatal care at an MIC clinic. These patients are referred to an MIC-FP center in their neighborhood for their post partum and family planning care. Others may come back to the hospital or are referred to a more convenient neighborhood facility. Appointment and counseling records follow the patients from hospital to clinic where a referral has been made. (Clinics have begun to participate in a joint record system whereby each patient is identified by a unique numbering system derived from her maiden name, date and place of birth.) The counselors have found almost all patients eager to discuss family planning (most have never discussed family planning before with a health worker) and to have their questions answered in their own language.\* All the hospitals participating started the counselors on the OB/GYN service with instructions to interview all post partum and all post-abort patients before discharge. Each counselor is able to reach about five to 10 patients each day. At the present time there are 51 counselors in 23 hospitals; in the month of May they interviewed more than 2,800 patients.

"The problems that have arisen are as interesting and as varied as the 23 hospitals with which we are working. Three OB/GYN chiefs objected to the immediate post-partum use of steroids, but were willing to prescribe other methods; patients wishing the pill in the three hospitals were given a supply of foam to use until their post partum appointment, and were informed that they would be started on the pill three to four weeks later. In a few hospitals, at the beginning, residents balked at cooperating with the program; they saw family planning as a low-priority item in their busy schedules and feared that the counselors would make extra work for them. Other hospitals did not have residents who were able to insert an IUD. One hospital pharmacy refused to dispense pills to patients before discharge; while in another the chief of obstetrics had to be persuaded not to ask the counselors to give pills to patients. A few floor nurses feared that the counselors would overlap some of their functions or "be in the way." This fear was quickly allayed as the nurses observed how well informed the counselors were, and how much the patients liked and trusted them. Soon nurses and other hospital personnel began to come and listen in on the patient-counselor discussions to become more closely acquainted with patient problems related to family planning. One hospital administrator questioned whether it was legal for a health department employee to work in the hospital. (He was reassured that liability for

\*Of the first 3,500 patients counseled in the program, half were Puerto Rican and only 200 were mainland white. Well over half of the counselors are bilingual in English and Spanish.

the counselor was assumed by the health department.) In several hospitals, operating room time is at a premium, and tubal ligations, though requested by patients and their husbands and approved by the hospital committee, cannot be performed before discharge. Such patients are asked to return when the hospital is less crowded and are provided with an interim method of contraception.

#### "STATISTICS

"Table 1 shows that between July 1, 1969 and May 1, 1970 family planning counselors interviewed 17,706 patients in 21 New York City hospitals. At least nine out of 10 patients interviewed indicated that they wished to begin contraception before discharge; 68 percent of this group received contraception while still in the hospital. Of those initiated on contraception in-hospital, 51 percent received pills, 19 percent IUD's, 10 percent tubal ligations and 20 percent foam and other methods. Some of the hospitals are much more committed and better staffed to implement patient choices about in-hospital initiation of contraception than others.

Thus in 13 hospitals where there is strong endorsement by the OB/GYN chief, and a resident assigned full-time to the program, more than 80 percent of patients interested were provided with contraception before discharge. In one hospital, 1,247 patients interviewed, 1,226 indicated that they wanted to start family planning and 1,212 were initiated on a method of contraception before hospital discharge. As the program becomes more smoothly integrated into the routine of more hospitals, it is expected that the number of contraceptive initiations will be closer to 100 percent of the patients interested. This trend can be seen in Table 1: Whereas 67 percent of patients counseled in the first six months received contraception in-hospital, 76 percent of patients counseled in April 1970 were so initiated. The number is not likely actually to reach 100 percent of patients, however, since the policy of the various hospitals about initiation of certain methods (namely orals and IUDs) immediately after parturition varies, as does their capability to perform certain procedures (e.g., tubal ligations) while the patient is in the hospital. Fifty-seven percent of the patients initiated on a method of contraception declared they wanted no more children. Sixty percent of the women accepting a method had two or fewer children. Fifty-six percent were married; forty-four percent were single, separated or divorced.

"TABLE 1.—NUMBER OF NEW YORK CITY WOMEN WHO HAVE RECEIVED IN-HOSPITAL FAMILY PLANNING COUNSELING, REQUESTED AND RECEIVED CONTRACEPTION IN PARTICIPATING HOSPITALS, JULY 1, 1969 TO MAY 1, 1970

Month	Number of patients counseled	Number requesting contraception	Number initiated on contraception before discharge	Number of participating hospitals
July 1969	712	677	454	10
August 1969	804	746	586	11
September 1969	1,000	894	698	18
October 1969	1,047	951	703	18
November 1969	1,891	1,790	1,032	19
December 1969	2,325	2,161	1,344	19
1969 (6 month) total	7,779	7,219	4,817	19
January 1970	2,382	2,136	1,306	19
February 1970	2,130	1,836	1,231	19
March 1970	2,667	2,356	1,668	21
April 1970	2,748	2,441	1,848	21
1970 total for 18 hospitals <sup>2</sup>	7,674	7,062	5,500	18
1970 total for 3 hospitals <sup>3</sup>	2,280	1,707	553	3
1970 (4 month) total	9,927	8,769	6,053	21
Grand total	17,706	15,988	10,870	21

<sup>1</sup> Participating hospitals are: Bellevue, Beth Israel, Bronx Lebanon, Brooklyn Jewish, Brooklyn-Cumberland, Brookdale, Flower-Fifth Avenue, Greenpoint, Kings County, Fordham, Lincoln, Long Island College, Methodist, Metropolitan, Morrisania, Roosevelt, St. Luke's, Sydenham, Coney Island, Harlem, Jacobi. (On June 1 the program was extended to Brooklyn Women's and Delafield Hospitals.)

<sup>2</sup> Hospitals in which all methods are prescribed prior to discharge.

<sup>3</sup> Hospitals in which the pill is not prescribed in-hospital.

#### "FOLLOW-UP

"Patients' visit behavior after hospital discharge is monitored through a simple visit information form. Clinics to which the patients are referred receive five visit forms numbered for the first and each subsequent patient visit, and are asked to return the forms each time an appointment is kept. These visit forms are filled out almost entirely by the family planning counselor, and stamped self-addressed envelopes are included to minimize demands on busy clinics. Since compliance is voluntary, however, response from the clinics is uneven (though it has shown considerable improvement in recent months as clinic clerks have become more used to the procedure). To check out the rate of return for the post partum clinic visit, the statistical form was matched with clinic medical records for an MIC-FP clinic and its affiliated hospital for one month. The study showed that the kept appointment rate for the hospital clinic was 71 percent and for the MIC-FP patients 89 percent. This compares to a kept appointment rate of 40 percent for hospitals and about 80 percent for MIC-FP clinics prior to initiation of the In-Hospital Family Planning Program.

"Using the established reporting system, non-MIC patients from three hospitals complying with the follow-up protocol were studied. The results add to the impression that pre-discharge initiation on a method helps to increase post partum return. An overall post partum return rate was calculated for each hospital. The samples were then dichotomized into 'initiated' and 'non-initiated' subsamples. The overall return rates for the three hospitals were: 40 percent, 50 percent and 63 percent respectively. Corresponding return rates for the 'initiated' subsamples were: 63 percent, 83 percent and 81 percent. For each hospital, the sample constituted patients counseled during one full month. Return was defined as a kept post partum appointment reported within three months of discharge. Of these initiated patients who returned for the post partum appointment, 97 percent, 87 percent and 84 percent, respectively, reported that they were active contraceptors in the interim period between hospital discharge and post partum return.

"Patient retention, however, is a general family planning in big cities; an average of 50 percent of family planning patients have dropped out of New York City clinic programs in the course of each year, mostly, it is believed, because of frequent changes of address. It is expected that increased in-hospital contraception and the resultant improved post partum returns should improve overall retention. Traditional follow-up and outreach programs involving home-visits to patients does not appear to be practical in New York City because of the high degree of mobility and the practice, on the part of some maternity patients, of falsifying address to gain admittance to a particular desired hospital. One New York City study found that the cost of locating each delinquent patient, utilizing trained community women as home visitors, averaged \$361.00 per patient who returned to the clinic.<sup>1</sup> Home visits, therefore, are only made where there is a specific medical indication, such as a positive Pap smear.

"Because of the known difficulties of following very mobile low-income families, a three-month pilot study of a new follow-up method was begun June 1 of this year in one voluntary and one municipal hospital chosen to provide a patient population representative of the city as a whole in terms of ethnicity, age, parity, economic status and contraceptive method chosen. Women who have begun a method of family planning in the hospital are being advised by the family planning counselors that a routine part of the service is a monitoring of her satisfaction with her chosen method after hospital discharge. Patients are told that other counselors will be available by telephone from 9 a.m. to 8 p.m. every day (except Saturday and Sunday) to answer questions. Patients are asked to telephone MIC-FP on dates suggested in advance for the first three months after hospital discharge.\*

"Each woman is asked to make the first call immediately after discharge to introduce herself to her 'woman's health counselor.' (The patient is given the

<sup>1</sup> R. K. Westheimer, 'Maternal Care, Family Planning, and the Paraprofessional Community Health Worker,' paper delivered at the Ninth Annual Meeting of the American Public Health Association, Philadelphia, November 1969.

\*It was considered that follow-up would prove successful only if patients were invited to participate in a personally meaningful service available from the moment they left the hospital. It was decided, therefore, that counseling would be provided by a rotating staff of the very counselors the patients had come to know as informed peers; counseling would be immediately available, all day and through the evening hours, in a single, central location where there is supporting professional personnel.

name of the health counselor by the family planning counselor.) All patients are asked to call every week until one week after the post-partum visit. From that time the frequency of calls is varied systematically by patient groups (weekly, biweekly and monthly) to study which is most effective.

"Patients are invited to call any time they have a question or problem, and are urged particularly to contact the counselor *before* discontinuing a method for any reason, or if they plan to move.

"All groups are provided with a calendar that displays the telephone call schedule, the name of the woman's health counselor assigned to the patient and the MIC-FP direct line telephone number she is to call. The calls are without cost to the patient. A special telephone installation immediately processes *all* incoming patient calls toll-free. For example, a patient calling from a public telephone has her dime returned by the operator before the call is actually placed. And the patient is spared the potential embarrassment of telling the operator she wants to place a collect call; the special letter and digit combination of the telephone number itself advises the operator of the fact that the cost of the call will be borne by MIC-FP.

"At least 50 percent of all patients counseled in the hospitals report having a phone in their own homes. The toll-free call system should encourage the use of public telephones among the balance of the women. The calls, whether placed from a home or a public phone, are a simple means to provide continuity.

"The telephone calls are received at the MIC-FP central office by neighborhood women who have received the same training as the in-hospital family planning counselors as well as additional training in understanding telephone interaction. A complete record for every patient is kept adjacent to the telephone for immediate reference each time a call is received. With each new contact the record is updated. Calls from patients with problems or questions that require expert response are referred to appropriate MIC-FP professional staff.

"A control group has been drawn from a similar patient population. Efforts will be made to contact this group three months after the counseling experience. In the interim these patients will not have had any deliberate reinforcement of their initial counseling other than that which would have occurred at the post-discharge clinic visits; opportunity for reinforcement of method use in the clinics is equally available to all groups. Substantive information secured from the study groups will be asked of the control patients at the time of delayed contact. Retention in the two groups will be compared.

#### "COST OF THE PROGRAM

"Unit cost for the first 11 months of the in-hospital program was calculated on the basis of the costs of professional, paraprofessional and clerical personnel, educational materials, operational supplies and reimbursements to hospital OB/GYN departments.

"The cost for each patient initiated on a family planning method before hospital discharge was \$15.23, of which \$7.25 (approximately 50 percent) represents a fixed per capita return to the participating OB/GYN departments. The cost of the family planning counseling service currently is \$6.23.\*

"The cost to the Department of Health and the Department of Hospitals for continuing family planning visits for these patients must also be considered. This is about \$40-50 per year per woman remaining on family planning. Thus, the total cost of initiating and maintaining a new patient on family planning is about \$55-65 the first year.

"In-hospital initiation thus appears to be a comparatively efficient and low cost means of bringing family planning to a post-delivery patient.

"It is expected that the in-hospital program may double in 1971 the number of new patients coming to tax-supported clinics in New York City as compared to the number of new patients admitted in 1969. The eventual additional cost of initiating and maintaining our target of 50,000 patients on family planning each year, will be in the neighborhood of \$3 million. This should be compared to current costs for care of unwanted children.

\*The proportion of the cost that represents reimbursement to hospitals is unaffected by cost-effectiveness considerations because it is fixed. The unit cost per patient interview, independent of initiation outcome, is the only aspect of cost that is sensitive to efficiency in the delivery of services.

"Applying the recent findings of Bumpass and Westoff<sup>1</sup> on unwanted pregnancies to New York City, there are at least 40,000 unwanted births occurring each year. The medical, hospital and related costs alone for these unwanted births are approximately \$60 million per year. The subsequent increased welfare costs, infant care costs, care of mentally retarded, etc. for these unwanted children create a far greater fiscal burden for the community each year.

#### "CONCLUSIONS

"Within 11 months the in-hospital program encompasses 23 hospitals and has counseled 18,000 patients. Currently, over 2,800 women a month are receiving counseling and more than seven out of 10 receive contraception before discharge from the hospital. The program is being expanded this year to the OPD department of all municipal hospitals and into the medicine, surgery and psychiatry departments in one voluntary hospital to determine whether our first priority should be to expand the program in participating hospitals or to extend services into OB/GYN departments of additional hospitals.

"Hospital OB/GYN departments and the Department of Health have demonstrated that they can cooperatively develop an effective and efficient program for initiating a family planning regime before women are discharged. We believe this program can be duplicated by other MIC-FP programs and by health departments working with hospital OB/GYN departments in many other cities. The end results, as measured by prevention of unwanted births, will not be known for several years, and then only if new methods of follow-up of highly mobile urban families are productive.

"The selection and education of peer level counselors is considered by the authors as the most important element in assuring success of such a program. Their proven usefulness in this program is evidence that peer level counseling can be used far more widely in family planning. For example, could not such family planning workers be valuable in such settings as junior and senior high schools where the community and teachers wish to initiate family planning discussions with teen-age boys and girls?"

#### "STATEMENT OF DR. ROGER B. BOST ON THE CHILDREN AND YOUTH PROJECT BEFORE THE HOUSE OF REPRESENTATIVES, COMMITTEE ON WAYS AND MEANS

#### "INTRODUCTION

"I welcome and appreciate this opportunity to talk with the Committee about a health care program, the continuance of which is vital to the State of Arkansas, individually, and the United States collectively—"The Children and Youth Project". I am Roger B. Bost, Director, Department of Social and Rehabilitative Services, State of Arkansas. I am also professor of Pediatrics at the University of Arkansas Medical Center, Fellow of the American Academy of Pediatrics and former Director of the Children and Youth Project in Little Rock, Arkansas.

#### "GENERAL

"The Little Rock Children and Youth (C&Y) Comprehensive Health Project 658 was funded 1 July 1968, initiating services 1 October 1968. Throughout its tenure, the Little Rock C&Y Project's primary thrust has been devoted to organizing and structuring a health care delivery system which would reflect the objectives envisioned by the 89th Congress in the 1965 Amendments to the Social Security Act. The prime objective has been to develop a system which would provide easily accessible, continuous comprehensive health care services for children of low-income families through promotion of health including, "early case finding, preventive health services, diagnosis, treatment, correction of defects, and follow-up utilizing a multidisciplinary approach." One index relative to the effectiveness of these efforts is manifested by the \$267,944 expended during Fiscal Year 1971 to support out-patient and in-patient services for our C&Y population.

<sup>1</sup>L. Bumpass and C. F. Westoff, "The "Perfect Contraceptive" Population: Extent and Implications of Unwanted Fertility in the U.S.," *Science* (in press).