

Early Elective Delivery

Change Package

2016 UPDATE

ELIMINATION OF ELECTIVE DELIVERIES PRIOR TO 39 WEEKS GESTATION

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How to Use this Change Package

This change package is intended for hospitals participating in the Hospital Engagement Network (HEN) 2.0 project led by the Centers for Medicare & Medicaid Services (CMS) and Partnership for Patients (PFP); it is meant to be a tool to help you make patient care safer and improve care transitions. This change package is a summary of themes from the successful practices of high performing health organizations across the country. It was developed through clinical practice sharing, organization site visits and subject matter expert contributions. This change package includes a menu of strategies, change concepts and specific actionable items that any hospital can choose to implement based on need or for purposes of improving patient quality of life and care. This change package is intended to be complementary to literature reviews and other evidence-based tools and resources.

PART 1: ADVERSE EVENT AREA (AEA) DEFINITION AND SCOPE

Early elective delivery (EED) refers to the delivery of an infant prior to the natural onset of labor, between 37-39 weeks gestation. It is accomplished through the use of medications or mechanical methods to trigger the onset of labor or through the use of scheduled cesarean-section delivery.¹

Magnitude of the Problem

Approximately four million births occur in the United States annually.² While the rate of EED has been steadily declining for the last four years, from 17 percent in 2010 to 4.6 percent in 2013, still nearly nine percent of U.S. births that were paid for by Medicaid in 2014 were early elective deliveries.^{3,4} A clear, enforceable “hard stop” policy for scheduling induced deliveries is one of the most effective methods to decrease the incidence of EEDs.⁵ In addition, there are many misconceptions among women about the safety of giving birth earlier than full term. A 2009 survey of insured women found that 92.4 percent of women reported that giving birth before 39 weeks was safe. A lack of understanding about the risks to both mother and infant have led to increased EED rates in the past.⁶ There are in fact many risks associated with EED. Labor induction can cause maternal complications such as: increased risk of infection and postpartum hemorrhage due to prolonged labor; increased risk of C-section (which often results in repeat C-sections in subsequent pregnancies); and increased use of instruments, such as forceps or vacuum, during delivery.^{1,7} Additionally, infants delivered prior to 39 weeks without medical reason are at an increased risk of having lower brain mass,⁸ low birth weight,⁹ feeding problems,¹⁰ respiratory distress syndrome¹¹ and longer hospital stays.¹²

HEN 1.0 Progress

Through the work of the AHA/HRET Hospital Engagement Network, from 2011 through 2014, over 1,400 hospitals worked to prevent early elective deliveries.

What does that Mean?

992

NUMBER OF NICU
ADMISSIONS PREVENTED



\$7,811,342

TOTAL PROJECTS
ESTIMATED COST SAVINGS



24 states
40% MEETING THE
REDUCTION GOAL

HEN 2.0 Reduction Goals

- Reduce the rate of EED by 40 percent by September 23, 2016.
- Achieve an EED rate of less than three percent by September 23, 2016.

PART 2: MEASUREMENT

A key component to making patient care safer in your hospital is to track your progress toward improvement. This section outlines the nationally recognized process and outcome measures that you will be collecting and submitting data on as part of the AHA/HRET HEN 2.0. Collecting these monthly data points at your hospital will guide your quality improvement efforts as part of the Plan-Do-Study-Act (PDSA) process. Tracking your data in this manner will provide valuable information needed to study your data across time and help determine the effect your improvement strategies are having in your hospital at reducing patient harm. Furthermore, collecting these standardized metrics will allow the AHA/HRET HEN to aggregate, analyze and report its progress toward reaching the project's 40/20 goals across all AEAs by September 2016.

Data elements to track EED are available in both administrative and non-administrative datasets. Administrative data are helpful to collect ICD9/10 diagnosis and procedure codes, but are poor sources of information for gestational age and induction of labor.

Nationally Recognized Measures: Process and Outcome

Please download and reference the encyclopedia of measures (EOM) on the AHA/HRET HEN website for additional measure specifications and for any updates after publication at: <http://www.hret-hen.org/audience/data-informatics-teams/EOM.pdf>

HEN 2.0 EVALUATION MEASURE

- Number of infants admitted to the NICU or transferred to another hospital for care after a scheduled elective induction or cesarean section between 37 and 38 weeks

PROCESS MEASURE

- Elective delivery rate prior to 39 weeks gestation

PART 3: APPROACHING YOUR AEA

Suggested Bundles and Toolkits

- The March of Dimes/California Maternal Quality Care Collaborative (CMQCC)/California Department of Public Health 39 Weeks Toolkit. Retrieved at: http://www.cmqcc.org/_39_week_toolkit
- National Quality Forum: Playbook for Successful Elimination of Early Elective Deliveries. Retrieved at: <http://www.39weeksfl.com/wp-content/uploads/2014/08/NQF-Maternity-Action-Team-Playbook-2014.pdf>
- Childbirth Connection: Resources for Induction of Labor. Retrieved at: <http://www.childbirthconnection.org/article.asp?ck=10654>
- AHA/HRET HEN 2.0 OB Harm Change Package. Retrieved at: <http://www.hret-hen.org/topics/obstetrical-adverse-event.shtml>
- For additional tools and resources related to help eliminate EED, visit www.hret-hen.org

Investigate Your Problem and Implement Best Practices

Driver diagrams: A driver diagram visually demonstrates the causal relationship between your change ideas, secondary drivers, primary drivers and your overall aim. A description of each of these components is outlined in the table below. This change package is organized by reviewing the components of the driver diagram to first, help provide you and your care team identify potential change ideas to implement at your facility and second, to show how this quality improvement tool can be used by your team to tackle new process problems.

Aim	Primary Driver	Secondary Driver	Change Idea
		Secondary Driver	Change Idea
	Primary Driver	Secondary Driver	Change Idea

AIM: A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable and time-bound.

PRIMARY DRIVER: System components or factors that contribute directly to achieving the aim.

SECONDARY DRIVER: Action, interventions or lower-level components necessary to achieve the primary driver.

CHANGE IDEAS: Specific change ideas which will support and achieve the secondary driver.

Drivers in This Change Package

Reduce Early Elective Delivery Rate	Reduce Demand for Elective Deliveries Prior to 39 Weeks	Increase awareness of risks with clinicians and patients	Change Idea
	Reduce Availability of Elective Deliveries Prior to 39 Weeks	Establish enforceable hospital policies and procedures	Change Idea

OVERALL AIM: REDUCE EED RATE

Primary Driver > Reduce Demand for Elective Deliveries Prior to 39 Weeks Gestation

Increasing awareness of the many risks associated with early elective deliveries reduces the demand for the procedure by both clinicians and patients. National guidelines have increased organizational support for the reduction of EED.

Secondary Driver > Increase awareness of risks with clinicians and patients

Providers and patients must understand the risks, to both mother and baby, when delivering earlier than 39 weeks without medical indications. Generally, resistance to change practices around deliveries scheduled earlier than 39 weeks is due to the perception that little or no harm to the baby or increased risk to the mother exists.

Change Ideas

Provide education to physicians and nursing staff:

- + Provide clinicians with data about their patients' complications (maternal and neonatal). Emphasize avoiding elective deliveries earlier than 39 weeks.
- + Provide a summary of evidence from literature to clinicians that details the risk of harm due to EED.
- + Use a physician champion to communicate the reasons for and importance of the initiative to medical staff.
- + Use a nurse champion to communicate the reasons for and importance of the initiative to the nursing staff.

Provide education to patients:

- + Provide patients with educational materials that define full term and emphasize the importance of eliminating EED. Materials can be distributed at physician offices and during prenatal classes.
- + Utilize marketing tools developed by the March of Dimes to reach patients online and in print. (See Appendix IV)

Suggested Process Measures for Your Test of Change

- Percent of clinicians who have been provided educational materials for their office practices
- Percent of maternal health, medical staff department meetings that review EED data

Hardwire the Process

Perform a retrospective review of hospital data findings on early elective deliveries to give the medical staff baseline data from which to work. Utilize a physician champion to address concerns by the medical staff and distribute current research and data at medical staff meetings and in newsletters. Assist the physician champion by providing him/her with the most up-to-date research from obstetrical quality resources.

Primary Driver > Reduce the Availability of Elective Deliveries Prior to 39 Weeks Gestation

Policies for elective inductions and the process for scheduling them must be driven by physicians, administered by nurses and supported by hospital leadership in order to reduce the availability of EEDs. If supported by physicians and hospital leaders, the implementation of a policy that includes a “hard stop” for cases that do not meet medical necessity will lead to a more successful reduction in EEDs.

Secondary Driver > Establish enforceable hospital policies and procedures

Formalizing the elimination of elective deliveries prior to 39 weeks gestation requires policies and procedures that govern care and are based on evidence-based protocol examples.¹³ A policy that specifically defines the acceptable instances of EEDs, eliminates guesswork for clinicians and hospital staff and sets clear guidelines for care delivery. Support from the medical staff and hospital leadership is necessary to assist and empower front line nursing staff to be gatekeepers for policies. It is imperative that staff members know that hospital leadership is supportive of the policy. An EED policy is primarily physician driven and will require buy-in from the medical staff to be successful.

Change Ideas

Include physicians in the development of the policy and procedure:

- + Utilize a physician champion to communicate with and engage the medical staff.
- + Establish ownership of the policy by the medical staff during the development of the policy.

Use established, evidence-based policies and protocols:

- + Utilize a sample policy already developed by either a maternal quality care collaborative or a perinatal safety program as the basis for your hospital policy.¹⁴

Establish procedures for approving exceptions to the policy:

- + Use physician leaders to assist in defining medical necessity for early deliveries based on American College of Obstetricians and Gynecologists (ACOG), The Joint Commission and other national quality recommendations.^{15,16}
- + Set clear guidelines and define the chain of command and escalation process for how an early induction that is medically necessary can receive timely approval within the organization.

Establish a defined procedure for scheduling medically necessary elective deliveries:

- + Define a clear process for scheduling elective deliveries, including the information required to schedule. (See Appendix III for an example)
- + Gestational age and the medical indication for induction or cesarean section should be required information.
- + Create standardized forms for scheduling that include all of the required information.

Include a “hard stop” or instructions on how to halt the scheduling process when an induction that does not meet criteria is scheduled:

- + Include specific details about the chain of command for both nursing and clinical leadership to be notified when a “hard stop” is implemented.
- + Include specific details about the responsibilities and expectations of team members when a “hard stop” is implemented and guidance to resolve the issue.

Suggested Process Measures for Your Test of Change

- Percent compliance with routine use of a scheduling form for all scheduled inductions
- Percent compliance with documentation of all required elements needed on the scheduling form for all scheduled inductions

Hardwire the Process

Measure compliance with the elective delivery policy by collecting data on deliveries prior to 39 weeks gestation. Complete an indepth review of any early elective deliveries that were not medically necessary to determine the cause(s). Continue to discuss the scheduling process with staff during staff meetings and use insight and feedback from staff to further refine and improve the scheduling process. Listen to physicians who provide feedback about potential delays in scheduling due to the new policy and use that feedback to also refine and improve the process. Continue to report outcomes and process data on all elective deliveries to the medical staff. Support from medical staff and hospital leadership is necessary to encourage front line nursing staff to be gatekeepers for such policies. It is imperative that staff members know that hospital leadership is supportive of the policy.

PDSA IN ACTION | TIPS ON HOW TO USE THE MODEL FOR IMPROVEMENT

Implement Small Tests of Change

Test the implementation of a “hard stop” process when attempts to schedule an inductions do not meet medical necessity criteria.

Test the implementation of an induction scheduling tool.

PLAN

Example Test: Assemble a team of stakeholders including physicians, other clinicians, nurses, surgical schedulers and a member of the hospital leadership team. This team should review current hospital practice along with sample “hard stop” policies from national perinatal quality associations. As a group, they should design a chain of command process that can be followed when an induction that is prior to 39 weeks, but that does not meet medical necessity criteria, is attempted to be scheduled.

Example Test: Assemble a team of stakeholders including physicians, other clinicians, nurses, surgical schedulers and a member of the hospital leadership team. This team should review current practices, EED data and sample scheduling tools from national perinatal quality associations. The group should develop a form that can be utilized when inductions are being scheduled. The intent of the form is to standardize the process for gathering information about gestational age and medical indications for induction.

DO

Example Test: Test the protocol with a scheduler.

Example Test: Test the protocol with one scheduler and one physician.

STUDY

Example Test: After the process has been tested the first time, huddle with the scheduler and the medical staff involved to determine what works and what could be done differently the next time.

Example Test: After the test, huddle with the scheduler, physician and physician's office to determine what works and what could be changed on the form.

ACT

Example Test: Make changes to the process based on the findings with input from the medical staff. Continue to refine the process with each episode.

Example Test: Make changes to the form based on the findings. Continue to test the changes on a broader scale until the form can be used for all inductions.

Potential Barriers

- Recognize that this is a change in clinician practice; decisions about the timing of deliveries has traditionally been directed by the physician not by a hospital policy.
- Hospital barriers include competing priorities for multiple safety initiatives and lack of institutional support for additional improvement work. Standardization of scheduling policies and procedures across organizations can help to alleviate barriers.
- Patient requests for scheduling an early delivery for non-medical reasons such as deployment of military personnel, alignment of when visitors can help with a new baby, etc. can be drivers for early inductions. Empowering patients through education about the risks associated with early non-medically indicated inductions can have a positive effect on the overall demand for the procedure and reduce rates.

Enlist Administrative Leadership to Sponsor and Encourage Change, Helping Remove or Mitigate Barriers

- Physicians and other clinicians may threaten to move to another hospital to perform elective deliveries if they perceive a significant, unjustifiable loss of clinical autonomy. This may create challenges for hospital administrators but the support of senior leadership is instrumental to mitigating this barrier. Senior leaders can collaborate with other local hospitals to adopt similar delivery practices to encourage all clinicians to adopt safe delivery practices.
- A multidisciplinary approach to developing protocols and workflow plans along with conducting education will encourage widespread adoption of best practices. Senior leadership can support early adopter clinicians to lead and recruit early adopter champions.
- A senior leader serving as an executive sponsor is crucial to developing solutions for what may be perceived as additional work or processes within a current workflow. By enlisting a senior leader as an executive sponsor, the improvement team is able to consider organization wide impact as well as staffing needs associated with adopting best practices.

Change not Only “The Practice” but also “The Culture”

- Reducing EED rates requires physicians to trade their traditional approach of individualizing pregnancy and delivery management to a more standardized and safe approach. Encourage adoption of order sets and practice bundles by enlisting physician champions who can connect with their physician peers.
- Reduction of EED requires small tests of change. These should be done prior to refining the processes or embedding best practices into the hospital’s culture and practices. Push back is common when instituting any change in policy or practice, but the ultimate goal is to ensure safe patient care.
- Implementing a new or updated scheduling process may require time before being fully incorporated into current workflows. Account for this transition time and prepare staff in advance through: 1) publicizing the process prior to roll-out; 2) training key staff; 3) streamlining the process; and 4) promoting the benefits to physicians and support staff.
- Use multiple methods to educate patients about the potential risks associated with EED. Engage patients in their pregnancies through shared decision making, education about neonatal brain development (see Appendix IV), social media interventions such as Text4Baby.org and discussions throughout prenatal care reinforcing 40 weeks gestation as full term.

PART 4: CONCLUSION & ACTION PLANNING

While great strides have been made in the last five years in the reduction of EED, there is still room for improvement. Hospitals that have maintained consistent EED rates below three percent may want to focus improvement efforts on looking at common factors among elective deliveries that still occur in those organizations or by focusing in on the medical necessity of all inductions at 39 weeks gestation. Hospitals that are still experiencing barriers to reaching the goal may want to partner with a regional perinatal organization or a perinatal quality collaborative for help in addressing barriers and learning from other hospitals experiencing the similar issues.

PART 5: APPENDICES

APPENDIX I: EARLY ELECTIVE DELIVERY TOP TEN CHECKLIST

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: A checklist to review current EEDs or initiate new interventions for elimination of elective deliveries prior to 39 weeks gestation

Reference: www.hret-hen.org

2016 Early Elective Delivery Top Ten Checklist				
Process Change	In Place	Not Done	Will Adopt	Notes (Responsible and By When?)
Educate the hospital governing board about the dangers of early elective deliveries (EED) and what the hospital's role in prevention can be.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use prenatal classes as an opportunity to educate patients about the dangers of EED and clearly articulate the hospital's policy on scheduled inductions. Provide information to patients about resources, websites and social media outlets that educate mothers-to-be about their babies' development at each week of the pregnancy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Partner with a physician willing to champion the effort to reduce EED. This physician does NOT have to be an obstetrician; a neonatologist or pediatrician can be very successful in this role.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
When writing a "hard stop" policy, have physicians and hospital leaders involved from the start in the creation of the policy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use prescriptive language in the "hard stop" policy that details the exact steps to be taken and by whom within the chain of command when an elective delivery is attempted to be scheduled that does not meet the criteria determined by the medical staff.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use policies, scheduling forms, educational materials and data-collection tools that are already created and available publicly from the March of Dimes, CMQCC and the National Quality Forum.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Review data as concurrently as possible with all stakeholders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Review all EED in the past 12 months to determine if any were admitted to NICU; use those stories as motivation to gain buy-in from stakeholders.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pick a system for determining gestational age in your organization and stick to it to prevent confusion when scheduling inductions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Don't try to include all possible medical indications for induction in the "hard stop" policy. The policy should have a process for immediate review of cases that do not meet criteria for early delivery to determine treatment options.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

APPENDIX II: MEASUREMENT GUIDELINES FOR PC-01

Associated Hospital/Organization: AHA/HRET HEN 2.0

Purpose of Tool: Instruction document to walk hospitals through the process of accurately reporting EED rates

Reference: www.hret-hen.org

Measurement Strategy, Calculating the PC-01 EED Rate

STEP 1

Count the number of patients that delivered babies between 37 and 38 6/7 weeks gestation.

STEP 2

Subtract the number of patients that meet exclusion criteria listed in Appendix A, Table 11.07 found in The Joint Commission Specifications Manual from Step 1. See links to resources:

- <https://manual.jointcommission.org/releases/TJC2015B/MIF0166.html>
- https://manual.jointcommission.org/releases/TJC2015B/AppendixATJC.html#Table_Number_11.07:_Conditions_Possibly_Justifying_Elective_Delivery_Prior_to_39_Weeks_Gestation
- https://manual.jointcommission.org/releases/TJC2014A/AppendixPTJCcrosswalks.html#Table_11.07:_Conditions_Possibly_Justifying_Elective_Delivery_Prior_to_39_Weeks_Gestation

Then, subtract any patients less than 8 years of age, greater than or equal to 65 years of age, length of stay >120 days, or enrolled in clinical trials. This is your DENOMINATOR.

STEP 3

Take the DENOMINATOR from Steps 1 and 2 and out of these cases, subtract the number of nonelective deliveries. (Note: Deliveries that do not meet the elective delivery definition are considered non-elective. These include patients that are admitted already in labor.) This is your NUMERATOR.

STEP 4

Divide the NUMERATOR by the DENOMINATOR to calculate the EED rate. The difference between the numerator and the denominator is that the NUMERATOR contains only those cases in which the mother delivered electively between 37 and 38 6/7 weeks, without a medical indication that is on the list provided in Appendix A, Table 11.07 from The Joint Commission Specifications Manual. The DENOMINATOR contains ALL cases in which the mother delivered between 37 and 38 6/7 weeks, either spontaneously or electively, minus the indications on the list in Appendix A, Table 11.07 or other exclusion.

APPENDIX II: MEASUREMENT GUIDELINES FOR PC-01 CONTINUED

MPC-01, Example Data Calculation

STEP 1

Last month's delivery log shows that there were 300 babies delivered between 37 and 38 6/7 weeks.

STEP 2

Of those 300 deliveries, 200 met criteria listed in Table 11.07, had prior uterine surgery, were in a clinical trial, or met the other listed acceptable medical indications.

$300 - 200 = 100$. This is your DENOMINATOR

STEP 3

Now that you have found your denominator (100), find your NUMERATOR by counting the number of non-elective deliveries and c-sections (those that come in to the hospital in labor or do not have a scheduled c-section) between 37 and 38 6/7 weeks.

For our example, let's say that number is 98. Subtract that number from your denominator.

$100 - 98 = 2$. This is your NUMERATOR.

STEP 4

Using our example, the PC-01 EED rate for the hospital would be: $2 / 100$ or 2%.

APPENDIX III: SAMPLE SCHEDULING FORM

Associated Hospital/Organization: March of Dimes / California Maternal Quality Care Collaborative / California Department of Public Health

Purpose of Tool: Provide an example of a scheduling form for inductions

Reference: Early Elective Delivery Toolkit. Available at: <https://www.cmqcc.org/resources-tool-kits/toolkits>

Form 3: March of Dimes Induction/Cesarean Section Delivery Scheduling Form (Used with permission of the March of Dimes)

Requesting Physician _____ Today's Date _____

Patient's Name _____ Age _____ G _____ P _____

Medical Record # _____ Requested Procedure Date _____ ☐ AM ☐ PM

Gestational Age on Date of Procedure _____

Method of Delivery Planned: ☐ Cesarean delivery: ☐ Primary or ☐ Repeat

☐ Induction: Fetal presentation _____ EFW _____ gms Bishop Score _____

Reasons for Scheduled Delivery: Check all appropriate indications below

Level 1

- ☐ Chorioamnionitis
- ☐ Preeclampsia / HELLP
- ☐ Abruptio placenta
- ☐ Bleeding D/T marginal placenta previa
- ☐ Non-reassuring fetal testing
- ☐ PROM
- ☐ Fetal hydrops / isoimmunization
- ☐ Oligohydramnios
- ☐ Blood group sensitization
- ☐ Fetal compromise (severe IUGR)
- ☐ Fetal anomaly
- ☐ Maternal medical conditions
- ☐ Gestational hypertension
- ☐ Multifetal gestation

Level 2

- ☐ ≥41 weeks gestation / Postterm pregnancy
- ☐ Gestational diabetes
- ☐ IUGR – reassuring testing
- ☐ Fetal demise
- ☐ Maternal HIV

Level 3

- ☐ Fetal malpresentation / Unstable lie
- ☐ History of HSV
- ☐ Prior myomectomy
- ☐ Prior vertical or T-incision C/S
- ☐ Prior C/S - VBAC not indicated
- ☐ Macrosomia (EFW greater than 4000 gms)

AND
Gestational age ≥ 39 weeks*

Level 4

- ☐ History of rapid labor
- ☐ Distance from hospital
- ☐ Term with favorable cervix
- ☐ Psychological factors
- ☐ Maternal request
- ☐ Prior C/S
 - Patient declines VBAC
 - VBAC not available

AND
Gestational age ≥ 39 weeks*

☐ Other indication _____

Clinical indications (with supporting data) _____

Confirmation of gestational age:

EDC _____ determined by: Check all that apply

☐ Ultrasound obtained at < 20 weeks on _____ date @ _____ gestational age weeks confirms gestational age

☐ Known date of conception on _____ date associated with infertility treatment

For Level 3 or 4 indications, if EDC was not determined by above methods, then identify documentation of fetal maturity:

☐ Amniocentesis performed on _____ Results: _____

* Provide explanation if scheduling Level 3 or 4 at < 39 weeks _____

Please fax form to _____

Procedure scheduling determination:

- ☐ Level 1 or Level 2 indication scheduled as requested
Medically indicated procedure necessitates delivery prior to 39 weeks gestation
- ☐ Level 3 or Level 4 procedure scheduled as requested
Gestational age ≥ 39 weeks on scheduled procedure date per ACOG recommendation
- ☐ Level 3 or Level 4 procedure scheduling request requires further review
 - ☐ Gestational age < 39 weeks on scheduled date of procedure
 - ☐ Gestational age or fetal maturity not determined using established criteria

Completed by _____

March of Dimes Scheduling Form Template Adapted from the Ohio Perinatal Quality Collaborative 8/17/09



APPENDIX III: SAMPLE SCHEDULING FORM CONTINUED

This chart is provided for your convenience to assist in calculating the Bishop Score. The final score should be entered on the front of this form where indicated. Vaginal exams should have been performed at least within the last 7 days.

Bishop Score					
Score	Dilation (cm)	Effacement (%)	Station* (-3 to +3)	Cervical Consistency	Cervical Position
0	Closed	0-30	-3	Firm	Posterior
1	1-2	40-50	-2	Medium	Midposition
2	3-4	60-70	-1	Soft	Anterior
3	≥5	≥80	+1, +2	–	–

**Station reflects a -3 to +3 scale-modified from Bishop EH Pelvic Scoring for Elective Induction, Obstet Gynecol 1964, 24(267)
Please state -5 to +5 for all other purposes.*

March of Dimes Scheduling Form Template Adapted from the Ohio Perinatal Quality Collaborative 8/17/09

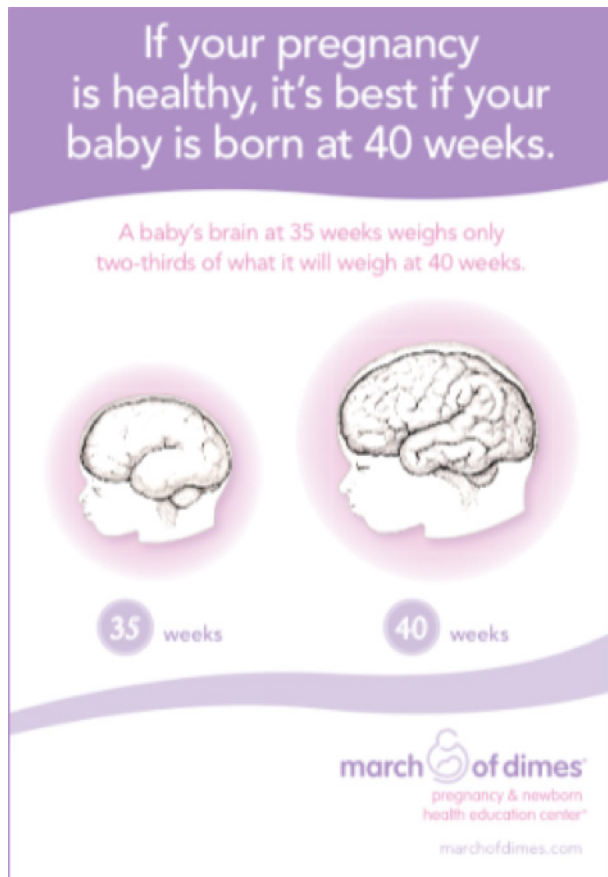


APPENDIX IV: NEONATAL BRAIN DEVELOPMENT PATIENT EDUCATION TOOL

Associated Hospital/Organization: March of Dimes / California Maternal Quality Care Collaborative / California Department of Public Health

Purpose of Tool: Educational tool for patients to demonstrate neonatal brain development between 37 and 39 weeks gestation

Reference: Early Elective Delivery Toolkit. Available at: <https://www.cmqcc.org/resources-tool-kits/toolkits>



- * In the last 6 weeks of pregnancy, your baby's brain adds connections needed for balance, coordination, learning and social functioning. During this time, the size of your baby's brain almost doubles.
- * Babies born early have more learning and behavior problems in childhood than babies born at 40 weeks.
- * Babies born early are more likely to have feeding problems because they can't coordinate sucking, swallowing and breathing as well as full-term babies.
- * Babies born early are likely to have breathing problems, like apnea. Apnea is when a baby stops breathing.
- * Babies born early are more likely to die of sudden infant death syndrome (SIDS). SIDS is when a baby dies suddenly and unexpectedly, often during sleep.

To order our catalog or multiple copies of our materials, call 1-800-367-6633.
#37-2229-07 Late-preterm Brain Development Card 2/08

March of Dimes materials are for information purposes only and are not to be used as medical advice. Always seek medical advice from your health care provider. Our materials reflect current scientific recommendations at time of publication. Check marchofdimes.com for updated information. Modeled after a fetal brain card developed by the Healthy Babies Are Worth the Wait™ initiative.

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APPENDIX V: 2016 SUMMARY OF SPECIFICATIONS FOR DATA ABSTRACTION OF PC-01 PERINATAL CORE MEASURE

Associated Hospital/Organization: California Maternal Quality Care Collaborative

Purpose of Tool: Instructional tool to assist hospitals to abstract early elective delivery data using a short algorithm and ICD-10 codes

Reference: California Maternal Quality Care Collaborative

Guide to The Joint Commission PC-01 Early Delivery Measure: Understanding what prevents a case from entering the Numerator

Elliott K. Main, MD
Medical Director, CMQCC
February 2016

The Early Elective Delivery measure (PC-01) has a complicated set of rules that can make it hard for providers and coders to keep on top of. Over the last several years The Joint Commission has responded to suggestions from the obstetric community to adjust the specifications for PC-01 to allow for a wider array of exclusions. Some of these have resulted to new ICD codes being added and others have required a list of new exclusions that can only be handled by chart reviews. Here we will attempt to collect all of the ways a case should not end up in the numerator. Technically, some of these steps remove the case from the denominator and other steps remove the case from the numerator but the net effect is the same—the case will not “count”. Most of the language below is taken verbatim from the JC specifications.

Step 1: Presence of any of the diagnoses on the list: Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation:

The list of 2106 PC-01 ICD-10 codes is 17 pages long so we have summarized the exclusion categories here and expanded to the actual diagnoses in a 2 page summary in the appendix.

- Any form of Hypertension, preeclampsia or renal disease in any period of pregnancy
- Any form of Diabetes and in any period of pregnancy
- Liver and Biliary diseases (includes cholestasis of pregnancy) in any period of pregnancy
- Other maternal conditions in any period of pregnancy, including HIV, Cardiovascular diseases and current use of anticoagulants
- Placenta Previa, Accreta, Abruption and Obstetric Hemorrhage in any period of pregnancy
- Labor and Delivery Conditions, including abnormality in fetal heart rate, prolapsed cord, fetal acid base abnormality unstable lie
- Rupture of membranes before the onset of labor—this is an important exclusion where it is **critical to document pre-labor rupture of membranes** or premature rupture of membranes not just spontaneous rupture of membranes.
- Intrauterine infection in any period of pregnancy
- Fetal malformations, conditions or damage in any period of pregnancy
- Poly- or oligo-hydramnios in any period of pregnancy
- Fetal demise, placental insufficiency, IUGR, decreased fetal movement in any period of pregnancy

Step 2: Documentation that the patient had undergone prior uterine surgery:

The **only** prior uterine surgeries considered for the purposes of the measure are:

- Prior classical cesarean birth which is defined as a vertical incision into the upper uterine segment
- Prior myomectomy
- Prior uterine surgery resulting in a perforation of the uterus due to an accidental injury
- History of a uterine window or thinning or defect of the uterine wall noted during prior uterine surgery or during a past or current ultrasound
- History of uterine rupture requiring surgical repair
- History of a cornual ectopic pregnancy
- History of transabdominal cerclage

Does not include:

- Prior low transverse cesarean birth
- Prior cesarean birth without specifying prior classical cesarean birth
- History of an ectopic pregnancy without specifying cornual ectopic pregnancy
- History of a cerclage without specifying transabdominal cerclage

APPENDIX V: 2016 SUMMARY OF SPECIFICATIONS FOR DATA ABSTRACTION OF PC-01 PERINATAL CORE MEASURE CONTINUED

Step 3: Documentation by the clinician that the patient was in labor prior to the cesarean birth or the labor induction. (Clinician can be a physician, CNM, PA or RN)

Note that the definition of labor is now much less specific than in prior specifications.

- Documentation of labor by the clinician should be abstracted at face value, e.g., admit for management of labor, orders for labor, etc. **There is no requirement for acceptable descriptors to be present** in order to answer "yes" to labor. In other words if the clinician says labor, it is labor. The alternative to the documented word "labor" is:
- Documentation of regular contractions with or without cervical change, e.g.:
 - > contractions every 4 to 5 minutes
 - > regular contractions and dilation
 - > effacement 50% with contractions every 3 minutes
 - > steady contractions
- Induction of labor is defined as the use of medications or other methods to bring on (induce) labor. **Note that if labor has already started (see above) it should NOT be coded as an induction** (most likely it would be coded as an augmentation).
Methods of induction of labor include, but are not limited to:
 - > Administration of Oxytocin (Pitocin)
 - > Artificial rupture of membranes (AROM) or amniotomy
 - > Insertion of a catheter with an inflatable balloon to dilate the cervix
 - > Ripening of the cervix with prostaglandins, i.e. Cervidil, Prepidil, Cytotec, etc
 - > Stripping of the membranes when the clinician sweeps a gloved finger over the thin membranes that connect the amniotic sac to the wall of the uterus.

APPENDIX V: 2016 SUMMARY OF SPECIFICATIONS FOR DATA ABSTRACTION OF PC-01 PERINATAL CORE MEASURE CONTINUED

The Joint Commission PC-01 Specifications: Version 2016A ICD-10 Code Exclusions
Table Number 11.07: Conditions Possibly Justifying Elective Delivery Prior to 39 Weeks Gestation
---Appendix: Simplified for Case Reviews---

Any form of Hypertension, preeclampsia or renal disease in any period of pregnancy:
Pre-existing essential hypertension complicating pregnancy
Pre-existing hypertensive heart disease complicating pregnancy
Pre-existing hypertensive chronic kidney disease complicating pregnancy
Pre-existing hypertensive heart and chronic kidney disease complicating pregnancy
Pre-existing secondary hypertension complicating pregnancy
Unspecified pre-existing hypertension complicating pregnancy
Pre-existing hypertension with preeclampsia
Gestational proteinuria
Gestational edema with proteinuria
Gestational [pregnancy-induced] hypertension without significant proteinuria
Mild to moderate preeclampsia
Severe preeclampsia
HELLP syndrome (HELLP)
Unspecified preeclampsia
Eclampsia
Unspecified maternal hypertension
Pregnancy related renal disease
Any form of Diabetes and in any period of pregnancy:
Pre-existing diabetes mellitus, type 1, in pregnancy
Pre-existing diabetes mellitus, type 2, in pregnancy
Unspecified pre-existing diabetes mellitus in pregnancy
Gestational diabetes mellitus in pregnancy
Other pre-existing diabetes mellitus in pregnancy
Unspecified diabetes mellitus in pregnancy
Abnormal glucose complicating pregnancy
Liver and Biliary diseases (includes cholestasis of pregnancy) in any period of pregnancy:
Liver and biliary tract disorders in pregnancy
Biliary cyst
Other specified diseases of biliary tract
Disorders of gallbladder, biliary tract and pancreas in diseases classified elsewhere
Other maternal conditions in any period of pregnancy:
Human immunodeficiency virus [HIV] disease
Asymptomatic human immunodeficiency virus [HIV] infection status
Supervision of pregnancy with other poor reproductive or obstetric history (e.g prior stillbirth)
Other diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism complicating pregnancy
Diseases of the circulatory system complicating pregnancy
Long term (current) use of anticoagulants
Previa, Accreta, Abruptio and Obstetric Hemorrhage in any period of pregnancy:
Placenta accreta, increta, or percreta
Placenta previa with hemorrhage or specified as without hemorrhage
Labor and delivery complicated by vasa previa
Premature separation of placenta (abruptio) with coagulation defect
Premature separation of placenta (abruptio), unspecified
Antepartum hemorrhage with coagulation defect, afibrinogenemia, or DIC
Other antepartum hemorrhage
Intrapartum hemorrhage with coagulation defect

APPENDIX V: 2016 SUMMARY OF SPECIFICATIONS FOR DATA ABSTRACTION OF PC-01 PERINATAL CORE MEASURE CONTINUED

Labor and Delivery Conditions
Post-term pregnancy
Labor and delivery complicated by abnormality of fetal acid-base balance
Labor and delivery complicated by prolapse of cord
Rupture of uterus before onset of labor
Abnormality in fetal heart rate and rhythm complicating labor and delivery
Maternal care for unstable lie
Maternal care for malpresentation of fetus, unspecified
Rupture of membranes before the onset of labor:
Preterm premature rupture of membranes, onset of labor within 24 hours of rupture, first trimester
Full-term premature rupture of membranes, onset of labor more than 24 hours following rupture
Preterm premature rupture of membranes, unspecified as to length of time between rupture and onset of labor
Full-term premature rupture of membranes, unspecified as to length of time between rupture and onset of labor
Intrauterine infection in any period of pregnancy:
Infection of amniotic sac and membranes, unspecified
Chorioamnionitis
Placentitis
FETAL CONDITIONS
All Multiple Gestations in any period of pregnancy:
All Twin, Triplet, Quadruplet, (etc) pregnancy variants
Continuing pregnancy after spontaneous abortion, intrauterine death, or elective fetal reduction of one fetus or more (multiple variants)
Fetal malformations, conditions or damage in any period of pregnancy:
Maternal care for (suspected) central nervous system malformation in fetus
Maternal care for (suspected) chromosomal abnormality in fetus
Maternal care for (suspected) damage to fetus from viral disease in mother
Maternal care for (suspected) damage to fetus from alcohol, or drugs, or radiation
Maternal care for other (suspected) fetal abnormality and damage
Maternal care for [Rh] antibodies or other isoimmunization
Fetomaternal placental transfusion syndrome
Poly- or oligo-hydramnios in any period of pregnancy:
Polyhydramnios
Oligohydramnios
Fetal demise, placental insufficiency, IUGR, decreased fetal movement in any period of pregnancy:
Maternal care for intrauterine death, not applicable or unspecified
Single stillbirth
Maternal care for known or suspected placental insufficiency
Maternal care for other known or suspected poor fetal growth
Decreased fetal movements

PART 6: REFERENCES

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