Executive Summary: Hospitals Nationally are Moving to Eliminate Early Elective Deliveries (Before 39 Weeks Gestation) When Non-Medically Indicated

Background

Problem of Increased Harm

Since 1979, ACOG has cautioned against performing inductions before 39 weeks gestation in the absence of a medical need. Many national quality organizations have now implemented programs supporting the elimination of such elective deliveries, including Leapfrog, March of Dimes and various state quality associations. Studies have shown complications of non-medically indicated early deliveries (NMI-EED) include increased harm resulting in more NICU admissions, increased transient tachypnea of the newborn, increased respiratory distress syndrome, increased ventilator support, increased sepsis, and other transition issues. One study reported death rates are doubled for each gestational week a baby was born prior to 38 weeks.

A 2007 HCO study reported NICU admission rates following elective deliveries:

Delivery at 37-37.6 weeks: 17.8%

Delivery at 38-38.6 weeks: 8.2%

Delivery at>39 weeks: 4.6%

Mean NICU stay for these infants was 4.5 days

NMI-EED often result in cesarean section, exposing the mother to unnecessary risks of surgery and setting up the likelihood that subsequent children will also need to be delivered similarly or require a more extensive trial of labor for VBAC. In many cases, physicians who schedule NMI-EED for convenience or to help the mother avoid a perceived painful labor do not inform the mothers of the increased risk of harms by moving up the delivery date.

Problem of Increased Cost and use of Clinical Care Resources

The induction of labor in an unripe cervix requires additional use of medications and staff monitoring time than a woman who is naturally reaching labor after 39 weeks. One hospital noted that inducing early delivery to a woman with an unripe cervix added $2600 to each delivery. According to a 2010 article in Managed Care Magazine, the average cost for infants hospitalized in neonatal intensive care units is around $3,000 per day (in 2010), and the infant harms noted above would, therefore, add nearly $4500 per NMI-EED.

Unfortunately, despite this evidence of increased harm and cost, the reported rate of labor induction in the US has more than doubled since 1990 from 9.5% to 22.5% in 2006, the most recent year for which induction data are available. Included in this trend are increasing rates of early elective deliveries (both inductions of labor and cesarean sections) for physician convenience and patient demand, among other reasons.

Strategies to Reduce Non-Medically Indicated Early Elective Deliveries

Low cost quality improvement interventions have been shown to be effective in reducing NMI-EED. They are particularly effective when the interventions are:

- data-driven,
- involve multidisciplinary teams, and
- reference specific guidelines that can be enforced

Establishing a "gatekeeper" to review all medical indications prior to the scheduling of an induction is paramount to ensuring that inductions are administered only when a medical exception is present. Published studies of improvement projects such as Intermountain Healthcare's and Magee Womens Hospital's show there was little change in the early elective delivery rate until physicians were held accountable, nurses were empowered, and guidelines were enforced. Successful implementation of such a program requires strong leadership and policy enforcement.

Assessing strategies to improve the process for all inductions and standardizing a policy/protocol to ensure that all patients are carefully evaluated prior to both elective induction and operative delivery are critical to ensuring the longevity of and adherence to a plan to reduce early elective deliveries.

Costs of Care and Reimbursement Issues

Intermountain Healthcare leaders estimated that their elective induction guidelines saved insurers (including Intermountain's own plan) nearly $1.7 million over a 5-year period. Best practices related to elective inductions typically result in fewer cesarean sections and NICU admissions, lower length of stay in labor and delivery, and other utilization reductions. While reducing harm can have a negative impact on hospital and health system revenues, most hospitals have decided to continue NMI-EED programs because providing improved outcomes for patients is consistent with their corporate mission and will position providers advantageously within the evolving healthcare "pay for performance" reforms.

In the coming years there may be a significant shift in the way Medicaid reimburses hospitals for inductions and cesarean deliveries before 39 weeks without a medical indication and proper documentation-if Medicaid is reimbursing at all. CMS has mandated every hospital in the US to begin reporting their early elective delivery rates, using the Joint Commission measure for elective induction (PC-01 Elective Deliveries), for discharges starting January 1, 2013, with the plan the measure will be used for pay for performance as of January 1, 2015.

The Leapfrog Group has reported that 39% of their reporting hospitals kept their EED rate under 5% and that 65% of reporting hospitals improved their rate in one year.

Reducing Liability Claims/Lawsuits

Several quality improvement efforts in obstetrics have shown that when fewer harms result from labor and delivery then fewer lawsuits should be filed. Obstetric claims are consistently double or triple the cost of other lawsuits both to defend and to resolve, because the long term need for medical care and

loss of lifetime earnings create high damages when a neonate is injured. There is also a great deal of sympathy for parents of an injured child. The prevention of even one birth injury from a NMI-EED can lead to significant savings to a hospital that is self-insured, and will avoid dramatic insurance premium increases which typically follow payment of large losses.

Summary: Reasons to Eliminate Non-medically Indicated Early Elective Deliveries

A program reducing early elective deliveries prior to 39 weeks results in improved outcomes for mothers and babies-including a reduced length of stay, reduction in mortality, reduced transfer to an elevated level of care, and decreased financial costs and clinical care time by the system.

Now that NMI-EEDs are being monitored as a national quality measure (National Quality Forum, Leapfrog Group, The Joint Commission, CMS), healthcare systems should expect that under pay-for-performance arrangements there is a potential for non-reimbursement in the future from Medicaid and private insurance plans.