Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IN-HOSPITAL VOLUNTARY PATERNITY ACKNOWLEDGMENT PROGRAM

Hospital Experiences in Sample States

JUNE GIBBS BROWN
Inspector General

AUGUST 1997
OEI-06-95-00161

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OEI's Dallas Regional Office prepared this report under the direction of Chester B. Slaughter, Regional Inspector General.

Project Staff included:

DALLAS REGION

Ruth Ann Dorrill, Project Leader
Michelle Adams, Ph.D
Karen Erickson, Intern
Lisa Lesh, Intern
Marnette Robertson
Sarah Taylor
Nancy Watts

HEADQUARTERS

Ann O'Connor, Program Specialist
Linda Moscoe
Barbara Tedesco

For additional copies of this report, please contact the Dallas Regional Office at (800) 848-8960.

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EXECUTIVE SUMMARY

PURPOSE

This report describes birthing hospital capability and progress in administering voluntary paternity acknowledgment programs in 15 sample States.

BACKGROUND

Federal law requires that States implement hospital-based programs for the voluntary acknowledgment of paternity, seeking to facilitate at-birth paternity establishment for children born to unmarried parents. Many States have long administered hospital-based programs, and even now the voluntary acknowledgment process may be administered largely at State discretion, but the intent of the Federal mandates is to make paternity acknowledgment part of the birth registration process. This places a great responsibility on birthing hospital staff to assist unmarried parents in voluntarily acknowledging paternity. Our facility-level study describes the experiences of birthing hospitals in implementing voluntary acknowledgment programs and the actions of State agencies to assist these hospitals. Comprehensive mail surveys were completed by child support and vital records agencies in 15 sample States, and by 429 birthing hospitals within those States. Our sample of States includes a broad spectrum of implementation experiences, but generally focuses on States which are farther along in implementation than the average of their national counterparts.

FINDINGS

Birthing hospitals in sample States are offering acknowledgment services, and State child support and vital records agencies believe hospitals are capable and willing to administer paternity programs. Also, both agencies report largely effective interaction with each other and progress toward smoother documentation procedures. However, in-hospital voluntary paternity acknowledgment programs could be improved by further State agency effort, including enhanced collaboration with hospitals, Statewide implementation of hospital assessments, and use of more interactive training and outreach methods.

Overall Program Rating

Nearly all birthing hospitals offer voluntary paternity acknowledgment services, and hospital staff are generally positive, viewing the programs as helpful to parents.

Over half of hospitals report the program is both simple to administer and easy for parents to understand, and most child support and vital records agencies rate hospital staff as good in their ability and effort to administer the programs.

Monitoring of Hospital Participation

Although hospitals report widespread program participation, only --of the 15 sample child support agencies monitor hospital participation.

Most hospital monitoring includes only the collection of data, and not the evaluation of process, and few child support agencies offer feedback to hospital staff.

Relationships Between Key Players

Most hospitals report effective relationships with vital records, and are fairly positive about child support agencies but often have trouble identifying them.

Child support agencies which pay hospitals for completed paternity acknowledgments report this enhances hospital relationships, but hospital respondents appear largely unaffected by payment.

Child Support and Vital Records Agency Assistance to Hospital Staff and Parents

Not all hospitals are provided with staff training materials to assist them in the acknowledgment process, and most hospitals rely primarily on brochures.

Child support agencies are not proactive in determining hospitals' continuing training needs, with nearly half relying on hospitals to request more materials.

Some child support agencies and hospitals conduct follow-up after discharge with parents who do not acknowledge paternity during their hospital stay.

Nearly all child support agencies in sample States report educational outreach efforts to parents, but for fewer hospitals report such materials are available and utilized, and only a quarter of hospitals conduct prenatal outreach.

Additional Program Constraints

The quality of hospital services is limited somewhat by internal hospital factors such as insufficient staffing levels and over-reliance on birth certificate worksheets.

Half of child support agencies and a quarter of hospitals requiring notarization of paternity documents report it negatively impacts acknowledgment.

There is a lack of clarity about the role of hospital staff in communicating with parents, particularly as it concerns their serving as advocates of paternity acknowledgment.

Factors external to hospitals, such as poor parent relationships, may also limit acknowledgments, although many fathers visit during the mother's stay.

RECOMMENDATIONS

Overall, we find hospitals are supportive of the paternity acknowledgment effort, appear to recognize its importance, and are increasingly capable of successfully conducting acknowledgment procedures. However, State agencies, particularly child support, could do more to assist hospitals in their administration of the voluntary acknowledgment process. Based on our findings, we recommend the Office of Child Support Enforcement (OCSE) take the following actions to improve the State operation of in-hospital paternity acknowledgment programs. The first and second recommendations duplicate those found in a companion report on nationwide program implementation:

AGENCY INTERACTION AND DIVISION OF DUTIES. **Promote interagency collaboration, and assure child support and vital records agencies more clearly define their respective agency roles.** OCSE should provide technical assistance to enhance agency interaction and encourage joint problem-solving among child support and vital records agencies, and should consider encouraging States to draft a flexible interagency agreement which would make clear the procedures and activities specific to each agency.

STATEWIDE HOSPITAL IMPLEMENTATION AND ASSESSMENT. **Monitor Statewide hospital implementation by assuring all States collect acknowledgment data for each birthing hospital and by encouraging development of hospital assessment procedures.** OCSE should provide technical assistance to States in creating hospital assessment procedures, and should consider developing a uniform reporting mechanism for States to monitor birth and acknowledgment data per hospital and to report hospital assessment procedures and outcomes.

DEFINITION OF HOSPITAL ROLE. **Clarify the appropriate role of birthing hospital staff in providing acknowledgment assistance to unmarried parents.** OCSE should help States develop policy outlining the appropriate content and tone of hospital contact with unmarried parents, particularly in regard to their advocating voluntary acknowledgment.

AGENCY ASSISTANCE TO HOSPITALS. **Encourage State agencies to more actively support hospital staff in implementing acknowledgment programs.** OCSE should provide technical assistance to help child support and vital records agencies better serve hospitals, emphasizing the distribution and use of education and outreach materials as well as techniques for providing feedback to hospital staff.

AGENCY COMMENTS

We have worked in close partnership with OCSE throughout the conduct of this inspection. Although we did not receive formal comments from ACF on our draft reports, they demonstrated through their collaboration a general agreement with this report and the companion reports. We worked with OCSE in developing a research methodology, provided extensive briefings on study findings and created additional documents to meet agency needs. We appreciate their cooperation and guidance, and will continue to work with them on the issues raised in these reports. The Office of the Assistant Secretary for Planning and Evaluation provided its general concurrence with both this report and the state implementation report.

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INTRODUCTION

PURPOSE

This report describes birthing hospital capability and progress in administering voluntary paternity acknowledgment programs in 15 sample States.

BACKGROUND

The Omnibus Budget Reconciliation Act of 1993 (OBRA) amends Title IV-D of the Social Security Act, requiring States to implement hospital-based programs for the voluntary acknowledgment of paternity. The objective of these programs is to facilitate at-birth paternity establishment for children born to unmarried parents. Without an establishment of paternity, unmarried mothers may never obtain a child support order and gain access to the enforcement services of their State child support office. Establishment of paternity at birth has many administrative, financial and emotional benefits. Mothers often lack information about the importance of and methods for establishing paternity. Consequently, they may not seek to establish paternity until a point at which the process becomes more difficult. Paternity researchers agree that the most opportune time for paternity establishment is the "happy hour" in the hospital immediately following birth and before the release of the mother and child. Once a child support order is issued, never-married women are as likely to receive payment as are divorced women.

Many States administered hospital-based programs before this legislation, and even now the voluntary paternity acknowledgment process may be structured and administered largely at State discretion. The voluntary paternity acknowledgment process seeks to reduce administrative burdens and provide a healthier, more positive introduction to parenting responsibilities. In most States, the use of the voluntary acknowledgment process in birthing hospitals[1] is the centerpiece of this effort. Under the OBRA mandate, State child support agencies must: 1) implement hospital-based voluntary paternity acknowledgment programs in every public and private birthing hospital; 2) require that a witness or notary public participate in the signing of voluntary acknowledgments; 3) make available voluntary acknowledgment outreach materials, including information on parental rights and responsibilities, and materials for training hospital staff; 4) and monitor birthing hospital compliance on an annual basis. At their discretion, OBRA allows States to provide Federal Financial Participation payments, not to exceed 20 dollars for each voluntary paternity acknowledgment, to birthing hospitals.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) further defines paternity establishment and encourages State uniformity and accountability. PRWORA requires the following refinements to the procedures listed above: 1) provision to mothers and fathers of both written materials and an oral explanation regarding the rights and responsibilities of paternity establishment; 2) a uniform 60-day window for rescission following a voluntary paternity acknowledgment, after which acknowledgment would establish a legal finding of paternity; and 3) the inclusion of State vital records agencies in

processing paternity acknowledgments and child support orders. Neither law precludes the use of the birth certificate, rather than a separate voluntary paternity acknowledgment form, in acknowledging paternity if the birth certificate includes the necessary data elements.

As interpreted by the Office of Child Support Enforcement (OCSE), the intent of both laws is to make voluntary paternity acknowledgment part of the birth registration process. This places a great responsibility on birthing hospital staff to assist unmarried parents in voluntarily acknowledging paternity. Although child support and vital records agencies may attempt to educate parents prior to or following hospital admission, the hospital provides the crucial arena for at-birth paternity acknowledgment.

METHODOLOGY

After extensive preinspection research, we surveyed both State agencies and birthing hospitals in each of 15 sample States. Our study objective was to describe birthing hospital capability and implementation, and the actions of child support and vital records agencies to assist hospitals in administering acknowledgments. This facility-level report describes the experiences of birthing hospitals in implementing voluntary acknowledgment programs and the action of State agencies to assist these hospitals. By using a sample of States, we set the stage for clearer analysis of the impact of State policy on hospital practices. Comprehensive, pre-tested mail surveys were sent to child support and vital records agencies and a sample of birthing hospitals in each sample State. We sampled States which ranked highest when combining indices of nonmarital births and number of hospitals with high-Medicaid discharge rates. We chose these measures to ensure adequate representation of those facilities more likely to assist unmarried parents and to have need for paternity acknowledgment services. The resulting list of States was modified somewhat for inclusion of some States which possessed and some States which did not possess the following characteristics: operation of a program prior to the Federal mandate, notarization requirement for paternity documents, and State practice of paying hospitals for completed acknowledgments.

Within each State, we constructed two strata of birthing hospitals and randomly sampled from each. The first stratum represents hospitals with a high number of Medicaid discharges, and the second stratum consists of all other birthing hospitals in the State.[2] Few significant differences were found to exist between the two strata, but comparisons of hospitals by Medicaid discharge rates and urbanization status are included in Appendix B. Our sample of States includes a broad spectrum of implementation strategies and experiences, but generally focuses on States which are farther along in implementation than the average of their national counterparts. One sample State, however, was just beginning program implementation at the time of our data collection. A comparison of sample and non-sample States is found in Appendix A, and confidence intervals for key survey questions are found in Appendix C. The 15 sample States account for 68 percent of all U.S. nonmarital births and 59 percent of all U.S. birthing hospitals.[3]

In addition to completing the survey, we asked the hospitals and State agencies to send examples of paternity acknowledgment outreach materials and photocopies of their birth certificates and voluntary acknowledgment forms. For child support agencies, the survey

instrument focused on the procedures in place for facilitating hospital-based paternity acknowledgment programs, their contact with and methods of evaluating birthing hospitals, and their procedures for acquiring completed voluntary acknowledgment forms. For vital records agencies, our focus was on the path of documentation of the voluntary acknowledgment data, but also covers interaction with child support offices, outreach to birthing hospitals and applicable State laws governing the use of birth registry information. In nearly all cases, the chief vital records registrar completed the survey. Child support enforcement agency surveys were sent to each States' child support office, where respondents were typically child support directors or paternity program coordinators. In some cases, small groups of agency officers completed the form together. We received completed surveys and documents from each of the 15 State child support and vital records agencies.[4]

The hospital survey instrument focused on hospitals' implementation of paternity acknowledgment programs and their relationships with State child support and vital records offices. Surveys were directed to birth registration clerks in each facility. In cases where the birth clerks were not responsible for the completion of paternity acknowledgments, the surveys typically were rerouted to the appropriate staff in obstetrics or women's health departments. Telephone follow-up was conducted with some one hundred hospitals who had not responded one month after the survey's due date. In most cases, non-responses were due to surveys not being routed properly. By sending second copies of the survey directly to those responsible for completion of paternity acknowledgments, and aggressive telephone follow-up, we were able to achieve a response rate of 78 percent (429 hospitals).[5]

Two companion reports will be issued as part of this study. The first entitled, "In-Hospital Voluntary Paternity Acknowledgment Programs: State Agency and Birthing Hospital Implementation" (OEI-06-95-00160) describes program implementation nationwide using survey responses from child support and vital records agencies in all States and the District of Columbia, and the second entitled, "In-Hospital Voluntary Paternity Acknowledgment Programs: Best Practices in Education and Outreach" (OEI-06-95-00162) highlights innovative approaches for educating unmarried parents and hospital staff. In addition, two documents were produced for OCSE during our inspection entitled "Sample State Summaries" and "Common Data Elements - State Paternity Acknowledgment Forms" to meet immediate needs pertaining to PRWORA implementation.

This study was conducted in accordance with the Quality Standards for Inspections issued by the President's Council on Integrity and Efficiency.

FINDINGS

While most birthing hospitals in sample States report offering voluntary paternity acknowledgment services, and State agencies believe hospitals capable of administering these services, unmarried parents could be better served by enhanced collaboration between State agencies and hospitals. Hospital staff training and educational outreach to unmarried parents are often insufficient, and many hospitals don't know where to turn for further assistance. Although hospital staff are positive about the worth of voluntary acknowledgment efforts, they are confused about their role in communicating acknowledgment information to parents. In-hospital voluntary paternity acknowledgment programs could be improved by further State child support and vital records agency effort, including Statewide implementation of hospital assessment procedures and use of more interactive training and outreach methods.

OVERALL PROGRAM RATING

Birthing Hospitals Offer Voluntary Paternity Acknowledgment Services, and Hospital Staff are Generally Positive, Viewing the Programs as Helpful to Parents.

Nearly all birthing hospitals surveyed report offering some form of voluntary paternity acknowledgment service (even in the State just beginning formal program implementation), and most hospital staff appear to value the purpose of paternity acknowledgment. Primary responsibility for implementing the in-hospital programs typically lies with birth registrars in the medical records department (57 percent) or birth registrars in the obstetrics department (20 percent), with another 42 percent of hospitals relying on other obstetrics staff to administer the program. Hospital social workers play a significant role in seven percent of hospitals.[6] Only a single hospital reports a social worker provided by child support held the primary responsibility.

Child support agencies report hospital staff resistance is rare. Thirteen of the 15 sample agencies report only a few or no hospitals express reluctance to participate in voluntary acknowledgment programs, and four report no reluctance at all among hospital staff in their State.[7] Our survey of hospital staff confirms this cooperative attitude. One birth registrar comments, *"It is very satisfying to fill a need for parents, and the process only adds a step or two to my job."*

Seventy percent of hospital respondents agree, rating the in-hospital paternity initiatives as helpful or very helpful to parents. Only three percent deem the programs not helpful to parents, with the remaining 27 percent rating the program as somewhat or a little helpful. An obstetrics nurse at a large urban hospital wrote, *"We have a heavy single mom Medicaid population, and many here feel fathers should be held accountable. While most feel marriage is preferable, this process does give an avenue to assume some responsibility/rights and privileges."* Only a few hospital respondents say the hospital stay is too hectic to expect parents to comprehend the process, or that they felt uncomfortable dealing with the issue.

Over Half of Hospital Respondents Report the Programs Both Simple to Administer and Easy for Parents to Understand, and Most Child Support and Vital Records Agencies Rate Hospital Staff as Showing a Good Ability and Effort in Administering the Programs.

Half of hospital respondents rate the paternity acknowledgment process as simple or very simple to administer. Another 39 percent say it is neither simple nor difficult, and only 11 percent of hospitals say the process is difficult or very difficult. Even more (58 percent) of hospital respondents find the voluntary paternity acknowledgment process to be easy or very easy for parents to understand, 31 percent find it neither easy nor hard, and only 11 percent believe it to be difficult or very difficult for parents to comprehend. A number of issues appear to affect whether a hospital rated the process as simple or difficult. For example, hospital staff receiving training and educational materials by their child support agency or some other source are more likely to rate the process as simple or very simple to administer compared with those not receiving training (61 vs. 48 percent). Hospitals reporting an effective relationship with the vital records agency also are more likely to rate the program as simple or very simple to administer (61 vs. 36 percent) compared with those with ineffective relationships. Hospitals finding the program simple or very simple to administer also perceive it more helpful to parents (84 vs. 3 percent) and easier to understand (72 vs. 7 percent). High-Medicaid urban hospitals are more likely than other types to rate their programs difficult to administer (19 vs. 9 percent),[8] as are hospitals which use a paternity affidavit form rather than the birth certificate for documentation of acknowledgment (26 vs. 8 percent).

Most State agencies rate both the ability and effort of hospital staff in administering acknowledgments as good, with child support agencies rating ability slightly higher than effort. Still, one-fourth of both child support and vital records agencies rate effort as fair or poor, representing a perceived need for improvement in a number of States. Interestingly, both State agencies respond quite similarly to this evaluation of hospital staff. Three vital records and two child support agencies in our sample States chose not to rate hospital staff. Both wrote that the quality of staff activities varies too much from hospital to hospital for them to provide an aggregate response. Agency ratings by the remaining States are shown in Table 1.

Table 1: ABILITY AND EFFORT OF HOSPITAL STAFF

	Ability		Effort	
	Child Support	**Vital Records**	**Child Support**	**Vital Records**
Excellent	8% (1)	8% (1)	8% (1)	8% (1)
Good	77% (10)	67% (8)	67% (8)	67% (8)
Fair	15% (2)	17% (2)	17% (2)	25% (3)
Poor or Very Poor	0% (0)	8% (1)	8% (1)	0% (0)

MONITORING OF HOSPITAL PARTICIPATION

Although Child Support and Vital Records Agencies as Well as Birthing Hospitals Report Widespread Program Participation, Only 73 Percent of Sample Child Support Agencies Monitor Hospital Participation.

Child support agencies in 11 of the 15 sample States (73 percent) report their hospitals were already offering minimal voluntary acknowledgment services prior to OBRA, and that they now have Statewide hospital participation. Of the remaining four sample States which do not report Statewide implementation, two have contacted all birthing hospitals to inform them of the acknowledgment program, one has not yet contacted all hospitals because it chose to first target those with a higher incidence of nonmarital births, and the other was just beginning to contact hospitals when surveyed. But even though implementation appears to be widespread, hospitals reporting use of acknowledgment procedures may not offer the same type and degree of service to parents. Some may only complete a paternity affidavit if requested by a parent, while others have very deliberate program implementation strategies which include training of hospital staff and outreach to unmarried parents. Child support agencies have been slow to adopt monitoring and assessment procedures which would allow them to evaluate hospital participation. Child support agencies in 11 of the sample States (73 percent) report they at least collect minimal data needed to monitor individual hospital participation.[9]

Most Hospital Monitoring Includes Only the Collection of Data, and Not the Evaluation of Process, and Few Child Support Agencies Offer Feedback to Hospital Staff.

Nearly all of the 11 States which do monitor hospitals only track the number of acknowledgments and nonmarital births from each hospital, which is the minimum required by the Federal mandate. Few yet attempt to evaluate other aspects of the hospital programs such as staff involvement or parent use of outreach materials, and most don't provide any feedback to the hospitals they have assessed. Of the four remaining sample States which don't yet assess hospital participation, three track the number of acknowledgments from each birthing hospital in their State but do not yet monitor hospital participation by comparing that information with the number of nonmarital births assisted.

Within the 11 States which monitor hospital participation, only 20 percent of hospitals report they were monitored or assessed in any way. Of those which do recognize being monitored, only half (54 percent) attribute the involvement to their child support agency. The other groups hospitals report most likely to monitor their programs or conduct hospital assessments are the vital records agency (28 percent), and their own hospital administration (7 percent). Therefore, only a small number of birthing hospitals (37) are aware of any program evaluation by a child support office. This could be because child support agency monitoring of hospitals is not done Statewide, or that our respondents, as frontline staff, are not made aware of the monitoring or assessments by hospital administrators. It is also possible some State child support agencies are monitoring hospital activity, but are not yet ready to provide feedback to hospitals or plan to contact hospitals only when problems arise. Regardless, our

hospital respondents, those directly responsible for contact with unmarried parents, are usually not aware of the results of any monitoring or assessment.[10] A companion report subtitled "Best Practices in Education and Outreach" will describe the efforts of States which have begun to conduct assessments of hospital process as well as outcome, and detail innovative ideas for offering feedback to hospital staff.

RELATIONSHIPS BETWEEN KEY PLAYERS

Most Birthing Hospitals Report Effective Relationships with Vital Records and Are Also Fairly Positive about Child Support Agencies, But Often Have Trouble Identifying Them.

Birthing hospitals and vital records agencies report positive ties with each other, enjoying long-standing relationships established through the birth registration process. Eighty-one percent of hospitals and 93 percent of vital records agencies rate their general relationship with each other as effective or very effective, although a few wrote their relationship did not reflect work on paternity acknowledgments as their vital records department hadn't yet become actively involved with this effort.[11] Only four percent of hospitals report an ineffective or very ineffective relationship with their vital records agency.[12] Seventy-six percent of hospital respondents find no barriers at all to this relationship, but of those who did list barriers, the most common are poor communication (30 percent), differences in levels of automation (25 percent), and inadequate training of hospital staff by vital records (24 percent).

Conversely, many birthing hospitals have difficulty characterizing a relationship with their child support agency. Child support agencies in the sample States rate their contact with birthing hospitals as positive, with 80 percent reporting effective or very effective relationships, but 53 percent of hospitals claim they have no relationship with their child support agency. In addition, nearly a third of hospitals (35 percent) report that, although they offer acknowledgment services and inform parents about paternity, they do not consider themselves to be part of a Statewide paternity acknowledgment program. Among high-Medicaid hospitals, urbanization affected the perception of participation in a Statewide program: 53 percent of high-Medicaid, rural hospitals did not consider themselves part of a Statewide paternity acknowledgment program contrasted with 33 percent high-Medicaid, urban hospitals and only 15 percent of high-Medicaid, suburban hospitals. It is important to note that of the nearly two hundred birthing hospitals which *did* recognize a relationship with their child support agency, 73 percent rate the relationship as effective or very effective.

Other hospital responses in part disprove this reported lack of a connection with the child support office and may point instead to a misunderstanding by hospital respondents. One cause of this claim of no relationship with child support agencies could be hospitals' difficulty in identifying the agency name or paternity program name.[13] Of those claiming no relationship, nearly half went on in our survey to identify specific program tasks which had been completed by child support personnel. Also, when a number of hospitals which report no relationship sent us their completed surveys, they included outreach and staff training materials which are clearly produced by their child support agency. Still, large numbers of hospital respondents reporting no relationship with a child support agency

signifies child support offices may not be proactive enough in identifying themselves to birthing hospitals. When this occurs, hospital staff may have difficulty requesting additional materials or program assistance. There appears to be a genuine need for more and better (particularly interactive) training and outreach to hospital staff by child support agencies. Not only would hospital staff benefit from the content of the training, but they would begin to develop ties to the child support office that would aid in further program collaboration.

Part of the problem birthing hospitals have in identifying their State's child support agency may also be that both child support and vital records agencies are unclear about their respective roles in the acknowledgment process. When asked which of the two State agencies has primary responsibility for administering the acknowledgment process, agencies in three States gave different answers. It should not be surprising in these States that hospitals have trouble identifying and distinguishing agency roles. When hospital respondents are able to identify their State or local child support agency and list barriers to effective collaboration, they most often list poor communication (46 percent), inadequate training of hospital staff by the child support agency (25 percent) and difficulty obtaining materials and assistance (18 percent). One hospital respondent wrote that she would benefit from having a single child support staff member serve as a contact for her hospital, and a few complain that phone lines were busy when they tried to call for more materials.

Child Support Agencies Which Pay Hospitals for Completed Acknowledgments Report This Enhances Relationships, But Hospital Respondents Appear Largely Unaffected by Payment.

Provisions allow, but do not require, child support agencies to pay hospitals an administrative fee for completed voluntary paternity acknowledgments.[14] There has been much policy discussion within the child support community regarding the appropriateness of this payment and its effect on service and relationships. Of the 15 sample States, eight child support offices report they currently pay hospitals for receipt of completed voluntary paternity acknowledgments, while one office did pay in the past and six have never paid. Not all of the States which pay responded about the effect of payment on services, but all five which did respond report an improvement in hospital service and in their relationship with hospitals as a result of payment.

However, 16 percent of hospitals in States which pay do not report receiving such payments. In two States this discrepancy is caused, at least in part, by the child support agency only paying hospitals on a per request basis, indicating that some hospitals may not have known that payment is available or are not interested in being paid. Other discrepancies may be because the frontline hospital staff responding to our survey may not be aware that payment is made to the hospital. The remaining seven States choose not to pay primarily because they consider it the hospital's job to process birth registration information and therefore can't justify payment (4 States), or they feel funds are too limited to allow payment (3 States).

Although child support agencies which pay believe payment helps hospitals and improves relationships, our hospital respondents report payment makes little difference. Most hospital respondents (77 percent) claim the additional funds make no difference or only a minimal difference in their hospital's ability to administer voluntary acknowledgments. Nineteen

percent report payment by their child support agency makes a great to moderate difference in administration, and the remaining four percent didn't know if it made a difference to their hospital. It could be that the money does make a difference to hospital administrators or comptrollers, but payment has less effect on the frontline workers who actually handle the paternity acknowledgments and who completed our survey. Some hospital respondents who did report the payment makes a difference cited the cost of staffing notaries as justification.[15] At the time regulations were written to provide guidance for implementation, policy makers expressed a fear that hospital payment for acknowledgments would dilute the voluntary nature of the process by providing a "bounty" for hospitals. Our survey results appear to disprove this fear, as frontline workers often report being unaffected by and even unaware of payment agreements.

ASSISTANCE TO HOSPITAL STAFF AND PARENTS

Not All Hospitals are Provided with Staff Training and Educational Materials to Assist them in the Acknowledgment Process, and Even Though Most Child Support Agencies Report Producing Videos and Conducting On-Site Training Sessions, a Much Smaller Percentage of Hospitals Report Use of These Methods, Relying Primarily on Brochures.

Only 72 percent of hospitals report receiving staff training or educational materials on paternity acknowledgment from one of the State agencies. Sixty percent of hospitals report receiving brochures, but far fewer appear to be using more interactive methods of staff training. Even though all child support and vital records agencies in the 15 sample States report they train hospital staff, and six child support agencies have produced training videos, only 18 percent of hospitals report using videos on the paternity acknowledgment process for staff training.

Additionally, high percentages (87 and 85 percent) of both child support and vital records agencies report conducting on-site lectures or seminars, but only 23 percent of hospitals report receiving such training (See Table 2). This discrepancy could be because training sessions are often conducted for the staff of several birthing hospitals from the same region and were therefore not identified by hospital survey respondents as "on-site training," but is more likely to be because on-site training by agencies has only been completed in a small number of the States' hospitals. Child support agencies in sample States report hospital staff training materials are most often created by their own staff (87 percent), with additional materials coming from vital records staff (20 percent), and private contractors (27 percent). It is important to note that although all vital records agencies train hospital staff, the focus of their training is usually on the birth registration process as a whole and not specifically on paternity acknowledgment for unmarried parents. Since vital records agencies must make contact with hospitals regarding birth registration anyway, it may be prudent for child support staff to work within this preexisting framework and collaborate with vital records in distributing paternity materials. PRWORA requires that vital records agencies offer paternity acknowledgment services, both in the hospital and at their State, regional and local offices.

Table 2: TYPE OF HOSPITAL STAFF TRAINING PROVIDED TO AND RECEIVED BY BIRTHING HOSPITALS			
	Child Support	**Vital Records**	**Hospitals**
Brochures/Pamphlets/Handbook	93% (14)	54% (7)	60% (242)
On-Site Lectures or Seminars	87% (13)	85% (11)	23% (106)
Video Tape Training	40% (6)	0% (0)	18% (57)
Other (examples: regional workshops, individual meetings, 1-800 phone number, etc.)	67% (10)	40% (6)	16% (68)

Even Though Child Support Agencies Have Created Training Materials, They Are Not All Proactive in Determining Hospitals' Training Needs and Hospitals Which Have Already Been Trained by Child Support Agencies Still Express the Need for More Training.

Significantly, even many hospital staff who received training do not yet feel comfortable administering the program, as 39 percent of hospitals reporting they need more training have recently been trained by their child support agency. Several mentioned a particular desire for interactive training methods, such as videos, seminars, and on-site visits. We received a number of calls from hospitals during the survey requesting information on video and seminar resources, and referred them to their State child support office. When training does take place, it targets hospital birth registrars primarily, but often includes obstetrics staff, and to a lesser degree, medical social workers, nursery attendants and pediatrics staff. Hospital staff training by child support agencies covers only paternity acknowledgment issues, but as mentioned above, training by vital records agencies must focus on the larger birth registration process. Some (20 percent) vital records agency training of hospital staff does not include information on voluntary paternity acknowledgment at all.

Even when initial training efforts are made, hospital staff turnover and high numbers of nonmarital births create a continual need for assistance. Adequate aid to hospitals requires that child support agencies determine changing hospital needs, but not all child support agencies make this effort. After initial training efforts, child support offices in six sample States (40 percent) rely on hospitals to notify them when there is a need for additional instruction and materials for new hospital employees, and make no effort to initiate contact with hospitals or assess their continuing needs. A few hospital respondents wrote that they would appreciate these contacts as a means of "moral support."

Among the remaining nine child support agencies which use more proactive methods to determine need, 53 percent place periodic phone calls, and 47 percent conduct status checks in-person. Only 13 percent of child support agencies in sample States automatically send new materials throughout the year. A small number of hospitals (5 percent), have begun to

create their own paternity acknowledgment training materials, usually simple step-by-step instruction sheets.

Some Child Support Agencies and Hospitals Conduct Follow-up After Discharge With Parents Who Do Not Acknowledge Paternity During Their Hospital Stay, But Some States Have Privacy Statutes Which Inhibit Such Efforts.

Because hospital stays are often brief, and births may not be registered for a week or more, three child support agencies and 19 percent of hospitals in sample States contact all unmarried mothers following discharge if they do not voluntarily acknowledge paternity in the hospital. The purpose of these contacts is to offer mothers another opportunity for assistance in acknowledging paternity before the birth is registered. Typical is a phone call or certified letter a week or more after discharge.[16] Child support offices most often receive the birth registration information necessary for these follow-ups from the State or local vital records agencies. Hospitals simply use the birth registration information they collect during the hospital stay. This follow-up is conducted irrespective of the family's child support status, but at least three of the sample States possess privacy statutes which would inhibit child support staff from receiving birth registration information such as phone numbers and addresses from unmarried parents not in the child support caseload. No vital records agency reports use of a follow-up procedure.

Nearly All Child Support Agencies in Sample States Report Educational Outreach Efforts to Parents (93 percent), but Fewer Hospitals (74 percent) Report Such Materials are Available and Utilized, and Only a Quarter of Hospitals Conduct Prenatal Outreach.

All but one sample child support agency report participating in outreach to parents regarding voluntary paternity acknowledgment, and the remaining State was creating an outreach program when surveyed. Among child support offices which distribute parent outreach materials, brochures and pamphlets are the most common outreach mechanism created (100 percent), followed by videos (79 percent), and workshops or lectures (71 percent). See Table 3 for a complete listing. Most (86 percent) of these States offer materials in languages besides English, with Spanish being the most common alternative. As with hospital staff training, child support agencies report their own staff create these materials most frequently (86 percent), and that private contractors create additional materials in 36 percent of sample States.

Table 3: TYPE OF PARENT OUTREACH PROVIDED TO AND USED BY BIRTHING HOSPITALS		
	Child Support	**Birthing Hospitals**
Brochures/Pamphlets/Handbook	100% (14)	67% (195)
Video Tape Training	79% (11)	23% (60)
On-site Lectures or Workshops	71% (10)	2% (7)
Other (examples: regional workshops, individual meetings, 1-800 numbers, etc.)	67% (10)	6% (18)

Though nearly all child support agencies report producing and distributing these materials, just 74 percent of responding hospitals are prepared with educational materials for unmarried parents, usually a brochure or paternity instruction packet (67 percent). Although a high number of child support offices produce videos and hold workshops for parents, only a quarter of hospitals (23 percent) report using videos[17] and only seven hospitals report holding workshops. The discrepancy between agency reported outreach efforts conducted and those materials actually being used in the hospital suggests that child support offices have often not distributed materials Statewide, they are not conducting follow-up to provide a continual supply of materials as mentioned above, or that hospital staff are not using the materials sent. In the case of the outreach workshops or lectures, child support offices which report use of these must have thus far reached only a very small number of their State's hospitals. When materials are widely distributed, lack of use could indicate a hospital administration problem in which materials received are not properly distributed to frontline hospital staff for use with parents.

Hospital staff not using available parent educational materials may be a result of insufficient program training on the part of the State child support or vital records agencies. During preinspection, one birth registrar in a large public hospital searched her office for a lengthy period following our request for materials, and eventually uncovered a large package of brochures sent to the hospital by the State child support agency. She had been given no instruction on use of the materials, and so had packed the brochures away as unimportant. In addition, only 20 percent of hospitals conduct any prenatal education on voluntary paternity acknowledgment, although a third of both child support and hospital respondents believe this prenatal education is important for encouraging unmarried parents to acknowledge.[18] Several sample States have begun more widespread outreach efforts, and in a companion report we will provide details regarding the variety of educational outreach techniques which States and hospitals use in their voluntary paternity acknowledgment programs.

ADDITIONAL PROGRAM CONSTRAINTS

Over Half of Hospitals Perceive No Barriers to Implementation, Although the Quality of Hospital Services is Reported to be Limited Somewhat by Internal Hospital Factors Such as Insufficient Staffing Levels, and Over-Reliance on Birth Certificate Worksheets.

Collaboration between State agencies and birthing hospitals is critical to the success of voluntary paternity acknowledgment programs, but a number of factors inherent in birthing hospitals may somewhat hamper program efforts. Child support agencies indicate a number of barriers, including lack of sufficient hospital staff (80 percent), staff not recognizing the importance of their role (80 percent), and staff being inflexible and resistant to change (33 percent). Vital records agencies agree strongly that the lack of hospital staff is an internal facility constraint (47 percent). Sample vital records agencies unanimously identify the inability of hospital staff to perceive a need for the program as a barrier, although far fewer sample child support agencies (40 percent) agree. This concern is not born out by the hospital survey, as 87 percent of hospital respondents report at least a moderate need for paternity services in their hospitals, and 55 percent even claim a great or very great need. A quarter of vital records agencies (27 percent) find no barriers at all to hospital participation (See Table 4).

Table 4: BARRIERS TO HOSPITAL PARTICIPATION

	Child Support	Vital Records
No Barriers Found	7% (1)	27% (4)
Hospital Understaffed to Deal with the Acknowledgment Process	80% (12)	47% (7)
High Staff Turnover Limits Knowledge and Expertise	N/A	64% (9)
Staff Doesn't Recognize the Importance of Their Role	80% (12)	13% (2)
Staff Perceive No Need For the Program in Their Hospitals	40% (6)	100% (14)
Staff is Inflexible and Resistant to Change	33% (5)	7% (1)
Little or No Payment to Hospitals by Child Support	7% (1)	N/A

An additional potential barrier to effective parental involvement is possible over-reliance on birth certificate worksheets. Eighty-four percent of responding birthing hospitals use birth certificate worksheets to obtain registration information from new parents, and the use of these worksheets may limit communication between parents and staff. We placed follow-up telephone calls to a number of hospitals which report using birth certificate worksheets, and find that they may considerably reduce the amount of time parents interact with hospital staff

such as birth registrars and obstetrics nurses. Hospital staff typically leave the worksheet with the unmarried mother for completion (possibly along with a brochure on paternity acknowledgment), and pick it up just prior to patient discharge.[19] In hospitals where worksheets are not used, hospital staff ask birth certificate questions of the mother directly. When asking questions pertaining to the father, staff who interview orally rather than using worksheets have a natural opportunity to inform the mother of the acknowledgment process. A heavy reliance on birth certificate worksheets may prove especially problematic under the PRWORA provision requiring hospital staff to give both written and oral notification of paternity rights and responsibilities.

Over half (54 percent) of responding birthing hospitals saw no internal barriers to participation in their State's voluntary paternity acknowledgment program, although many hospital respondents do agree with agencies that sufficient staffing can be a problem. Of those hospitals identifying facility barriers, the most common are lack of sufficient hospital staff (37 percent), paternity acknowledgment being given a low priority by hospitals (24 percent), and hospital budget constraints (18 percent). Of hospital respondents who did perceive facility barriers, half report only one barrier, while 20 percent report two barriers, 25 percent report three, and only 5 percent find four or more barriers, suggesting that hospitals respondents feel fairly positive about the capability of their hospital to administer the program. During our preinspection interviews, child support personnel often mentioned high hospital staff turnover as a barrier to program implementation. Although 64 percent of vital records respondents cite this as a barrier (the child support survey did not list this option), few hospitals (6 percent) see high staff turnover as a barrier to program implementation.

Half of Child Support Agencies and a Quarter of Hospitals Report Requiring Notarization of Paternity Documents Negatively Impacts the Voluntary Acknowledgment Program, Primarily Due to Limited Availability of Notaries.

Because most paternity establishments were formerly completed through a judicial process, notarization of paternity documents is thought by some to add credibility to the new administrative procedures. Because notarization of paternity documents requires that hospitals have access to certified notaries public, the requirement is a potential barrier to smooth program operations. Notarization of paternity acknowledgment affidavits is required in 11 sample States, with the remaining four requiring witnessing of paternity documentation.[20] Only 23 percent of hospitals in notarizing States report the requirement has an overall negative impact, with 36 percent claiming a positive impact, and the remaining 40 percent reporting no impact. Suburban hospitals are more likely to report a positive impact (46 percent) compared with both urban and rural hospitals (36 and 32 percent). Although the reaction to notarization is not strongly negative, over half (57 percent) of hospitals which require notarization did indicate that unavailability of notaries can be a barrier to acknowledgment. But of the 57 percent of hospitals which report lack of availability of notaries as a problem, two-thirds (66 percent) claim notarization has a positive impact or no impact on their programs. It may be that some birth registrars are burdened a bit by the availability issue, but still don't see notarization as a negative because they believe in its importance. Comments include, "*requiring a notary to sign the forms makes me feel*

more comfortable in knowing that the forms have been completed," and "*parents take the process more seriously and may be more likely to understand its importance.*"

Child support agencies are more negative than hospitals on the issue of notarization. Six child support agencies in the 11 sample States which require notarization report it has a negative impact on their programs, four agencies claim a positive impact and one reports no impact. Further, most child support agencies which have chosen to require only a witness cite the lack of availability of notaries as the reason. These agencies appear to assume notarization places a greater strain on hospital staff than the hospitals themselves report. A few hospitals (12) say it is difficult to have both the mother and father present at the same time the notary is available[21], and the father may often lack proper identification.

Hospitals perceiving availability of notaries as a problem often note this can cause a delay in signing, with 40 hospitals mentioning evenings and weekends as particularly problematic. In 64 percent of responding hospitals, notaries are available only during weekday business hours. Another 11 percent of hospitals also report notaries are only available during business hours, but are on-call at other times. Only six percent of responding birthing hospitals for whom notarization was required had notaries on staff seven days a week, 24 hours a day. The remaining 19 percent gave a wide variety of responses, usually indicating notary staffing changed from day to day. The availability of notaries is less likely to affect the completion of acknowledgments in rural hospitals (48 percent) compared with suburban or urban hospitals (65 and 63 percent). While 9 percent of responding hospitals require completion of acknowledgments before the mother is released, most hospital birth registrars will accept an acknowledgment affidavit from parents after discharge.[22]

Lack of Clarity About the Responsibilities of Hospital Staff in Communicating with Unmarried Parents, Particularly as it Concerns Their Role as Advocates of Paternity Acknowledgment, Creates a Disparity Among Hospitals in Their Service to Parents.

Hospitals and State agencies give varied and inconsistent answers regarding the responsibilities of frontline hospital staff in assisting unmarried parents through the acknowledgment process. Our survey outlines three areas of potential hospital staff responsibility: acknowledgment documentation; parental rights and responsibilities; and advocacy of paternity acknowledgment. Based on the Federal statutes, the first two areas are clear responsibilities of hospital staff. Hospital staff obviously must help to facilitate the documentation of voluntary acknowledgments and, according to OBRA and PRWORA, must also inform parents of their rights and responsibilities. However, only 10 vital records agencies in the sample States identified these two key tasks. All sample child support agencies identify documentation assistance, but two do not believe explanation of rights and responsibilities to be the role of hospital staff (see Table 5).

The third potential area of responsibility (hospital staff acting as advocates of paternity acknowledgment) is somewhat controversial. Some child support advocates believe that hospital staff should not actively urge or encourage acknowledgment, especially if the hospital is being paid for submitting completed forms, as this may jeopardize the voluntary nature of acknowledgment. However, 10 child support agencies and 7 vital records

respondents in sample States support this more proactive role by hospital staff. Of birthing hospitals, 38 percent felt an obligation to actively urge or encourage unmarried parents to acknowledge paternity. Interestingly, high-Medicaid, suburban and urban hospitals are more likely to actively promote the idea of paternity acknowledgment to parents as a perceived role of hospital staff (63 and 47 percent) compared with low-Medicaid, urban hospitals (26 percent). Based on these divergent responses, it appears both State agencies and hospitals are somewhat confused about the role of hospital staff. All key players may benefit from guidance regarding the content, tone and tenor of contact between unmarried parents and hospital staff.[23] Unless both child support and vital records agencies construct a unified set of guidelines and inform their own personnel, as well as birthing hospital staff, there is less likelihood that parents will receive a clear and consistent message on the voluntary acknowledgment process.

Table 5: ROLE OF HOSPITAL STAFF

	Child Support	Vital Records	Hospitals
Informing Parents of their Rights and Responsibilities	87% (13)	71% (10)	76% (317)
Helping to Facilitate the Documentation of Acknowledgment	100% (15)	71% (10)	59% (249)
Actively Urging or Encouraging Parents to Acknowledge	67% (10)	50% (7)	38% (168)

Factors External to Hospital Programs, Such as Poor Parent Relationships, May Also Limit Paternity Acknowledgments, Although Hospitals Report Large Numbers of Fathers Visit During the Mother's Stay.

The success or failure of voluntary paternity acknowledgment programs lies ultimately with the parents themselves. Both child support agencies and hospital respondents affirm that the parent relationship is crucial in making the decision to acknowledge. Hospitals and child support agencies largely agree about what influences parents to acknowledge, with both citing the putative father as slightly more likely than the mother to create a barrier to acknowledgment. Among hospital respondents, 57 percent believe it is most often the father who creates a barrier to acknowledging paternity, 24 percent report the mother and father equally share responsibility for not acknowledging, and 19 percent report the mother is most often reluctant.[24] Child support agencies cite a number of factors that have a strong or very strong influence on whether or not parents choose to acknowledge paternity. The most common factors influencing parents to acknowledge include the new parents cohabitating or in a long relationship, their exposure to the idea of paternity establishment by hospital staff, and strong emotional feelings upon the baby's arrival (see Table 6).

Not many differences exist between child support and hospital staff responses regarding what influences parents to acknowledge, but, interestingly, child support agencies are more likely than hospital respondents to credit parental exposure to the idea of paternity acknowledgment

by hospital staff.[25] Hospitals are much more likely than child support to mention the influence of both maternal and paternal grandparents. Even though it was not provided as an option on our survey instrument, a number of hospital respondents wrote that naming the father on the birth certificate is also an incentive for parents to acknowledge.

Table 6: Factors Reported to Strongly or Very Strongly Influence Unmarried Parents to Acknowledge Paternity at the Hospital

	Child Support	Hospitals
New parents cohabitating or in long relationship	80% (12)	82% (258)
Emotional feelings with baby's arrival	68% (10)	75% (260)
Exposure to idea of paternity from hospital staff	68% (10)	41% (161)
Exposure to idea of paternity from prenatal care providers	33% (5)	33% (63)
Pressure from paternal grandparents	14% (2)	28% (56)
Pressure from maternal grandparents	14% (2)	39% (85)

Factors having the greatest influence on parents who choose *not* to acknowledge include a bad relationship between the new parents, the putative father not visiting the hospital, the new mother's fear of sharing custody, and the short length of her hospital stay (see Table 7). The closest agreement between agencies and hospitals is the mother's fear of violence from the father, the father not visiting the hospital, and the mother's fear of losing AFDC and other public benefits. However, child support agencies give much more credence than hospitals to the effect of parents' poor understanding about paternity, the length of the mother's hospital stay[26], and the mother's fear of losing custody. Again, hospital respondents affirm the significance of both paternal and maternal grandparents. Although not listed as an option on our survey instrument, several hospital respondents wrote that fathers may not sign at the time of birth because they believe they will then be responsible for the hospital bill. Other negative influences mentioned by hospital respondents were the fear of paying child support, and uncertainty about the identity of the father.

When the father doesn't visit the hospital it creates, of course, a strong influence against acknowledgment. However, most hospital respondents (68 percent) estimate all or most unmarried fathers come to the hospital during the mother and baby's hospital stay. Another 22 percent estimate that about half of unmarried fathers come, and only five percent report few or no fathers come to the hospital.[27] Rural, low-Medicaid hospitals experience the greatest number of fathers visiting the hospital (82 percent) compared with 68 percent of all suburban hospitals and 61 percent of all urban hospitals. Father visitation is lowest in high-

Medicaid urban hospitals compared with other hospital types, with only 52 percent of these hospitals report that all or most fathers come to the hospital. Forty-five percent of all hospital respondents estimate that most or all of these fathers who visit also participate in the labor and delivery process, with another 25 percent reporting about half of unmarried fathers participate and 11 percent claiming only a few or no fathers participate.[28] Therefore, a relatively large number of fathers appear to be present during the hospital stay but still choose not to acknowledge paternity.

Table 7: Factors Agencies Report to Strongly or Very Strongly Influence Unmarried Parents *Not* to Acknowledge Paternity at the Hospital

	Child Support	Hospitals
Bad Relationship Between the Unmarried Parents	100% (15)	75% (253)
Father Doesn't Visit the Hospital	87% (13)	76% (246)
Mother's Fear of Sharing Custody With the Father	87% (13)	42% (128)
Length of the Hospital Stay Short	80% (12)	41% (131)
Lack of Understanding About Paternity Establishment	60% (9)	31% (104)
Mother's Fear of Not Receiving AFDC or Other Benefits	50% (7)	61% (180)
Mother's Fear of Violence From Father	46% (6)	36% (74)
Pressure From Maternal Grandparents	8% (1)	26% (56)
Pressure From Paternal Grandparents	8% (1)	20% (41)

RECOMMENDATIONS

Overall, we find hospitals are supportive of the paternity acknowledgment effort, appear to recognize the importance of paternity establishment, and are increasingly capable of successfully administering acknowledgments. However, State agencies, particularly child support, could do more to assist hospitals in program administration. Based on our findings, we recommend the Office of Child Support Enforcement (OCSE) take the following actions to improve the State operation of in-hospital paternity acknowledgment programs. The first and second recommendations duplicate those found in a companion report on nationwide program implementation:

AGENCY INTERACTION AND DIVISION OF DUTIES. **Promote interagency collaboration, and assure child support and vital records agencies more clearly define their respective agency roles.** In a number of States, hospital staff do not understand the responsibilities of the two respective agencies. Over half of hospital respondents couldn't even identify their child support agency, and a number even called our office for assistance after receiving their survey. This confusion could create delays in documentation, as well as gaps in service to hospitals and in outreach to unmarried parents. OCSE should provide technical assistance to enhance agency interaction and encourage joint problem-solving among child support and vital records agencies, and should consider encouraging States to draft a flexible interagency agreement which would make clear the procedures and activities specific to each agency. Such an agreement may help to provide hospitals with a clear contact point, avoiding possible duplication of effort, developing efficient administrative mechanisms and maximizing the use of State and Federal resources.

STATEWIDE HOSPITAL IMPLEMENTATION AND ASSESSMENT. **Monitor Statewide hospital implementation by assuring all States collect acknowledgment and nonmarital birth data for each birthing hospital and by encouraging development of hospital assessment procedures.** Although nearly all sample child support agencies have contacted their birthing hospitals regarding the Federal mandates, only 73 percent report Statewide hospital participation. In addition, we find that programs vary widely among hospitals even in States which have achieved Statewide compliance. Only 73 percent of child support agencies in sample States have implemented hospital monitoring procedures by collecting data on the number of acknowledgments received per hospital and comparing it to the number of nonmarital births each hospital assists. OCSE should consider developing a uniform reporting mechanism for States to record data collected for each birthing hospital. OBRA requires States at a minimum collect this data on hospital nonmarital births and acknowledgments received, but States should be encouraged to also assess hospital practices and procedures in obtaining these acknowledgments. OCSE should provide technical assistance to States in creating hospital assessment procedures, and in doing so consider developing assessment criteria which would evaluate the *process* birthing hospitals use to obtain acknowledgments as well as the *outcome* of acknowledgments received. Examples of potential assessment criteria include use of hospital staff training and outreach materials, hospital staff contact with unmarried parents, and documentation handling. Not only are many hospitals often not monitored in their program participation, but few child support

offices conduct follow-up efforts to determine continuing hospital needs. A uniform State reporting mechanism would serve to determine State compliance with the hospital data collection requirement, allow OCSE to monitor Statewide program implementation, and would also hold child support agencies more accountable for responding to the needs of *every* hospital.

DEFINITION OF HOSPITAL ROLE. **Clarify the appropriate role of birthing hospital staff in providing acknowledgment assistance to unmarried parents.** Both agencies and hospital staff members are unclear about the content and tone of hospital contact with unmarried parents. Lack of clarity about the responsibilities of hospital staff in communicating with unmarried parents, particularly as it concerns their role as potential advocates of voluntary paternity acknowledgment, creates a disparity among hospitals in their service to unmarried parents. Unless both child support and vital records agencies construct a unified set of guidelines and inform their own personnel as well as birthing hospital staff, there is less likelihood that parents will receive a clear, repetitive and singular message on the voluntary acknowledgment process. OCSE should help States to determine the desired role of hospital staff, and provide guidance to State child support agencies in educating staff accordingly.

AGENCY ASSISTANCE TO HOSPITALS. **Encourage State child support and vital records agencies to more actively support hospital staff in implementing acknowledgment programs.** OCSE should provide technical assistance to child support and vital records agencies which would focus on providing better service to hospitals, including aid in addressing issues which create barriers to program services. OCSE should also create and/or distribute sample hospital staff training and parent outreach materials, including interactive methods, to give focus to State and hospital educational efforts. These educational materials should be accompanied by instructions or ideas which would help States to ensure the materials are actually used by hospital staff and distributed to unmarried parents. Because many hospitals in States which provide materials do not use these resources, we know that creation and perfunctory distribution to hospitals does not guarantee use.

AGENCY COMMENTS

We have worked in close partnership with OCSE throughout the conduct of this inspection. Although we did not receive formal comments from ACF on our draft reports, they demonstrated through their collaboration a general agreement with this report and the companion reports. We worked with OCSE in developing a research methodology, provided extensive briefings on study findings and created additional documents to meet agency needs. We appreciate their cooperation and guidance, and will continue to work with them on the issues raised in these reports. The Office of the Assistant Secretary for Planning and Evaluation provided its general concurrence with both this report and the state implementation report.

ENDNOTES

1. A 'birthing hospital' is a hospital which has an obstetric care unit or provides obstetric services, or a birthing center associated with a hospital. (Federal Register, Vol. 59, No. 246).

2. Within each stratum (high-Medicaid and low-Medicaid), we disproportionately sampled 20 birthing hospitals from each State. In a few cases, States had less than 20 birthing hospitals within each stratum. In those cases, we sampled all hospitals that met our criteria. Hospital survey responses were weighted to reflect the correct proportion of birthing hospitals within each stratum. All charts list the weighted percentages and the unweighted number of respondents in parentheses.

3. Sample states include Alabama, Arkansas, California, Colorado, Florida, Illinois, Kentucky, Massachusetts, Michigan, Minnesota, Missouri, Pennsylvania, Texas, Virginia, and Washington.

4. Child support and vital records agency surveys were received between April and August of 1996.

5. Birthing hospital surveys were received between June and November of 1996.

6. A number of hospitals listed more than one department as having primary responsibility, so percentages equal greater than one hundred. One hospital which shares responsibility between the obstetrics and medical records departments reports interdepartmental collaboration by using a paging system wherein obstetrics nurses alert the birth registrar when the father comes to visit mother and baby so the registrar may then introduce the paternity affidavit.

7. When staff did express reluctance, they often cited lack of time to perform acknowledgment duties and occasionally wrote they believe paternity is too personal an issue to discuss with patients. One obstetric nurse reports that discussing paternity casts a *"judgmental"* shadow over her relationship with patients during the hospital stay.

8. This difference could reflect the greater need for paternity acknowledgment services in these hospitals and the additional challenge this creates in training staff and allocating resources for the program.

9. Regulations written to interpret OBRA '93 require States to "assess" each birthing hospital's program on at least an annual basis (Federal Register, Vol. 59, No. 246). This "assessment" requirement specifies only the collection of data on nonmarital births assisted and acknowledgments received per hospital. Following consultation with OCSE, we use in this report the phrase "monitor

hospital participation" to refer to this type of data collection. The term "hospital assessment" refers to a broader effort which would include the evaluation of hospital *procedures* as well as *outcomes*.

10. One benefit of child support offices paying hospitals for the processing of acknowledgments is that the financial transaction required guarantees a natural count or tracking of acknowledgments per birthing hospital.

11. At the time of data collection, one sample vital records agency played no role in administering its State's voluntary acknowledgment program.

12. Suburban hospitals are less likely to report their relationship with vital records agencies as effective or very effective (72 percent) contrasted with urban and rural hospitals (85 and 84 percent).

13. Birthing hospital respondents were given latitude in identifying their child support office for our survey. For example, if they used the agency's departmental name such as "Social Services" instead of "Child Support Office," we credited them as having identified the correct office.

14. Payments may be made up to $20 to birthing hospitals and other entities that provide prenatal or birthing services for each voluntary acknowledgment obtained pursuant to an agreement with the child support agency (Federal Register, Vol. 59, No. 246).

15. One birthing hospital writes that their staff notaries were paid directly by hospital administration, each receiving $7 of the $20 fee charged to child support for their services in notarizing paternity affidavits.

16. Occasionally hospital staff members were more proactive in conducting follow-up with mothers who did not acknowledge. For example, one respondent in California writes that he places phone calls to the mothers on a daily basis prior to birth registration to check for understanding and encourage acknowledgment, and another in Massachusetts writes that she makes appointments with parents to come back to sign the form.

17. One hospital respondent reports that videos are a particularly important medium for parent outreach because the reading skills of some parents do not enable them to comprehend written materials.

18. A number of hospital respondents emphasize the importance of prenatal outreach, writing that "*Mothers listen to their prenatal care providers*," and "*Parents often don't know the definition of the word paternity when they come to the hospital.*"

19. Hospitals or prenatal care providers may distribute birth certificate worksheets *prior* to admittance, but at least one hospital respondent reports that these are rarely returned.

20. The child support agency from one of the 15 sample states did not respond when asked about notarization.

21. Not all State voluntary paternity acknowledgment affidavits include space for separate notary seals for the mother and father's signatures, although a Paternity Affidavit Taskforce formed by OCSE following passage of PRWORA has recommended all States begin to allow space for two seals.

22. These registrars allow parents from one to ninety days to return to the hospital for assistance in completing acknowledgments, with five days being the most common grace period. In addition, parents in all sample States may bring the form directly to the local or State vital records offices at any point following the child's birth. Hospital staff may need more complete information regarding birth registration and paternity documentation so they may refer parents who do not acknowledge during the hospital stay to the appropriate public offices.

23. A few hospital respondents write they may occasionally risk violence when communicating with parents, particularly when they tell the parents that notarization of the paternity form will require the father to present identification or when the husband is not the child's father. One birth registrar contributed the following: *"I am finding a marked increase in complicated social circumstances. Often violent behavior is involved with these situations. There have been times I have felt endangered because of the reactions of the parents. . ."*

24. Sometimes the father may be labeled as creating a barrier by not visiting the hospital, when it is actually the mother who is refusing to allow him to participate and acknowledge paternity. One birth registrar writes, *"If there is a strained relationship between parents, it is the mother who doesn't want the father listed or who can actively prevent (the) father from acknowledging paternity by providing no information,"* and a child support agency paternity coordinator calls mothers, *"the gatekeepers of paternity information."*

25. This finding replicates data from Table 4 that indicates 80 percent of child support agencies believe hospital staff do not recognize the importance of their role in communicating with unmarried parents.

26. Regarding the length of hospital stay being too short to complete paternity acknowledgment, one obstetric nurse writes, *"Mom and dad have too many emotional and educational demands at that time to focus on something they may perceive as unimportant."*

27. Some fathers may not visit during the mother's hospital stay, but may come in on subsequent days to sign the acknowledgment before the birth is registered. However, these post-discharge appearances by fathers may not materialize as often as hospital staff would like. One respondent writes, *"We have held many a certificate to the time limit because the mother thought she could get the dad to come in to sign."*

28. High-Medicaid, urban hospitals again had the lowest rate of father participation, with only 37 percent reporting all or most fathers participate during labor and delivery contrasted with 48 percent of all other hospitals.

APPENDIX A

COMPARISON OF SAMPLE AND NON-SAMPLE STATES

The fifteen States selected for the hospital-level analysis differed significantly from non-sample States in both structural and perceptual ways based on child support responses (see Table 1 below). The most striking differences deal with payment issues, barriers to relationships with vital records and hospitals, monitoring of hospital participation, training and training materials, and ratings of hospitals and acknowledgment programs.

Sample States are more likely to pay both vital records and hospitals for their help in administering the hospital acknowledgement programs compared to non-sample States. Specifically, sample States are over twice as likely (57 vs. 25 percent) to pay vital records than those in the non-sample States and also to report that the payment improved their service with vital records. Likewise, child support respondents from sample States are twice as likely (79 vs. 37 percent) to believe they should pay vital records for their assistance than non-sample States. In addition, 53 percent of sample States currently pay fees to hospitals per acknowledgment compared with only 25 percent of non-sample States.
Child support agencies in sample States also differ in their relationship with both vital records and hospitals. Fifty percent of them report *no* barriers in dealing with vital records compared with 22 percent of non-sample States. However, only seven percent of the child support agencies in the sample States find there are *no* barriers in their relationship with hospitals as opposed to 29 percent of the non-sample States. Sample States are also more likely (93 vs. 66 percent) to track the number of acknowledgments per hospital compared with non-sample States and to monitor hospital participation (73 vs. 44 percent).

All of the child support agencies surveyed in the sample States provide training for hospital staff compared with 86 percent of non-sample States and 87 percent provide on-site training in comparison with 58 percent of non-sample States. In addition, 40 percent of sample State child support agencies present a training video to the hospital staff compared with only 29 percent of non-sample States. Child support agencies in sample States also report more proactive follow-up with hospitals, and are more likely to make a phone call or in-person visit to hospitals to check on the supply of hospitals' training materials. Sample States are also at least twice as likely (79 vs. 39 percent) to provide an educational video for training parents, in-person instruction for parents (71 vs. 32 percent), and training in other languages (86 vs. 43 percent) than non-sample States.

Additionally, child support agencies are much less likely to rate the hospital's ability (8 vs. 25 percent) and effort (8 vs. 31 percent) in administering the paternity acknowledgment program as excellent compared with non-sample States. However, they find a greater number of advantages in the program for parents.

Table 1: DATA OF CHILD SUPPORT AGENCIES			
Key Questions	**Sample States**	**Non-Sample States**	**Overall**
<u>Payment Issues</u>			
Child Support Respondent Believes They Should Pay Vital Records	79% (11)	37% (13)	49% (24)
Child Support Currently Pays Vital Records	57% (8)	25% (9)	34% (17)
Payment Has Improved Service With Vital Records	100% (7)	44% (4)	69% (11)
Child Support Pays Fees to Hospitals Per Acknowledgment	53% (8)	25% (9)	33% (17)
<u>Barriers to Relationships</u>			
Reported <u>No</u> Barriers With:			
Vital Records	50% (7)	22% (8)	30% (15)
Hospitals	7% (1)	29% (10)	22% (11)
<u>Monitoring of Hospital Participation</u>			
Track # of Acknowledgments Per Hospital	93% (14)	66% (23)	74% (37)
Monitor Hospitals by Comparing Acknowledgments Received to Births Assisted	73% (11)	44% (16)	53% (27)
<u>Training/Training Materials</u>			
Provided to Hospital Staff:			
Child Support Training	100% (14)	86% (31)	90% (45)
On-Site Training	87% (13)	58% (18)	67% (31)
Training Video	40% (6)	29% (9)	33% (15)
Proactive Follow-up With Hospitals:			
By Phone	53% (8)	30% (10)	38% (18)
In-Person	47% (7)	27% (9)	33% (16)
Provided to Parents:			
Educational Video	79% (11)	39% (12)	51% (23)
In-person Instruction	71% (10)	32% (10)	44% (20)

Table 1: DATA OF CHILD SUPPORT AGENCIES			
Key Questions	**Sample States**	**Non-Sample States**	**Overall**
Training/Training Materials *Provided to Parents:* Materials in Other Languages	86% (12)	43% (13)	57% (25)
Ratings of Hospitals & Acknowledgment Program Rating of Hospital's Ability: Excellent	8% (1)	25% (7)	20% (8)
Rating of Hospital's Effort: Excellent	8% (1)	31% (8)	23% (9)
Advantages/Disadvantages of Program for Parents: Find Five or More Advantages	87% (13)	67% (24)	73% (37)
Find Only One Disadvantage	40% (6)	44% (16)	43% (22)

APPENDIX B

COMPARISON OF HOSPITAL SURVEY DATA BY URBANIZATION AND MEDICAID DISCHARGE RATES

Birthing hospital survey data from our 15 Sample States were analyzed by whether they are located in urban, suburban or rural areas[1] and by their Medicaid discharge rate.[2] The Medicaid discharge rate served as a proxy for identifying birthing hospitals which may have a larger number of unmarried or low-income clients. We constructed four separate variables for this analysis; one for urbanization; one for Medicaid discharge status; one comparing high-Medicaid, urban hospitals to all others; and one comparing high and low-Medicaid discharges by whether they are urban, rural or suburban birthing hospitals.

We find very few significant differences between these variables on key birthing hospital survey questions. However, in a few areas differences existed worth noting because they illustrate how hospital implementation varies based on location and type of patients served. If an issue is not represented in this appendix, it can be assumed that no differences were found pertaining to that issue as it concerns Medicaid discharge rates or urbanization.

Urban, Suburban, or Rural Status

Birthing hospitals vary significantly regarding notarization, especially on the availability of notaries, its effect on the completion of acknowledgments and its overall impact, based on urbanization (see Table 1). Intuitively many of these differences could be linked to a lesser demand for paternity acknowledgment services and/or a smaller hospital staff to do notarization in rural or suburban hospitals, as notaries are more likely to be available *only* during weekday business hours in rural and suburban hospitals (68 and 64 percent) compared to urban hospitals (55 percent). The availability of notaries is less likely to affect the completion of acknowledgments in rural hospitals (48 percent) compared to suburban or urban hospitals (65 and 63 percent). Suburban hospitals are more likely to report a positive impact of notarization (46 percent) compared to both urban and rural hospitals (36 and 32 percent).

However, suburban hospitals are less likely to report their relationship with their vital records agency as effective or very effective (72 percent) contrasted with urban and rural hospitals (85 and 84 percent). Rural hospitals experience the greatest number of fathers visiting the hospital (71 percent) compared to 68 percent of suburban hospitals and 61 percent of urban hospitals.

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[1] Urbanization status is based on self-reported information by hospital respondent.

[2] As previously mentioned, we sampled hospitals based on whether they had high-Medicaid discharges (over 12 percent) or low-Medicaid discharges (less than 12 percent).

Table 1: HOSPITAL DATA BY URBAN, SUBURBAN OR RURAL STATUS			
	Urban	**Suburban**	**Rural**
Notaries only available during weekday business hours	55% (45)	64% (39)	68% (106)
Availability of notaries affects completion of acknowledgments	63% (60)	65% (45)	48% (79)
Reported positive impact of notarization	36% (33)	46% (39)	32% (53)
Reported relationship with vital records agency as effective or very effective	85% (109)	72% (70)	84% (157)
All or most fathers estimated to come to the hospital	61% (75)	68% (69)	71% (129)

Medicaid Discharge Rate

Demographic factors comprise the most notable differences between hospitals with a high and low-Medicaid discharge rate (see Table 2). High-Medicaid hospitals are more likely to be public hospitals (68 percent) compared to low-Medicaid hospitals (60 percent). In addition, 39 percent of high-Medicaid hospitals are located in urban areas compared to 27 percent of low-Medicaid hospitals. Far fewer (16 vs. 31 percent) high Medicaid hospitals are found in suburban areas compared to low-Medicaid hospitals. However, little difference exists in rural hospitals based on Medicaid discharge status, with 43 percent of high-Medicaid hospitals located in rural areas compared to 41 percent of low-Medicaid hospitals. The greatest need for offering acknowledgment services exists at high-Medicaid hospitals (60 percent) contrasted with low-Medicaid hospitals (51 percent). High-Medicaid hospitals are also more likely to conduct prenatal education on paternity acknowledgment.

Table 2: HOSPITAL DATA BY MEDICAID DISCHARGE STATUS		
	Over 12% Medicaid Discharge	**Under 12% Medicaid Discharge**
Ownership Type		
Public Hospital	68% (146)	60% (144)
Private Hospital	25% (40)	33% (71)
Urbanization		
Urban Hospital	39% (69)	27% (62)
Suburban Hospital	16% (29)	31% (67)
Rural Hospital	43% (91)	41% (96)
Great or very great need at hospital for offering acknowledgment services	60% (128)	51% (133)
Hospital conducts prenatal education on paternity acknowledgment for parents	24% (32)	17% (24)

High-Medicaid, Urban Hospitals

Although very few hospitals report the program difficult or very difficult to administer, high-Medicaid, urban hospitals are more likely to report this compared to other hospitals (18 vs. 11 percent). See Table 3 for a complete listing. This difference could reflect the greater need for paternity acknowledgment services in these hospitals and the additional challenge this creates in training staff and allocating resources for the program. Father participation is also less likely in high-Medicaid, urban hospitals compared to other hospital types. Only 52 of these hospitals report that all or most fathers come to the hospital compared to 70 percent of all other hospitals. Only 37 percent of high- Medicaid, urban hospitals report all or most fathers participate during labor and delivery contrasted with 48 percent of fathers from other hospitals.

Table 3: HOSPITAL DATA BY HIGH MEDICAID, URBAN STATUS		
	High Medicaid/ Urban Hospital	Other Hospital Types
Find program difficult or very difficult to administer	18% (13)	11% (30)
Father participation		
All or most of fathers come to the hospital	52% (37)	70% (236)
All or most of fathers participate during the labor and delivery	37% (26)	48% (163)

Medicaid Status by Urbanization

Hospitals also vary significantly based on a combination of their Medicaid discharge rates and urbanization (see Table 4). Fifty-three percent of high-Medicaid, rural hospitals did not consider themselves part of a Statewide paternity acknowledgment program contrasted with only 15 percent of high-Medicaid, suburban hospitals.

High-Medicaid, suburban and urban hospitals are more likely to actively promote the idea of paternity acknowledgment to parents as a perceived role of hospital staff (63 and 47 percent) compared with low-Medicaid, urban hospitals (26 percent). The hospitals most likely to report all or most fathers come to the hospital are low-Medicaid, rural hospitals (82 percent) compared to only 52 percent of high-Medicaid, urban hospitals.

Table 4: HOSPITAL DATA BY MEDICAID STATUS BY URBANIZATION						
	High-Medicaid Hospital			Low-Medicaid Hospital		
	Urban	Suburban	Rural	Urban	Suburban	Rural
Reported they do not consider themselves part of Statewide paternity acknowledgment program	33% (21)	15% (4)	53% (43)	35% (20)	38% (24)	23% (24)
Actively promote the idea of paternity acknowledgment to parents as perceived role of hospital staff	47% (32)	63% (17)	30% (29)	26% (18)	37% (27)	39% (38)
All or most of fathers come to the hospital	52% (37)	77% (22)	58% (54)	70% (38)	65% (47)	82% (75)

APPENDIX C

ESTIMATES AND CONFIDENCE INTERVALS

The chart below summarizes the estimated proportions and the 95 percent confidence intervals for key statistics presented in this report. This stratified random sample required using SUDAAN[3] to compute the correct standard errors for the estimates, based on weighted data.

Table 1: POINT ESTIMATES AND CONFIDENCE INTERVALS FOR KEY QUESTIONS.

Question	Point Estimate	95% Confidence Interval
Proportion of hospitals viewing acknowledgment program as helpful or very helpful to parents.		
	70.0%	65.0% - 75.0%
Proportion of hospitals rating acknowledgment process as easy or very easy for parents to understand.		
	57.8%	52.7% - 63.0%
Proportion of hospitals rating acknowledgment program as simple or very simple to administer.		
	49.8%	44.7% - 54.9%
Proportion of hospitals describing their relationship with the vital records agency in working together as effective or very effective.		
	81.2%	77.0% - 85.4%
Proportion of hospitals reporting no barriers hinder their relationship with the vital records agency.		
	75.9%	71.6% - 80.3%
Proportion of hospitals reporting no relationship exists with the child support enforcement agency in administering acknowledgment program.		
	52.5%	47.1% - 57.9%
Proportion of hospitals that do not consider themselves to be part of Statewide program.		
	34.5%	29.4% - 39.5%
Proportion of hospitals reporting an effective or very effective relationship with child support agency.		
	73.0%	66.2% - 79.8%
Proportion of hospitals currently paid or have been paid in the past for processing acknowledgments.		
	83.6%	78.7% - 88.5%

[3] SUDAAN - Release 7.11, Research Triangle Park, North Carolina: Research Triangle Institute, 1997.

Table 1: POINT ESTIMATES AND CONFIDENCE INTERVALS FOR KEY QUESTIONS.		
Question	**Point Estimate**	**95% Confidence Interval**
Proportion of hospitals finding the payment for processing acknowledgments made a moderate or great difference in their hospital's ability to administer the program.		
	76.6%	69.3% - 83.9%
Proportion of hospitals receiving staff training and educational materials on the acknowledgment process.		
	71.8%	67.2% - 76.4%
Proportion of hospitals provided brochures, pamphlets, or handbooks for staff training.		
	57.0%	51.9% - 62.1%
Proportion of hospitals attempting follow-up contact with parents who leave the hospital without acknowledging paternity.		
	18.7%	14.7% - 22.7%
Proportion of hospitals providing parents with training and educational materials on paternity acknowledgment.		
	73.8%	69.3% - 78.4%
Proportion of hospitals using brochures, pamphlets, or handbooks to train parents.		
	67.2%	62.4% - 72.1%
Proportion of hospitals using birth certificate worksheets to fill out prior to discussing birth registration and paternity acknowledgment with a staff member.		
	83.9%	79.8% - 88.0%
Proportion of hospitals reporting no internal barriers to providing paternity acknowledgment services.		
	54.4%	49.2% - 59.6%
Proportion of hospitals reporting notarization has a negative impact on their acknowledgment process.		
	23.5%	18.3% - 28.6%
Proportion of hospitals reporting the availability of notaries affects the completion of acknowledgments.		
	57.4%	51.8% - 63.0%
Proportion of hospitals reporting that notaries are available only during weekday business hours.		
	63.5%	58.9% - 68.2%
Proportion of hospitals reporting their role is to inform parents about the rights and responsibilities that accompany paternity acknowledgment.		
	75.5%	71.0% - 80.0%

Table 1: POINT ESTIMATES AND CONFIDENCE INTERVALS FOR KEY QUESTIONS.		
Question	**Point Estimate**	**95% Confidence Interval**
Proportion of hospitals reporting the father most often creates a barrier to acknowledging paternity.		
	56.9%	51.0% - 62.7%
Proportion of hospitals finding that new parents cohabitating or in a long relationship strongly or very strongly influences parents who voluntarily acknowledge paternity at the hospital.		
	81.0%	76.7% - 85.4%
Proportion of hospitals reporting that all or most unmarried fathers come to the hospital during the mother and baby's hospital stay.		
	67.7%	62.8% - 72.7%
Proportion of hospitals estimating that all or most unmarried fathers participate during labor and delivery.		
	45.3%	40.4% - 50.2%
Proportion of hospitals reporting that a bad relationship between the new parents strongly or very strongly influences parents who do not voluntarily acknowledge paternity at the hospital.		
	75.2%	69.9% - 80.5%