



Can we reduce the rate of scheduled births that occur earlier than 39 weeks of gestation?

YES A statewide quality collective in Ohio reduced the percentage of scheduled births that lacked an appropriate medical indication between 36.0 and 38.6 weeks' gestation from 25% to less than 5% over 14 months.

Donovan EF, Lannon C, Bailit J, Rose B, Iams JD, Byczkowski T, for the Ohio Perinatal Quality Collaborative Writing Committee. A statewide initiative to reduce inappropriate scheduled births at 36(0/7) - 38(6/7) weeks' gestation. Am J Obstet Gynecol. 2010;202(3):243.e1-e8.

► EXPERT COMMENTARY

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This interesting study from the Ohio Perinatal Quality Collaborative (OPQC) tackles an important topic—reducing the number of scheduled deliveries that take place before 39 weeks' gestation. Infants born before 39 weeks have a higher rate of NICU admission in addition to measurable morbidity. The March of Dimes and other organizations have recognized the reduction of these births as an important goal, and ACOG recently refined and clarified the medical indications for them.¹

Details of the study

Twenty maternity hospitals in Ohio collected baseline data on the rate of scheduled delivery between 36.0 and 38.6 weeks' gestation over a 60-day period. Members of the OPQC (which included perinatologists) then visited each participating hospital to introduce the project and explain how it would be sustained using techniques from the Institute for Healthcare Improvement Breakthrough Series.² Each hospital developed a three-person team—a physician, a nurse, and a data manager—to lead the effort. OPQC faculty

developed a list of interventions, including the following broad techniques:

- promote optimal determination of gestational age using ultrasonography (US)
- use ACOG criteria for the indication and timing of scheduled births
- educate physicians, nurses, and pregnant women of the risks and benefits of birth between 36.0 and 38.6 weeks' gestation
- improve communication between obstetricians and pediatricians through chart

WHAT THIS EVIDENCE MEANS FOR PRACTICE

I offer five key points about any program to reduce the number of scheduled births between 36.0 and 38.6 weeks' gestation:

- it requires a lot of work and commitment on the part of all members of the health care team to change a behavior. Educate team members about the goal and the reasons behind it, and encourage them to contribute ideas to achieve it
- consider cooperating with state agencies to obtain data that can be used as baseline information and to measure the effect of an intervention
- a “one size fits all” approach is unlikely to be effective. Each hospital and physician is unique, and interventions should be individualized
- although the result of this 14-month study is impressive, real change must be maintained over the long term. Keep this in mind when you are planning interventions
- efforts such as this one have a financial cost associated with them, and I would hope that the government would contribute funding.

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In Ohio, a statewide initiative reduced scheduled births between 36.0 and 38.6 weeks' gestation from 25% to <5% over 14 months



documentation of clear patient hand-offs and monthly reporting of statistics to physicians, nurses, and administrators

- include scheduled births in an overall “culture of safety,” with regular discussion of the matter at department and quality meetings.

Staff at participating hospitals had much latitude in selecting and refining interventions for their institution. After implementation of specific initiatives, each hospital tracked and reported relevant outcomes, especially the rate of scheduled deliveries between 36.0 and 38.6 weeks’ gestation. Each hospital received a monthly report, and staff members were encouraged to share the results internally.

Dramatic result was validated

The result of this initiative is impressive: The rate of inappropriate scheduled births was reduced from 25% to less than 5% over 14 months. This finding was validated in two ways:

- by checking Ohio birth certificate data
- by determining whether there was a concomitant rise in the rate of deliveries

between 39 and 41 weeks’ gestation in the same hospitals.

Both validations confirmed that the OPQC interventions were significantly effective.

Project was not truly “statewide”

No study is perfect. A potential limitation of this study is the fact that it did not include all hospitals in the state of Ohio—only a sampling of larger hospitals. This makes it unclear whether the approach would be as effective in smaller institutions. Moreover, it is possible that physicians simply got better at documenting a reason for scheduled delivery as the study progressed—although I doubt that this reason alone would explain the striking findings. 🚫

References

1. American College of Obstetricians and Gynecologists Committee on Practice Bulletins—Obstetrics. ACOG Practice Bulletin #107, August 2009: Induction of labor. *Obstet Gynecol.* 2009;114(2, part 1):386-397.
2. The Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement. IHI Innovation Series white paper. Boston: Institute for Healthcare Improvement Website. 2003. <http://www.ihi.org/IHI/Results/WhitePapers/TheBreakthroughSeriesIHI’sCollaborativeModelforAchieving+BreakthroughImprovement.htm>. Accessed May 4, 2010.

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