Perinatal Quality Collaborative
SUCCESS STORY

New York State Perinatal Quality Collaborative Increases the Proportion of Babies Born Full-Term

Every week of pregnancy matters, and research shows that babies born full-term (from 39 up to 41 weeks) have better outcomes than those born preterm (before 37 weeks) or early term (from 37 up to 39 weeks).

Some early deliveries (before 39 weeks gestation) are unavoidable for medical reasons. However, some scheduled early deliveries—by induction or cesarean section (C-section)—may not be medically necessary and could be postponed until the baby is full term. In 2010, under the leadership of the New York State Department of Health, 17 New York State Regional Perinatal Centers (RPCs) joined the New York State Perinatal Quality Collaborative (NYSPQC) Obstetrical Improvement Project.

The project's goal was to reduce scheduled C-sections and inductions without a medical indication from 36 up to 39 weeks gestation. In 2012, the project aligned with the New York State Partnership for Patients (NYSPFP), a Centers for Medicare and Medicaid Services initiative—also focused on reducing scheduled deliveries before 39 weeks without a medical indication. Together, the NYSPQC and NYSPFP expanded the project to include all interested hospitals in New York State—currently 98 of 128 state-wide.

1 of 9 infants is born preterm (before 37 weeks) in New York State.

77% of birthing hospitals in New York State are participating in a collaborative to reduce delivery before 39 weeks.

98% decline in scheduled deliveries without a medical indication occurred among the 17 birthing hospitals participating since 2010.

What Steps NYSPQC Took

Participating hospitals worked with project partners and the New York State Department of Health to develop policies and practices related to scheduled deliveries, implement system changes, and educate staff on best practices and project objectives. Some of NYSPQC's activities include—

- Convening an Obstetrical Expert Work Group to provide clinical oversight for the project.
- Identifying valid medical indications for delivery from 36 up to 39 weeks gestation.
- Developing systems to collect and analyze data on scheduled deliveries.
- Identifying a key team at each birthing hospital to work on the project objectives (senior leadership, improvement team, team coordinator, and data manager).

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- Engaging hospital teams in a learning model—the Institute for Healthcare Improvement's Breakthrough Series—allowing them to assess their current practices, make small tests of change, and implement effective strategies within their hospital.
- Providing in-person learning sessions, monthly coaching calls, and educational Webinars to participating hospitals, as well as a project e-mail box, list serve, and Web site.

What NYSPQC Accomplished

Participating hospitals entered data into an electronic database on scheduled deliveries that occurred from 36 up to 39 weeks gestation. Ten outcome measures were used to track the progress of these hospitals. From September 2010 through December 2013, the NYSPQC reviewed 13,773 scheduled deliveries at the 17 RPCs. During this time, the RPCs reported a 98% decline in scheduled deliveries without a medical indication, from 26.1% to 0.4%.

During the project's expansion in New York State from June 2012 through December 2013, all 98 participating hospitals reported a 92% decrease in scheduled deliveries without medical indication from 36 up to 39 weeks gestation, from 17.9% to 1.5%. This included an 86% decrease in scheduled inductions without medical indication and a 94% decrease in scheduled C-sections without medical indication.

Additionally, participating hospitals reported a 91% decrease in scheduled primary C-sections without medical indication from 36 up to 39 weeks of gestational age, and a 41% increase in documentation of maternal education on the risks and benefits of preterm scheduled delivery.

What NYSPQC Learned

Data and evidence are critical to support and improve clinical practice. Clinicians ultimately want to do what is best for their patients—being able to see their data helps them to improve practice and change their hospital's culture. Presenting hospital rates in comparison with other hospitals motivates providers toward improving practices.

Opportunities to improve care exist. Although hospitals may be skeptical at first about joining the initiative because they assume that improvement is not needed, review and discussion of their data often help them realize that improvements can be made.

Communication is a key to success. Coaching calls and in-person learning sessions together with a project e-mail box, a list serve, and a Web site were key for keeping participants and stakeholders informed.

Leadership involvement is critical. Buy-in from all disciplines (executive, administrative, physicians, midwives, nurses, etc.) results in success for most hospital teams. Identifying early adopters is an effective strategy to lead change and design processes specific to a hospital and its culture.

Internal and external collaboration is essential. The strength of a collaborative lies not only in offering resources, but in providing a safe forum for hospitals to learn from each other and share challenges. Having the experience and expertise of leaders in clinical and quality improvement as well as support from national organizations such as the American Congress of Obstetricians and Gynecologists and the March of Dimes provides greater credibility and is vital to success.

The findings and conclusions in this success story are those of authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention (CDC).

Learn more about Perinatal Quality Collaboratives from CDC's Division of Reproductive Health.

Resources

- For more information, visit the NYSPQC Web site or send an e-mail to NYSPQC@health.state.ny.us
- Quality Improvement Toolkit: Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age