Policy Toolkit to Support Reduction of Early Elective Deliveries
**Background**

Leaders from several of our region’s health systems and hospitals are working collaboratively with physicians and with representatives of health plans, employers and community agencies to reduce early elective deliveries throughout the St. Louis area.

As part of this effort, the Midwest Health Initiative Hospital Innovators Council partnered with the Maternal, Child and Family Health Coalition to create this toolkit. The toolkit includes draft policy components, sample scheduling forms and sample consent forms that can be adapted to fit your clinical culture. The policy materials were developed by clinicians from several of our region’s hospitals and health systems using nationally recognized standards and best practices. The consumer materials were developed with information from the March of Dimes and in partnership with Health Literacy Missouri.

As you know, babies induced in early term, between 37 and 39 weeks, have a higher risk for neonatal mortality and morbidity, including significant respiratory problems and impaired cognitive function. This practice also leads to a significantly higher risk of cesarean section (Clark & Miller, 2009).

For 30 years, the American Congress of Obstetricians and Gynecologists has recommended against physicians performing inductions or cesarean sections without a medical indication prior to 39 weeks. However, hospital policies, patient requests, physician preferences and payment models have not always supported consistent adherence to these recommendations. While local figures are not yet available, it is estimated that more than 20 percent of babies nationally are born electively before 39 weeks (Martin, Hamilton, Sutton, & Ventura, 2007). Communities across the country, including St. Louis, are working to reverse these trends. The most successful have relied on partnerships of patients, providers and purchasers.

We hope this toolkit will inform your policy and procedure development. We would look forward to connecting you with additional technical assistance should it be of interest. For more information on technical assistance opportunities, please contact Julie Moyer at jmoyer@stl-mcfhc.org.

**References:**


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Community Policy Statement

Elements of Best Practice Hospital Policies

Sample Scheduling Forms

Informed Consent Form Developed with Health Literacy Missouri

Information for Consumers on Inductions, C-sections and the Risks of Preterm and Early Term Deliveries

Special thanks to the Midwest Health Initiative Hospital Innovators Council and the Maternal, Child and Family Health Coalition Fetal Infant Mortality Review Committee for their work to develop this toolkit. Special thanks also to the March of Dimes and the Leapfrog Group for the information provided and for their steady focus on reducing early elective deliveries.
Community Policy Statement

Inductions or cesarean deliveries should not occur before 39 weeks gestation without a medical indication.
Hospital Policy

Part 1: Policy Statement
Elective births will be performed at 39 completed weeks of gestation or greater as recommended by the American College of Obstetricians and Gynecologists (ACOG, 2009), the American Academy of Pediatrics (AAP & ACOG, 2007) and the National Institute of Child Health and Human Development (NICHD, 2011). This includes induction of labor and cesarean birth.

Rationale: Since 1979, ACOG has cautioned against elective births prior to 39 weeks gestation due to increased risk of neonatal complications including increased NICU admissions, increased transient tachypnea of the newborn, increased respiratory distress syndrome, increased ventilator support, increased suspected or proven sepsis, increased newborn feeding problems and other transition issues.

Part 2: Scheduling
- When the primary care provider wishes to schedule an elective birth, a process for insuring gestational age ≥ 39 weeks, if elective, is in place based on at least one of three ACOG criteria:
  1. Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater
  2. Fetal heart tones have been documented as present for 30 weeks by Doppler ultrasonography
  3. It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test result.

Rationale: To ensure that gestational age criteria for scheduling a patient for labor induction or cesarean birth are consistent and clinically sound.

Part 3: Maternal or fetal conditions
According to ACOG (2009), the following are examples of maternal or fetal conditions that may be indications for induction of labor:
- Abruptio placentae
- Chorioamnionitis
- Fetal demise
- Gestational hypertension
- Preeclampsia, eclampsia
- Premature rupture of membranes
- Postterm pregnancy
- Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome)
- Fetal compromise (e.g., severe fetal growth restriction, isoimmunization, oligohydramnios)

Further recommendations from NICHD (2011) are included in the table on pages 3-4.

Rationale: Indications for induction of labor are not absolute but should take into account maternal and fetal conditions, gestational age, cervical status, and other factors.

Part 4: Process for clinical questions
- If there is a clinical question as to the proposed medical indication for a labor induction or cesarean birth before 39 weeks, a process for reaching consensus is in place including a chain of consultation that may consist of the nursing, obstetric, and/or administrative leadership teams.
Rationale: A clear chain of consultation agreed upon by all parties will prevent “policing” and encourage respectful and analytical dialogue. For example, any scheduling conflicts will be directed to the OB Department Chair or Director of Labor and Delivery for resolution. Ongoing problems that are identified will be taken care of as soon as possible by the responsible party or discussed at department meetings.

Part 5: Performing the Labor Induction or Cesarean Birth

- When a woman presents for a labor induction or cesarean birth before 39 weeks gestation without a documented medical indication consistent with ACOG/NICHD, a process for reaching consensus regarding the medical indication is in place including a chain of consultation that may consist of the nursing, obstetric and/or administrative leadership teams.

Rationale: In the event that a woman presents to labor induction before 39 weeks gestation not in labor, without a scheduled date and time for labor induction or cesarean birth, and without a documented medical indication process in place, a clear chain of consultation agreed upon by all parties will prevent “policing” and encourage respected and analytical dialogue regarding the best course of action for the woman.

Part 6: Fetal Lung Maturity Testing

Testing for fetal lung maturity should not be performed, and is contraindicated, when delivery is mandated for fetal or maternal indications. Conversely, a mature fetal lung maturity test result before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is not an indication for birth (ACOG, 2008).

Rationale: Respiratory difficulties are common in neonates born with immature lung development. There is a risk of Respiratory Distress Syndrome even with a positive fetal lung maturity test result and this risk varies by gestational age.
Part 7: Suggested Medical Indications for Births Prior to 39 Weeks Gestation (National Institute of Child Health and Human Development/Society of Maternal Fetal Medicine workshop, 2011)

**Rationale:** Optimal timing for delivery for specific conditions determined by consensus based on available data and expert opinion; potential risks and benefits of delivery compared with continued pregnancy prior to 39 weeks gestation.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Gestational Age* at Delivery</th>
<th>Grade of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placental and uterine issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Placenta previa</td>
<td>36–37 wk</td>
<td>B</td>
</tr>
<tr>
<td>Suspected placenta accreta, increta, or percreta with placenta previa</td>
<td>34–35 wk</td>
<td>B</td>
</tr>
<tr>
<td>Prior classical cesarean (upper segment uterine incision)</td>
<td>36–37 wk</td>
<td>B</td>
</tr>
<tr>
<td>Prior myomectomy necessitating cesarean delivery</td>
<td>37–38 wk (may require earlier delivery, similar to prior classical cesarean, in situations with more extensive or complicated myomectomy)</td>
<td>B</td>
</tr>
<tr>
<td>Fetal issues</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fetal growth restriction-singleton</td>
<td>38–39 wk:</td>
<td>B</td>
</tr>
<tr>
<td>• Otherwise uncomplicated, no concurrent findings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>34–37 wk:</td>
<td></td>
<td>B</td>
</tr>
<tr>
<td>• Concurrent conditions (oligohydramnios, abnormal Doppler studies, maternal risk factors, co-morbidity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expeditious delivery regardless of gestational age:</td>
<td>Persistent abnormal fetal surveillance suggesting imminent fetal jeopardy</td>
<td></td>
</tr>
<tr>
<td>Fetal growth restriction-twin gestation</td>
<td>36–37 wk:</td>
<td>B</td>
</tr>
<tr>
<td>• Dichorionic-diamniotic twins with isolated fetal growth restriction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32–34 wk:</td>
<td></td>
<td>B</td>
</tr>
<tr>
<td>• Monochorionic-diamniotic twins with isolated fetal growth restriction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Concurrent conditions (oligohydramnios, abnormal Doppler studies, maternal risk factors, co-morbidity)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expeditious delivery regardless of gestational age:</td>
<td>Persistent abnormal fetal surveillance suggesting imminent fetal jeopardy</td>
<td></td>
</tr>
<tr>
<td>Fetal congenital malformations*</td>
<td>34–39 wk:</td>
<td>B</td>
</tr>
<tr>
<td>• Suspected worsening of fetal organ damage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Potential for fetal intracranial hemorrage (eg. vein of Galen aneurysm, neonatal alloimmune thrombocytopenia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When delivery prior to labor is preferred (eg. EXIT procedure)</td>
<td></td>
<td></td>
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<tr>
<td>• Previous fetal intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Concurrent maternal disease (eg. preeclampsia, chronic hypertension)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Potential for adverse maternal effect from fetal condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expeditious delivery regardless of gestational age:</td>
<td>When intervention is expected to be beneficial</td>
<td></td>
</tr>
<tr>
<td>• Fetal complications develop (abnormal fetal surveillance, new-onset hydrops fetalis, progressive or new-onset organ injury)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maternal complications develop (mirror syndrome)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multiple gestations: dichorionic-diamniotic*</td>
<td>38 wk</td>
<td>B</td>
</tr>
<tr>
<td>Multiple gestations: monochorionic-diamniotic*</td>
<td>34–37 wk</td>
<td>B</td>
</tr>
<tr>
<td>Multiple gestations: dichorionic-diamniotic or monochorionic-diamniotic with single fetal death*</td>
<td>If occurs at or after 34 wk, consider delivery (recommendation limited to pregnancies at or after 34 wk; if occurs before 34 wk, individualize based on concurrent maternal or fetal conditions)</td>
<td>B</td>
</tr>
</tbody>
</table>
Part 8: Associated forms

Scheduling form
Informed Consent
Standardized orders

**Rationale:** The strongest policies are supported by expedient and effective procedures. A scheduling form, informed consent, and standardized orders that reflect the policy to reduce early elective deliveries will allow for a smooth transition and adaptation of policy to practice.
Part 9: References


**BEST MEDICAL CENTER**

SAMPLE SCHEDULING FORM FOR INDUCTIONS AND CESAREAN SECTIONS

Call XXX.XXX.XXXX or Fax XXX.XXX.XXXX

<table>
<thead>
<tr>
<th>Today's Date</th>
<th>Medical Record</th>
<th>Patient Birthdate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>G/P</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OB Provider/Requesting Physician</th>
<th>Phone/Pager</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TYPE OF DELIVERY PLANNED**

- **Induction:**
  - Fetal presentation
  - EFW
  - Bishop Score
  - Date of exam
  - (within 7 days of induction)

- **C/S:**
  - Primary
  - Repeat

Requested Date/Time: ________________

**DATING**

- EDC: ____________________________ Gestational Age at Date of Induction or C/S: ____________________________ (week+day)

- EDC Based on:
  - US <20 weeks;
  - Doppler FHT+ for 30 weeks;
  - +hCG for 36 weeks

- Other dating criteria: ____________________________ (details)

*Documentation of fetal lung maturity in the absence of clinical indication is not considered an indication for delivery for women less than 39 weeks gestation.*

**REASON FOR SCHEDULED DELIVERY <39 weeks**

- Abruptio placenta
- Chorioamnionitis
- Fetal demise
- Gestational hypertension
- Pre-eclampsia, eclampsia
- Premature rupture of membranes
- Postterm pregnancy
- Other indication: ____________________________

Supporting description/details:

**REASON FOR SCHEDULED DELIVERY >39 weeks**

<table>
<thead>
<tr>
<th>Induction</th>
<th>Cesarean Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of rapid labor</td>
<td>Prior C/S</td>
</tr>
<tr>
<td>Distance from hospital</td>
<td>Prior classical C/S</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>Prior myomectomy</td>
</tr>
<tr>
<td>Patient choice</td>
<td>Fetal malpresentation</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
</tbody>
</table>

Supporting description/details:

**SCHEDULING OFFICE USE:**

- Not scheduled
- Referred to [Department Chair]

Scheduled: ________________

Prenatal Record in LD: **Yes** **No**
Patient Safety Checklist

SCHEDULING INDUCTION OF LABOR

Date _______________ Patient __________________________ Date of birth _______________ MR # ____________
Physician or certified nurse–midwife __________________________ Last menstrual period ____________
Gravidity/Parity __________________________
Estimated date of delivery _______________ Best estimated gestational age at delivery _______________
Proposed induction date _______________ Proposed admission time _______________

☐ Gestational age of 39 0/7 weeks or older confirmed by either of the following criteria (1):
  ☐ Ultrasound measurement at less than 20 weeks of gestation supports gestational age of
    39 weeks or greater
  ☐ Fetal heart tones have been documented as present at 30 weeks of gestation by
    Doppler ultrasonography

Indication for induction: (choose one)
  ☐ Medical complication or condition (1): Diagnosis: ________________________________
  ☐ Nonmedically indicated (1–3): Circumstances: ________________________________

Patient counseled about risks, benefits, and alternatives to induction of labor (1)

☐ Consent form signed as required by institution

Bishop Score (see below) (1): ________

<table>
<thead>
<tr>
<th>Score</th>
<th>Dilation (cm)</th>
<th>Position of Cervix</th>
<th>Effacement (%)</th>
<th>Station*</th>
<th>Cervical Consistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Closed</td>
<td>Posterior</td>
<td>0–30</td>
<td>-3</td>
<td>Firm</td>
</tr>
<tr>
<td>1</td>
<td>1–2</td>
<td>Midposition</td>
<td>40–50</td>
<td>-2</td>
<td>Medium</td>
</tr>
<tr>
<td>2</td>
<td>3–4</td>
<td>Anterior</td>
<td>60–70</td>
<td>-1, 0</td>
<td>Soft</td>
</tr>
<tr>
<td>3</td>
<td>5–6</td>
<td>—</td>
<td>80</td>
<td>+1, +2</td>
<td>—</td>
</tr>
</tbody>
</table>

*Station reflects a −3 to +3 scale.

☐ Pertinent prenatal laboratory test results (eg, group B streptococci or hematocrit) available (4, 5)

☐ Special concerns (eg, allergies, medical problems, and special needs): ________________________________

To be completed by reviewer:
  ☐ Approved induction after 39 0/7 weeks of gestation by aforementioned dating criteria
  ☐ Approved induction before 39 0/7 weeks of gestation (medical indication)
  ☐ HARD STOP – gestational age, indication, consent, or other issues prevent initiating induction without further
    information or consultation with department chair
This will help you decide if you should induce your labor.

What is induced labor?
Induced labor, also called ‘induction,’ is the process of starting your labor rather than waiting for it to begin on its own.

How does it work?
Your doctor will choose the best way for you:
- Medicine. Often with Oxytocin or Pitocin®. We will increase the dose over time to progress your labor. We will closely check your baby’s heart rate and your contractions.
- Breaking your water. This may be called breaking your ‘bag of water’ or ‘amniotic sac.’ If your cervix is dilated, your doctor may choose this way.

What are the risks of being induced?
You may have a higher chance of these and other risks:
- C-section, mainly if your cervix is not dilated. (A cesarean birth)
- A longer labor
- Use of vacuum or forceps during birth
- Side effects or other results from the medicine, such as contractions that are too frequent and may affect your baby’s heart rate. This is why we watch your baby’s heart rate.

Should I be induced?
Some women choose to be induced for health reasons:
- You are well past your due date.
- You have a health issue that places you or your baby at risk, such as high blood pressure, diabetes, or rupture of the bag of water.
- Your baby may be small or the amniotic fluid too low.
Some women choose to be induced for non-health reasons after 39 weeks. This may occur with your doctor’s consent.

Talk with your doctor about whether or not you should be induced.

A note about being induced for non-health reasons
The risks may outweigh the benefits, mostly if this is your first labor. Choosing to be induced before 39 weeks may harm your baby. Problems include trouble breathing that may require treatment in a Neonatal Intensive Care Unit. This may result in bloodstream infections, trouble feeding, and other problems.

Sign here if you give your consent to induce your labor
“I’ve read this sheet and asked all of my questions. My doctor answered my questions. I wish to be induced.”

__________________________  __________________________
Patient Signature Date

__________________________  __________________________
Witness Signature Date

Patient ID: ____________
Reason: _________________________________________
C-section by request
A cesarean section is the birth of a baby by surgery. You may need a c-section if you or your baby’s health is at risk. Some women may prefer to have a c-section, even without medical need. It may be appealing for both the woman and the health care provider to consider cesarean because it helps them plan their schedules. Some women ask for c-section because they are worried about pain.

There is not enough research to fully compare the risks and benefits of c-section by request with vaginal delivery. Because of this, the decision to have a c-section by request must be based on the individual needs of the woman and her baby. If you plan to have several children, cesarean section by request is not recommended. This is because the risk of placenta previa and accreta rises with each cesarean birth. It is also important to remember recovery from a c-section is longer than from a vaginal birth.

Concern about pain is usually not a good reason to request c-section. Safe and effective pain management options are available to help women cope with vaginal delivery. Some of these methods use drugs; others do not.

Induction by request
Some women may prefer to have an induction, even without medical need. Inducing labor may appeal to both the woman and the health care provider because it helps them plan their schedules. The March of Dimes recommends that labor be induced only when the health of the woman or baby is at risk. In 2003, labor was induced in 1 out of 5 deliveries in the United States. The rate has more than doubled since 1990. Some health care providers believe that many inductions are medically unnecessary.

The risk of late preterm or early term birth
With any cesarean or induction, it’s important that it be done at 39 completed weeks of pregnancy or later, unless there’s a medical reason to deliver earlier. C-sections and inductions may contribute to the growing number of babies who are born "late preterm," between 34 and 36 weeks gestation or “early term” which is 37 to 39 weeks gestation. While babies born at this time are usually considered healthy, they are more likely to have medical problems than babies born after 39 completed weeks of pregnancy.

Babies born before 39 weeks are more likely to have problems with:
- Breathing
- Feeding
- Learning reading and spelling later on in school

It can be hard to pinpoint the date your baby was conceived. Being off by just a week or two can result in a premature birth. This may make a difference in your baby’s health. Keep this in mind if you are considering elective c-section or induction. If you are considering a c-section or induction by request, talk to your health care provider and be sure you fully understand the risks and benefits.

These questions may be useful:
- What problems can a c-section or induction cause for me and my baby?
- Will I need to have a c-section in future pregnancies?
- How will you induce my labor?
- Will inducing increase the chance I will need a c-section?

The Midwest Health Initiative thanks the March of Dimes for providing the information above.
For more information or to obtain additional toolkits, please contact Mary Jo Condon at mjcondon@stlbhc.org or 314-721-7800.

The Maternal Child and Family Health Coalition is dedicated to improving birth outcomes, promoting healthy families and building healthy communities.

For more information, visit www.stl-mcfhc.org.