Elimination of Elective Deliveries
at Prior to 39 Weeks Gestation

Health Research & Educational Trust (HRET) Contact
Email: hen@aha.org
(312) 834-7056
www.hret-hen.org

This change package, originally published by HRET, has been slightly enhanced to reflect the Kansas experience. Modifications for the Kansas Hospital Engagement Network (HEN) are indicated with an asterisk (*).

info@khconline.org
(785) 235-0763
www.khconline.org
July, 2012
Table of Contents

OBSTETRICAL HARM/EARLY ELECTIVE DELIVERY (EED) OVERVIEW........................................................................... 3
  BACKGROUND: ....................................................................................................................................................... 3
  SUGGESTED AIMS: .................................................................................................................................................. 3
  POTENTIAL MEASURES: .......................................................................................................................................... 3
  MAKING CHANGES: .................................................................................................................................................. 3
  KEY RESOURCES: .................................................................................................................................................... 3

REDUCTION OF ELECTIVE DELIVERIES AT PRIOR TO 39 WEEKS DRIVER DIAGRAM ......................................................... 4

REDUCING ELECTIVE DELIVERIES PRIOR TO 39 WEEKS GESTATION ............................................................................. 7

SUGGESTED AIM STATEMENTS ........................................................................................................................................ 7

REDUCE DEMAND FOR ELECTIVE DELIVERIES AT PRIOR TO 39 WEEKS GESTATION ......................................................... 7
  SECONDARY DRIVER: AWARENESS OF RISKS OF EARLY ELECTIVE DELIVERIES BY PHYSICIANS, NURSES AND PATIENTS .................................................................................................................. 7
    Change Ideas: Provide education to physicians and nursing staff ........................................................................... 7
    Change Ideas: Provide education to patients ............................................................................................................. 7
  “HARDWIRING” THE REDUCTION IN DEMAND FOR ELECTIVE DELIVERIES AT PRIOR TO 39 WEEKS AS PART OF THE IMPROVEMENT PLAN: ............................................................ 8

REDUCE AVAILABILITY OF ELECTIVE DELIVERIES AT PRIOR TO 39 WEEKS GESTATION ......................................................... 8
  SECONDARY DRIVER: AN ENFORCEABLE HOSPITAL POLICY AND PROCEDURE ................................................................. 8
    Change Ideas: Include physicians in the development of the policy and procedure .................................................... 8
    Change Ideas: Use an established, evidence based policy/protocol ........................................................................... 8
    Change Ideas: Establish procedures for approving exceptions to the policy ............................................................. 9
    Change Ideas: Establish a defined procedure for scheduling elective deliveries ....................................................... 9
    Change Ideas: Include a “Hard Stop,” or instruction for halting the scheduling process when an attempt is made to
      schedule an induction that does not meet criteria ................................................................................................... 9
  “HARDWIRING” THE REDUCTION IN AVAILABILITY FOR ELECTIVE DELIVERIES AT PRIOR TO 39 WEEKS AS PART OF THE IMPROVEMENT PLAN ............................................................ 9

SUGGESTED PROCESS MEASURES .................................................................................................................................. 9

POTENTIAL BARRIERS .................................................................................................................................................... 9

TIPS ON HOW TO USE THE MODEL FOR IMPROVEMENT ................................................................. 10
  REDUCE THE DEMAND FOR EARLY ELECTIVE DELIVERIES .................................................................................... 10
  REDUCE THE AVAILABILITY OF ELECTIVE DELIVERIES AT LESS THAN 39 WEEKS ................................................................................................................................. 10

KEY RESOURCES ....................................................................................................................................................... 12

APPENDIX I SAMPLE SCHEDULING FORM ........................................................................................................ 13

ENDNOTES .............................................................................................................................................................. 14
Obstetrical Harm/Early Elective Delivery (EED) Overview

Background:
- Obstetrical adverse events of some sort occur in approximately 9% of all US deliveries and range from perineal tears to hemorrhage for the mother and skeletal or spinal cord injuries to the neonate, as well as unplanned admits to the NICU. At least 50% of these events are preventable.
- Currently, many publications illustrate using the care bundle concept for process improvement that results in improved outcomes. This has been applied successfully in perinatal care.
- The Leapfrog Group announced that 39% of reporting hospitals kept their Early (<39 week) Elective Delivery (EED) rate under 5% and that 65% of reporting hospitals improved their rate in one year. Reducing elective deliveries prior to 39 weeks results in improved outcomes for mothers and babies - including a reduced length of stay, reduced transfer to an elevated level of care, and decreased financial costs to the system.

Suggested AIMS:*
- Reduce the elective delivery rate at less than 39 weeks confirmed gestation to <3% by December 31, 2013.
- Demonstrate 95% or greater compliance on the IHI Bundles (Oxytocin and Vacuum) by December 31, 2013.

Kansas Measures:*
Outcome: - Elective Delivery Rateprior to 39 weeks gestation
Process: Use of standardized tool for scheduling cesarean sections and induction of labor
- Documentation of indication prior to induction of labor as part of induction bundle
- Record review of scheduled cesarean sections and inductions of labor less than 39 weeks gestation

<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
</tr>
</thead>
</table>
| Involve Perinatal Leadership | ✓ Senior and middle level leaders assigned to local improvement team
| | ✓ Identify and nurture physician champions to support the implementation of policies to reduce EED
| Reduce variation | ✓ Implement March of Dimes (MOD) <39-Week Toolkit
| | ✓ Create a “hard stop” to assess the rationale for EED
| | ✓ Develop standard processes and protocols for response to obstetrical emergencies such as shoulder dystocia, postpartum hemorrhage, and emergency cesarean section.
| | ✓ Standardize administration of high alert meds – oxytocin, magnesium sulfate, epidurals
| Effective Teamwork & Communication | ✓ Adopt common language using NICHD criteria
| | ✓ Implement team training, such as TeamSTEPPS or Crew Resource Management (CRM)
| | ✓ Implement techniques for effective communication and improved handoffs, i.e. SBAR
| | ✓ Design and implement simulation training
| | ✓ Empower and support clinical staff to escalate issues when necessary
| Respectful Patient Partnerships | ✓ Design processes to support partnership in care between provider, patient and family
| | ✓ Educate patients and families about the benefits of full term (39-41 weeks) delivery
| | ✓ Include patients and families on design and improvement teams
| | ✓ Communicate openly and honestly with family and patients at regular intervals

Making Changes:
- This intervention will be supported as an individual collaborative with best practice webinars, change packages and other tools that will augment state hospital association activities. Initially, the focus will be on EED and later move to other forms of perinatal harm.

Key Resources:
- IHI Perinatal Care Improvement Project: [http://www.ihi.org/IHI/Topics/PerinatalCare/](http://www.ihi.org/IHI/Topics/PerinatalCare/)
- March of Dimes/CMQCC <39 Week Tool Kit: [http://www.cmqcc.org/_39_week_toolkit](http://www.cmqcc.org/_39_week_toolkit)
Reduction of Elective Deliveries at Prior to 39 Weeks Driver Diagram  
2012-2013

AIM: Reduce the elective delivery rate at less than 39 weeks gestation to fewer than 3% of all deliveries by December 31, 2013*

<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Ideas</th>
</tr>
</thead>
</table>
| Reduction in DEMAND for elective deliveries at prior to 39 weeks gestation | • Raise awareness of risks of EED for physicians, nurses and hospital staff  
• Raise the awareness of risks of EED for patients/families and the community | - Provide education to physicians and nursing staff regarding the risks of early elective deliveries  
- Provide data regarding outcomes of early elective deliveries in your hospital – hospital specific data are most beneficial*  
- Utilize a physician champion to help educate and influence the medical staff. Select local experts such as OB, MFM, Pediatricians.*  
- Provide education to patients regarding the risks of early elective delivery  
- Assist staff physicians to obtain available national educational tools to distribute in their offices  
- Include this education in the admitting materials distributed to patients and childbirth preparation classes*  
- Partner with community organizations, the media and other groups to highlight the risks with EED  
- Provide scripting for physicians and nurses* |

| Reduction in AVAILABILITY of elective deliveries at prior to 39 weeks gestation | • Create a hospital policy and procedure that guides scheduling and oversight for elective deliveries  
• Develop mechanisms to support the appropriate implementation and enforcement of policies and procedures (cont.) | ✓ Include physicians in the development of the policy and procedure  
- The policy is physician driven, and physician input and buy in from the start is crucial  
- Use the physician champion to bridge the gaps  
✓ Use an established, evidence based policy/protocol example for the policy that follows ACOG and national quality criteria. (cont.) |
<table>
<thead>
<tr>
<th>Primary Drivers</th>
<th>Secondary Drivers</th>
<th>Change Ideas</th>
</tr>
</thead>
</table>
|                | • Partner with other area hospitals – implement together*  
• Anticipate barriers*  
Anticipate Barriers and Address –  
Use hospital specific data*  
Physician concerns of increased uterine rupture secondary to spontaneous labor with uterine scar; increased spontaneous birth resulting in more deliveries (vaginal & C/S) in the middle of the night; concern that patients will transfer to provider who will induce early* | - Include the elements of an elective induction bundle in the policy, such as the IHI Labor Induction Bundle  
- Use an established policy sample from a statewide or national perinatal improvement organization, such as the 39 Week Toolkit from CMQCC, MOD, AWHONN*  
✓ Establish procedures for approving exceptions to the policy (Physician and Nursing Policy/Procedure)*  
- Medical indications and exceptions must be decided upon by the Medical Staff, and be readily available*  
- Use established standards for exceptions from ACOG or The Joint Commission as a baseline*  
- Clearly define in the policy who can determine the exception, such as the Chair of the Department  
✓ Consider implementation in stages if too much resistance – i.e. no hard stop initially – just education, peer review of all cases less than 39 weeks. Once physicians are on board, initiate hard stop.*  
✓ Establish a defined procedure for scheduling elective deliveries  
- A defined procedure includes a standardized format for scheduling that covers all required details for elective deliveries, such as gestational age and reason for induction – by adding GA and indication for delivery to current form/log*  
✓ Include a “Hard Stop,” or instruction for halting the scheduling process when an attempt is made to schedule an induction that does not meet criteria  
- Define in the policy the escalation process for the Chain of Command to be notified to make decisions when a Hard Stop occurs. May be stepwise process and must be specific* |
Key Resources:

Institute for Healthcare Improvement (IHI) Elective Induction and Augmentation Bundles; Update January 2009; [www.IHI.org](http://www.IHI.org)

California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care/ 39 Week Toolkit; First edition published by March of Dimes, July 2010. [www.CMQCC.org](http://www.CMQCC.org)


TJC. Specifications Manual for Joint Commission National Quality Core Measures (20101a); Perinatal Care Core Measure Set. [www.jointcommission.org](http://www.jointcommission.org)

Additional secondary drivers and change ideas specific to the Kansas HEN, Obstetrics Collaborative, June, 2012.*
Reducing Elective Deliveries Prior to 39 Weeks Gestation

The last few weeks of pregnancy are critical to a baby’s health because important organs, including the brain and lungs, are not completely developed until the end of pregnancy. A baby’s birth should not be scheduled before 39 weeks of pregnancy, unless medically necessary. The Leapfrog Group, a coalition of public and private healthcare purchasers, reports that hospital rates of early elective deliveries range from less than 5% to more than 40%. The 773 hospitals from around the country that voluntarily provided Leapfrog with information on this measure reported over 57,000 early elective deliveries by cesarean section or induction during the reporting period. The variation in hospital rates has long been talked about in the health care community, but Leapfrog’s release of 2010 data is the first real evidence that the practice of scheduling newborn deliveries before 39 weeks without a medical reason is common and varied among hospitals even in the same state or community.

Elimination of early elective deliveries requires effort on behalf of physicians, nurses and hospital leaders. Successful implementation of a 39-week induction program can only come from a commitment to providing care that is patient-centered and safe.

Suggested AIM Statements

Before the implementation work starts, the team must have a goal at which to aim. An AIM statement for Early Elective Delivery reduction efforts could include one of the following:

- Decrease the elective delivery rate at less than 39 weeks gestation to less than 3% of all deliveries by December 31, 2013.
- Decrease the early elective delivery rate by 50% within 12 months and achieve a rate of less than 3% of all deliveries by December 31, 2013.

Reduce DEMAND for Elective Deliveries at Prior to 39 Weeks Gestation

Reducing the demand comes from education to both clinicians and patients. An awareness of the risks involved curtails the requests for convenience, or early elective, deliveries. National guidelines, media attention and successful regions that have eliminated elective deliveries prior to 39 weeks gestation are all helpful in increasing the organizational will to reduce demand.

Secondary Driver: Awareness of Risks of Early Elective Deliveries by Physicians, Nurses and Patients

Patients and practitioners must understand the risks when delivering at less than 39 weeks without medical indications. Generally, resistance to change around <39-week deliveries is due to perception of little or no harm to the baby or increased risk to the mother. Provide a summary of evidence from literature to clinicians who are resistant to change, and provide data and feedback on your hospital outcomes in general and specifically on the clinician’s practices.

Change Ideas: Provide education to physicians and nursing staff

- Provide clinicians with data about their patients’ complications (maternal and neonatal). Emphasize avoiding elective deliveries at less than 39 weeks.
- Use a physician champion to communicate the reasons for and importance of the initiative to medical staff.
- Use a nursing champion to communicate the reasons for and importance of the initiative to the nursing staff.

Change Ideas: Provide education to patients

- Provide patients with educational materials that define “full term” and emphasize the importance of eliminating elective deliveries prior to that time.
- Use hospital marketing to educate patients about the 39 week initiative.
• Work with local media on the 39 week initiative.
• Connect with the March of Dimes program in your region on the 39-week initiative.
• Develop patient education materials and provide to your physicians’ offices for their waiting rooms and for distribution during prenatal classes.

“Hardwiring” the reduction in demand for elective deliveries at prior to 39 weeks as part of the improvement plan:

Assist the physician champion by arming him/her with the most up to date research from obstetrical quality resources. Have the physician champion discuss the research and current recommendations at medical staff meetings and in newsletters. Do a retrospective review of hospital data findings from elective deliveries at prior to 39 weeks’ gestation to give the medical staff baseline data from which to work. Utilize the physician champion to address concerns by the medical staff, and to distribute current research and data. A physician champion does not need to be a physician who holds a “title,” such as department chair or department director. A good physician champion is:

✓ Respected as a physician by his/her peers.
✓ Good at communicating with other physicians and hospital staff.
✓ Willing to stand up when needed (has courage, but not a bully).
✓ One who possesses good social skills and relationships within the hospital.

Reduce AVAILABILITY of Elective Deliveries at Prior to 39 Weeks Gestation

Reducing the availability comes from a physician-driven, nurse-administered, hospital leadership-supported policy for elective inductions and the process for scheduling. Implementing the elective induction bundle and a policy that includes a “hard stop,” if supported by physician and hospital leadership, will lead to successful reduction in convenience deliveries.

Secondary Driver: An enforceable hospital policy and procedure

Formalizing the elimination of elective deliveries at prior to 39 weeks’ gestation requires policies and procedures that govern care and are based on evidence based protocol examples. A policy that specifically defines acceptable instances of early elective delivery eliminates guesswork for clinicians and hospital staff, and sets clear guidelines for care delivery. Support from medical staff and hospital leadership is necessary to assist front-line nursing staff to be the “gate-keepers” for policies. It is imperative that staff members know that hospital leadership is in support of the policy. An elective delivery policy is primarily physician driven and requires buy-in from the medical staff to be successful.

Change Ideas: Include physicians in the development of the policy and procedure

• Utilize a physician champion to communicate with and engage the Medical Staff in the improvement project.
• Establish “ownership” of the policy by the Medical Staff in the policy.

Change Ideas: Use an established, evidence based policy/protocol

• Include the Elective Induction Labor Bundle elements in the policy:

1. Gestational age 39 weeks or greater required to induce the patient.
2. Organization should specify method of dating pregnancies.
3. Reassure fetal status prior to induction.
4. Organization should specify a required amount of time for fetal monitoring prior to induction
5. Pelvic exam prior to induction.
6. Pelvic exam necessary to check for cephalo-pelvic disproportions, assess potential difficulties during delivery.
7. Absence of hyper stimulation on fetal monitor.
8. Organization should implement NICHD Standardized Nomenclature\(^4\) for fetal monitoring documentation in order to eliminate confusion regarding fetal status.

- Use a sample policy already developed by a maternal quality care collaborative such as The March of Dimes, state Medicaid programs, or perinatal safety programs.\(^5\)

**Change Ideas: Establish procedures for approving exceptions to the policy**

- Use physician leadership to define “medical necessity” for elective deliveries at prior to 39 weeks using ACOG and national quality criteria.\(^6\),\(^7\)
- Set clear guidelines and define the escalation process for who can approve an early elective delivery based on medical necessity, such as the Chair of the Department.

**Change Ideas: Establish a defined procedure for scheduling elective deliveries**

- The policy should clearly define the process for scheduling elective deliveries that include the required information in order to schedule.
- This information should include gestational age and indication for induction/cesarean section.
- The procedure should also clearly define the chain of command if an induction/cesarean section does not meet criteria.
- Create standardized forms for scheduling that includes all of the required information (See Appendix A)

**Change Ideas: Include a “Hard Stop,” or instruction for halting the scheduling process, when an attempt is made to schedule an induction that does not meet criteria**

- Include specific detail about the chain of command to be notified when a “Hard Stop” is implemented.
- Include specific detail about the responsibilities and expectations for team members when a “Hard Stop” is implemented and guidance to resolve the issue

“Hardwiring” the reduction in availability for elective deliveries at prior to 39 weeks as part of the improvement plan:

Measure compliance with the elective delivery policy by collecting data on deliveries at prior to 39 weeks gestation. Complete an in-depth review of any “fallouts” to determine the cause(s). Continue to discuss the scheduling process with staff during staff meetings and use the feedback from team members to further refine and improve the scheduling process. Listen to physicians who provide feedback about potential delays in scheduling due to the new policy and use that feedback to also refine and improve the process. Continue to report outcomes data on all elective deliveries to the medical staff. Support from medical staff and hospital leadership is necessary to assist front-line nursing staff to be the “gatekeepers” for policies. It is imperative that staff members know that hospital leadership is in support of the policy.

**Suggested Process Measures:**

- Measure the use and completion of a standardized tool for scheduling elective deliveries.
- Review all “fallouts” (early elective deliveries without medical indications) with medical staff and nursing staff.
- Measure compliance with all elements of the labor induction bundle.

**Potential Barriers:**

Recognize that for many physicians this will be a change in their practice. Decisions about timing of deliveries have always been at the discretion of the physician, not a function directed by policy. Include lead physicians in the improvement team. Select these leads to work as champions to dialogue with physician colleges and achieve accelerated implementation. Order sets and protocols maybe seen by some physicians as “cookbook” medicine. It is actually “best recipe” medicine that uses what is known in the literature to provide the best opportunity for each patient based on his/her individual needs to receive the care that will reduce risk for harm.
Use administrative leadership sponsorship to help remove or mitigate barriers.

If physicians perceive a significant, unjustifiable loss of clinical autonomy, they may discuss moving to a nearby hospital for future elective deliveries. This may create a business and social challenge for the administration. Getting nearby hospitals to also implement the policy removes this barrier. Also, creating community awareness of the 39-week initiative makes it harder to “practice as usual” in a different location.

Including bedside nurses, physicians, and hospital leadership in the improvement team to develop protocols, work flows, conduct peer to peer education has been shown to be effective in successfully implementing best practices. It is important to start with the one early adopter physician who can help lead and then recruit early adopter champions.

A management executive sponsor, recognizing the value to the patients and the value to the organization of preventing harm, can help brainstorm solutions to what may appear to be added work, or provide resources to mitigate that additional work. An executive sponsor can also help to see the “big picture” on how this may impact organization-wide, and champion through requests for workflow change or supplies. Executive sponsors can help educate, lead and provide solutions to staffing barriers.

A senior or opinion leader physician is crucial to accomplish the goal of organization-wide adoption of best practices order sets.

This is not just a change in practice but may also be a change in culture:

This may very well require a change in culture, particularly physician culture. The physicians will be asked to trade their traditional way of individualizing pregnancy management for each patient for a more standardized and safe approach. This may appear to be a loss of control for the physician. Order sets and practice bundles can be worrisome to physicians who are not used to them. This will be a change in how they work. Physicians learn from peers. Most physicians will follow their peers before they will follow “expert advice.”

EED is also an example of an innovation that will require small tests of changes and planned spread driven by success. The ideal end result is the development of team based care where each member of the team contributes to better and safer patient care. The new/updated scheduling process may be different, with more requirements than before its implementation. It is important to publicize the scheduling process well in advance; train schedulers and nursing staff to facilitate its implementation; and streamline the process, making it easy for physicians and their office staff to schedule patients.

**Tips on How to Use the Model for Improvement to:**

**Reduce the Demand for Early Elective Deliveries**

- Review the current hospital baseline data with one physician to start. Consider examining baseline rates for all physicians.
- Borrow from other organizations that have successfully implemented a 39-week delivery program.
- Utilize the national and statewide resources already working on this topic to obtain educational materials and other resources.
- Connect the physician champion with a national or statewide perinatal safety collaborative for support and resources.

**Reduce the Availability of Elective Deliveries at Less Than 39 Weeks**

- Put together a small team that includes physicians, nurses and hospital leadership. Review sample policies
and forms.
✓ Ask one or two of the physicians on the committee to review the sample policies for help with adoption at your facility.
✓ Voluntary participation through the method of “asking for help improving, not approving” will often generate momentum and rapid improvement of the process.
✓ Forcing order sets on physicians before there is a critical mass of adopters generally is not effective and often sets the improvement effort back.
✓ Design a small pilot on the unit where the lead physicians and nurses are comfortable with testing the sample policy to determine any issues with implementation prior to piloting the policy and protocol on a larger scale. Remember that a small pilot test can be just that – small. Start with one patient, one physician, and one nurse.
✓ Don’t wait for approval from all departments. The results of multiple small tests of change will ultimately guide successful implementation.
Key Resources:

- Comprehensive Guide to Current Research and Recommendations for Safe Perinatal care

The Institute for Healthcare Improvement on Perinatal Care Improvement, http://www.ihi.org/IHI/Topics/PerinatalCare/
- Complete listing of bundle elements for the Elective Induction and Labor Augmentation bundles

The March of Dimes/CMQCC 39 Weeks Toolkit http://www.cmqcc.org/_39_week_toolkit
- Includes sample policies, scheduling forms, implementation tips, education guide, data abstraction guide, and numerous tools to aid in implementation


# Appendix I: Sample Scheduling Form

**BEST MEDICAL CENTER**  
**SAMPLE SCHEDULING FORM FOR INDUCTIONS AND CESAREAN SECTIONS**  
Call XXXX-XXXX or Fax XXXX-XXXX XXXX

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Type of Delivery Proposed:**  
- ICD: Induction/CES (Select Date Time: )

**Gestation:**  
- Gestational age at date of induction or CES: ________ [Wk/Day/Time]  
- Based on: [ ] LMP [ ] 10/20 weeks [ ] Dilation E+T, for 30 weeks [ ] HDCS for 36 weeks
- Other dating criteria: __________________________

**Indication:**  
- Medical: __________________________
- Other: __________________________

**Fetal Lung Maturity Test Result:**  
- Date: __________________________

<table>
<thead>
<tr>
<th>Conditions and Medical Conditions (OK [ ] 7 weeks)</th>
<th>Scheduled C/S [ ] 39 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perinatal: __________________________</td>
<td>Prior C/S: __________________________</td>
</tr>
<tr>
<td>Weight: __________________________</td>
<td>Prior preterm D/R: __________________________</td>
</tr>
<tr>
<td>Atremia: __________________________</td>
<td>Prior malignancy: __________________________</td>
</tr>
<tr>
<td>Preterm: __________________________</td>
<td>Severe respiratory distress: __________________________</td>
</tr>
<tr>
<td>Oxygen: __________________________</td>
<td>Other medical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
<tr>
<td>Other: __________________________</td>
<td>Other obstetrical condition: __________________________</td>
</tr>
</tbody>
</table>

**Description/Details:** __________________________

**CERVICAL EXAM:** (no inductions)

- Date of exam: __________________________
- Bishop Score: __________________________

**SCHEDULING OFFICE USE**  
- Scheduled? [ ] by __________________________
- Confirmed Date/Time: __________________________
- Referral to Due Date?: __________________________
- Prenatally referred to D/R?: __________________________
- D/R: __________________________

**March of Dimes 39 Week Toolkit**  
[www.cmqcc.org](http://www.cmqcc.org) / 39 Week Toolkit
Endnotes:


5 Main E, Oshiro B, Chagolla B, Bingham D, Dang-Kilduff L, and Kowalewski L. Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age. (California Maternal Quality Care Collaborative Toolkit to Transform Maternity Care) Developed under contract #08-85012 with the California Department of Public Health; Maternal, Child and Adolescent Health Division; First edition published by March of Dimes, July 2010.


7 TJC. Specifications Manual for Joint Commission National Quality Core Measures (2010a); Perinatal Care Core Measure Set. 2009 [cited November 21, 2009]; Available from: http://www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/Perinatal+Care+Core+Measure+Set.html