



# FAX

**To:** OB/GYN Providers **From:** Molina Healthcare, UM Department

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**Pg:** 4 pages including cover sheet

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**Date:** July 9, 2010

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**Re:** Elective deliveries prior to 39 completed weeks of gestation

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July 13, 2010

Dear Provider:

In an effort to promote the highest quality of care for pregnant women and newborns, Molina Healthcare of Michigan (Molina Healthcare) is providing the attached American College of Obstetrics and Gynecology (ACOG) bulletin. Molina Healthcare is concerned that unnecessary and preventable NICU stays may be occurring due to elective deliveries prior to 39 weeks of gestation.

ACOG discourages elective deliveries prior to 39 weeks and has written recommendations. Please see attached ACOG Practice Bulletin. The ACOG Practice Bulletin also confirms that a mature fetal lung test before 39 weeks of gestation, in the absence of appropriate clinical circumstances, is alone not an indication for elective delivery prior to 39 weeks.

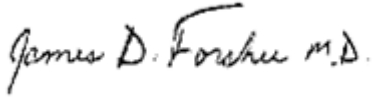
Furthermore, the Joint Commission Set Measure ID PC-01 focuses on patients with elective vaginal deliveries or elective cesarean sections at 37 to 39 weeks of gestation completed. The rationale for the measure is as follows:

**“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). “**

Molina Healthcare agrees with the ACOG quality initiative and is very concerned about the adverse effect of elective pre-term deliveries on patient outcomes, quality of life, and health care costs. A letter is being sent to all Molina Healthcare participating facilities asking them to implement a policy restricting elective pre-term deliveries. We would also ask that you adopt a similar policy in your practice.

If you have any questions please do not hesitate to call.



James F Forshee, M.D., M.B.A.  
Chief Medical Officer, Molina Healthcare of Michigan

Attachment

References:

**American Academy of Family Physicians. (2000). Tips from Other Journals: Elective induction doubles cesarean delivery rate, 61, 4. Retrieved December 29, 2008 at: <http://www.aafp.org/afp/20000215/tips/39.html>.**

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**Clark, S., Miller, D., Belfort, M., Dildy, G., Frye, D., & Meyers, J. (2009). Neonatal and maternal outcomes associated with elective delivery. [Electronic Version]. *Am J Obstet Gynecol.* 200:156.e1-156.e4.**

**Glantz, J. (Apr.2005). Elective induction vs. spontaneous labor associations and outcomes. [Electronic Version]. *J Reprod Med.* 50(4):235-40.**

**Tita, A., Landon, M., Spong, C., Lai, Y., Leveno, K., Varner, M, et al. (2009). Timing of elective repeat cesarean delivery at term and neonatal outcomes. [Electronic Version]. *NEJM.* 360:2, 111-120.**



THE AMERICAN COLLEGE OF  
OBSTETRICIANS AND GYNECOLOGISTS

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## ACOG Issues Revision of Labor Induction Guidelines

**Washington, DC** -- Revised guidelines on when and how to induce labor in pregnant women were issued today by The American College of Obstetricians and Gynecologists (ACOG). The guidelines provide physicians with guidance regarding which induction methods may be most appropriate under particular circumstances, as well as the safety requirements, and risks and benefits of the different methods. ACOG's Practice Bulletin "Induction of Labor" is published in the August 2009 issue of *Obstetrics & Gynecology*.

The rate of labor induction in the US has more than doubled since 1990. In 2006, more than 22% (roughly 1 out of every 5) of all pregnant women had their labor induced. The goal of labor induction is to artificially stimulate uterine contractions so that pregnant women can deliver vaginally. As with all procedures, the risks must be weighed against the benefits to the woman and the fetus.

"There are certain health conditions, in either the woman or the fetus, where the benefit of inducing labor is clear-cut," says Susan Ramin, MD, from the University of Texas Medical School in Houston who helped lead the development of ACOG's Practice Bulletin. "And, there are some nonmedical situations in which induction also may be prudent, for instance, in rural areas where the distance to the hospital is just too great to risk waiting for spontaneous labor to happen at home." In circumstances like these, the ACOG recommendations say the gestational age of the fetus should be determined to be at least 39 weeks or that fetal lung maturity must be established before induction.

Cervical ripening is the first component to labor induction. If the cervix is not sufficiently dilated, then drugs or mechanical cervical dilators should be used to ripen the cervix before labor is induced. Once the cervix is dilated, labor can be induced with oxytocin, membrane stripping, rupture of the amniotic membrane, or nipple stimulation. Misoprostol, a medication for peptic ulcers, is a commonly used off-label drug that both ripens the cervix and induces labor. The ACOG guidelines indicate that inducing labor with misoprostol should be avoided in women who have had even one prior cesarean delivery due to the possibility of uterine rupture (which can be catastrophic).

According to ACOG, there are a number of health conditions that may warrant inducing labor but physicians should take into account maternal and infant conditions, cervical status, gestational age, and other factors. Some examples in which labor induction is indicated include (but are not limited to) gestational or chronic hypertension, preeclampsia, eclampsia, diabetes, premature rupture of membranes, severe fetal growth restriction, and postterm pregnancy.

"There are certain situations where labor induction is contraindicated," says Dr. Ramin. These situations include (but are not limited to) transverse fetal position, umbilical cord prolapse, active genital herpes infection, placenta previa, and women who have had a previous myomectomy (fibroid removal) from the inside of the uterus, according to ACOG.

"A physician capable of performing a cesarean should be readily available any time induction is used in the event that the induction isn't successful in producing a vaginal delivery," notes Dr. Ramin. Although rare, there are potential complications with some methods of labor induction. "These guidelines will help physicians utilize the most appropriate method depending on the unique characteristics of the pregnant woman and her fetus."

Practice Bulletin #107, "Induction of Labor," is published in the August 2009 issue of *Obstetrics & Gynecology*.

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*The American College of Obstetricians and Gynecologists (ACOG) is the nation's leading group of physicians providing health care for women. As a private, voluntary, nonprofit membership organization, ACOG: strongly advocates for quality health care for women; maintains the highest standards of clinical practice and continuing education of its members; promotes patient education; and increases awareness among its members and the public of the changing issues facing women's health care.*