An article appeared on Medical News Today titled Hospitals Tighten Rules For Elective Inductions, C-Sections Ahead Of New Joint Commission Reporting Requirements.

In anticipation of new quality reporting requirements that will take effect in the spring, some hospitals are tightening rules for elective inductions and caesarean sections, the AP/Google News reports. National guidelines from the American College of Obstetricians and Gynecologists discourage elective deliveries prior to 39 weeks’ gestation, but many physicians and hospitals allow inductions and scheduled c-sections at 37 weeks, according to the AP/Google News. According to the Centers for Disease Control and Prevention, one in five pregnancies is induced, double the rate in 1990. There is little data on the percentage of inductions that are elective, though a Hospital Corporation of America study of nearly 18,000 births at its 27 hospitals placed the figure at 10% of all births before 39 weeks. Recent research shows that infants born prior to 39 weeks face a higher risk of breathing disorders and other problems than those who remain in the womb longer.

Two relevant measures from the Specifications Manual for Joint Commission National Quality Core Measures are Elective Delivery and Cesarean Section, which are found in the Joint Commission measure set Perinatal Care(PC).

**Set Measure ID:** PC-01

**Performance Measure Name:** Elective Delivery
Patients with elective vaginal deliveries or elective cesarean sections at 37 to 39 weeks of gestation completed

For almost 3 decades, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) have had in place a standard requiring 39 completed weeks gestation prior to ELECTIVE delivery, either vaginal or operative (ACOG, 1996). A survey conducted in 2007 of almost 20,000 births in HCA hospitals throughout the U.S. carried out in conjunction with the March of Dimes at the request of ACOG revealed that almost 1/3 of all babies delivered in the United States are electively delivered with 5% of all deliveries in the U.S. delivered in a manner violating ACOG/AAP guidelines. Most of these are for convenience, and result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13-21%) (Clark et al., 2009).

According to Glantz (2005), compared to spontaneous labor, elective inductions result in more cesarean deliveries and longer maternal length of stay. The American Academy of Family Physicians (2000) also notes that elective induction doubles the cesarean delivery rate. Repeat elective cesarean sections before 39 weeks gestation also result in higher rates of adverse respiratory outcomes, mechanical ventilation, sepsis and hypoglycemia for the newborns (Tita et al., 2009).

Type of Measure: Process

Improvement Noted As: Decrease in the rate

Note the following statement: "The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean section (CS) rates.”

Set Measure ID: PC-02

Performance Measure Name: Cesarean Section

Nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section

The removal of any pressure to not perform a cesarean birth has led to a skyrocketing of hospital, state and national cesarean section (CS) rates. Some hospitals now have CS rates over 50%. Hospitals with CS rates at 15-20% have infant outcomes that are just as good and better maternal outcomes (Gould et al., 2004). There are no data that higher rates improve any outcomes, yet the CS rates continue to rise. This measure seeks to focus attention on the most variable portion of the CS epidemic, the term labor CS in nulliparous women. This population segment accounts for the large majority of the variable portion of the CS rate, and is the area most affected by subjectivity.

As compared to other CS measures, what is different about NTSV CS rate (Low-risk Primary CS in first births) is that there are clear cut quality improvement activities that can be done to address the
Main et al. (2006) found that over 60% of the variation among hospitals can be attributed to first birth labor induction rates and first birth early labor admission rates. The results showed if labor was forced when the cervix was not ready the outcomes were poorer. Alfirevic et al. (2004) also showed that labor and delivery guidelines can make a difference in labor outcomes. Many authors have shown that physician factors, rather than patient characteristics or obstetric diagnoses are the major driver for the difference in rates within a hospital (Berkowitz, et al., 1989; Goyert et al., 1989; Luthy et al., 2003). The dramatic variation in NTSV rates seen in all populations studied is striking according to Menacker (2006). Hospitals within a state (Coonrod et al., 2008; California Office of Statewide Hospital Planning and Development [OSHPD], 2007) and physicians within a hospital (Main, 1999) have rates with a 3-5 fold variation.

**Type of Measure:** Outcome

**Improvement Noted As:** Decrease in the rate