New Governance Leads to Reduction in Early Elective Deliveries

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Beds: 729
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The Problem

As one of the top three delivery centers in Missouri, CoxHealth Systems had seen a steady increase in early elective inductions (EEDs.) But a growing body of research and the three-hospital system's own experience showed that babies born at 37 and 38 weeks through elective induction are at greater risk for a host of respiratory and other health problems. Spearheaded by the labor-and-delivery unit-based quality team, CoxHealth launched an ambitious program to decrease elective inductions by 50% in six months and to less than 3% of all deliveries within a year, with the ultimate goal of as close to zero as possible.

The Solution

CoxHealth first made its case for the need to lower elective deliveries at the CoxSouth Hospital's multidisciplinary Ob-gyn Section, which consists of obstetricians, neonatalogists, nursing unit leadership, administrative leadership and quality improvement staff. The hospital then announced a voluntary program to decrease these inductions, which was discussed at length at another monthly Ob-Gyn section meeting.

After a few months, the new approach brought down elective deliveries to 9%. But the drop was not enough for CoxHealth's medical leaders. Led by the OB chief and chief medical officer, CoxHealth's Medical Executive Council decided to institute a "hard stop" to scheduling any elective inductions prior to 39 weeks. The hospital's medical leadership created a list of medical indications that, if met, allowed physicians to schedule inductions prior to 39 weeks. Any exceptions have to be approved by the OB chief or perinatologist.

CoxHealth also put in place new governance. If a physician does an elective delivery prior to 39 weeks that does not meet the hospital criteria, he or she receives a letter that reiterates the hospital policy and possible consequences if there are more violations, signed by the OB chief and Chief Medical Officer. If a doctor receives three such letters, the doctor is required to appear before a peer review board.

To support the mandatory policy, CoxHealth held information meetings and training for the Charge RN group, which does the labor and delivery scheduling. The focus was on empowering the staff and dealing with physician conflict. The quality team also met monthly with the charge RNs to troubleshoot, encourage and support them in helping enforce the new approach.

In addition, CoxHealth established monthly tracking and progress reports. The hospital tracks the percent and number of EEDs compared to all elective deliveries and NICU admissions of elective deliveries. It also reports to the Missouri Hospital Association the number of elective and total deliveries at 37 to 39 weeks.

The Result

The hard-stop policy led to rapid improvement, with EEDs down to 2% within two months. After six months, the monthly rate of elective inductions averaged less than .03 percent, with most months at zero. For the year, the rate is .002 overall.

“Our ultimate goal was to improve neonatal outcomes,’ explains Rhonda Donnelly, RNC, Nurse Manager for Labor and Delivery. Since putting in place the mandatory hard stop, CoxHealth has had no admissions to the NICU for babies born through elective inductions prior to 39 weeks. Also, during this period, the cesarean rate on elective inductions has decreased from 17.8% to 10.4% although some of the drop is also probably due to new guidelines on Pitocin/tachsystole that went into effect about the same time.

The mandatory policy did meet some physician resistance and attempts at 'back-door' inductions. Patients were sent over from an office visit with one high blood pressure reading or they would come into triage contracting but not in labor and the physician would choose to induce “since she’s already here.” The other area of initial physician pushback involved scheduling repeat cesarean sections, with obstetricians worried the women could go into labor before 39 weeks. Strong medical leadership and the governance structure have eliminated most of these situations.

“Our mantra is 38.6 weeks is not 39 weeks,” says Ms. Donnelly. This slippery slope, often spurred by trying to avoid deliveries on weekends or other inconvenient times, led to many of the early inductions. “Charge RNs need to have the power to say no when pressured by obstetricians and know they have the support of unit and physician leaders,” she says.

While zero EEDs remains the goal, it’s important to allow for exceptions. CoxHealth approved an early induction for a woman whose husband was deploying to Iraq the week she was due so he could have a chance to bond with his baby. The hospital also allowed an early delivery so the new mother could travel to see her dying mother, who passed away less than a week after her daughter gave birth.

Current Status

The policy has become accepted as best practice and most physicians are supporters now. Monthly tracking will continue, as will consequences for any physicians who don't follow the policy. Because of the dramatic improvement seen at the CoxSouth campus, CoxHealth plans to roll out the hard-stop policy on elective inductions prior to 39 weeks and governance structure at Cox Monett, its Level 1 critical access hospital.

Pearls of Wisdom

It's critical to have strong physician and executive support for such an initiative, says Ms. Donnelly. To gain their support, the labor and delivery unit-based quality team did its homework, presenting research about outcomes for infants due to EEDs and best practices according to the American Congress of Obstetricians and Gynecologists, Joint Commission and others. She also strongly recommends a mandatory policy on EEDs rather than a voluntary one. And the policy needs to include clear-cut criteria for medical inductions, with an empowered staff backed by physician leadership and consequences for those who violate the policy. Importantly, Ms. Donnelly advocates collecting data from the start, as a baseline to compare later results and to provide an objective view for tracking progress.

Contact Information

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