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How do institutions change their practices? In medicine, the usual answer is “slowly.” Clinical trials can show the efficacy of a new practice — yet, decades later, many physicians still haven’t gotten the message.

Until four years ago, it seemed like early elective delivery was a textbook example of evidence widely ignored. These are induced or cesarean section deliveries after 37 completed weeks but before 39 completed weeks of gestation, when not medically necessary. The reason is usually convenience — the family is coming in for Christmas or the obstetrician will be off next week.

Delivery at 37 or 38 weeks was widely considered benign — but it is not. Infant mortality is at least 50 percent higher for babies at 37 or 38 weeks than at 39 or 40 (at 41 weeks the rate rises again). These babies are also more likely to suffer breathing, feeding and developmental problems.

The American College of Obstetricians and Gynecologists had been warning against early elective delivery since 1979. The March of Dimes, one of the most respected advocacy groups in America, had long campaigned to discourage the practice.

Reducing these deliveries shouldn’t have been hard — at least, they should have been easier to change than many other harmful practices. For one thing, a reduction in these deliveries saves money. An elective C-section costs a lot more than letting the baby choose the birth date. And fewer early deliveries mean fewer babies in the neonatal intensive care unit — one of the most expensive rooms in the hospital. (Average charge: \$76,000, according to the March of Dimes (pdf).)

Another advantage was that the practice was clearly defined — there was relatively little debate about what “medically necessary” means. The message from advocacy groups and medical societies was unified and unambiguous. Nor were the steps needed to reduce such deliveries complex: hospitals could simply bar them unless a doctor could show medical necessity. This is rare for safety improvements. Bringing down infection rates, for example, requires an entire hospital work force to adopt time-consuming new behaviors and routines.

Despite the expert warnings, nothing happened. In 2010, these deliveries accounted for 17 percent of births. In some states, such as South Carolina, they represented more than a quarter of all deliveries.

But 2010 began a vertiginous drop, according to a survey of hospitals released last week by The Leapfrog Group, an organization funded by businesses that are large purchasers of health care to work for quality and safety improvement. Last year the national average was down to 4.6 percent — a fall of 73 percent in three years. “In health care, we talk about a 1 to 2 percent change as spectacular — wow, we’ve really improved,” said Leah Binder, the president and chief executive of The Leapfrog Group. “I have never in my career seen anything like the progress we’re seeing on early elective deliveries.”

Something happened in 2010 that didn’t happen before with these deliveries — and doesn’t happen with other harmful practices. And that something may offer important clues to how to speed things up elsewhere.

*** Models for change.** Elliott Main teaches obstetrics and gynecology at Stanford University and is medical director of the California Maternal Quality Care Collaborative. He’s studied the drop in early elective deliveries, and said that the spark for it most likely came from a pair of articles published in the journal *Obstetrics and Gynecology* in 2009. They described programs in a hospital in Pennsylvania and a group of hospitals in Utah that produced dramatic reductions in early elective deliveries. “Those certainly made everybody sit up and say, yes we can improve obstetric care,” said Main. “It showed there was a pressure point that was reducible.”

*** Measurement.** In 2010, the Leapfrog Group began asking hospitals to report early elective deliveries. About 750 hospitals, accounting for about half the births in the United States, complied. The rates they found shocked a lot of people. “Even hospitals themselves didn’t know they themselves have high rates,” said Binder. “I can’t tell you how many medical directors called me and said, ‘this can’t be right.’”

The hospitals Leapfrog count reported voluntarily, which means there could be some selection bias. But in 2013, the government’s Centers for Medicare and Medicaid Services — which under this administration has introduced *glasnost* to health care statistics — began requiring hospitals to report. The data coming in is consistent with Leapfrog’s. The Joint Commission, an influential nonprofit that accredits hospitals, also recently began including this measure.

Measuring and publicizing rates of early elective delivery has helped in several ways. It revealed the dimensions of the problem. It tells hospitals how they are doing. It allows patients to choose safer hospitals, which exerts pressure for more safety. And it creates the basis for reimbursing hospitals in a way that discourages these deliveries.

*** Payment reform.** The pioneers have been Texas and South Carolina. Texas in 2011 barred Medicaid (that’s a state program; Medicare is federal), which pays for 55 percent of births, from reimbursing hospitals for early elective deliveries.

In 2011, South Carolina began the Birth Outcomes Initiative, a program designed to reduce prematurity, increase breast-feeding and make other changes for healthier babies. Those were not the only goals. Medicaid spending accounted for more than a quarter of the entire state budget. “We were looking to improve health outcomes and at the same time reduce our cost,” said

Melanie Giese, the program's director. The state's 43 hospitals that did births came together and signed a pledge to reduce these deliveries.

Tony Keck, the state's health and human services director, announced that if the voluntary effort was insufficient, the state would stop reimbursing hospitals for these deliveries. The only payments that South Carolina's government directly controlled were Medicaid ones. But the state was unusual in that its commercial market was dominated by one huge insurer: Blue Cross Blue Shield. Between them, Medicaid and Blue Cross covered 85 percent of the state's births. So when Blue Cross agreed to go along, hospitals listened. "Even the hint that payment reform was coming meant that hospitals put that on the top of their priority list," said Binder.

Every hospital appointed one person to lead the drive to stop early elective deliveries. There were — still are — monthly meetings attended by more than 100 people. Each meeting begins with a success story from an individual hospital. Then attendees go to work on specific strategies and tactics. (For details see this case study by the group Catalyst for Payment Reform.)

A year later, there was good progress, but South Carolina had started with one of the country's highest rates, and officials worried that progress had reached a plateau. Keck announced that the state would cut off payments the next year. The state's program gradually prepared hospitals to make the switch.

On Jan. 1, 2013, payments stopped. Data from that quarter shows that early elective inductions dropped by more than 45 percent since 2011. (Since reasons for C-sections are harder to collect and interpret, the state doesn't have good data for the program's effects on early elective C-sections.) NICU admissions were down. The state saved \$6 million that quarter — 25 percent of it from cheaper deliveries and 75 percent from fewer NICU admissions.

South Carolina is the only state to halt reimbursements from Medicaid and private insurers. "It's important to have the all-payer approach," said Main. "Medicaid doesn't pay very much for births. Doctors are much more sensitive to what commercial plans pay." The state is now a national model. "We've talked to 20 different states who have called us and asked how we did it," said Giese.

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The federal government is also starting to reform payments for early elective deliveries — through Medicare. It might seem odd that Medicare has anything to say about this issue. (How many 65-year-olds have babies?) But Medicare does pay for some births, to disabled women. More to the point, it's the big stick, accounting for 35 to 55 percent of hospitals' revenue. Medicare is now linking 1.25 percent of its reimbursement to how well hospitals score on a basket of safety measures. Now that the Centers for Medicare and Medicaid Services requires hospitals to report early elective deliveries, that measure is likely to be added to the basket next year.

Medicare reimburses hospitals less than commercial payers do, so even 1.25 percent can determine whether a hospital breaks even on Medicare or not. Still, it could be a lot more — the bigger the percentage, the more hospitals will prioritize safety.

One argument for raising the percentage is that it has to be big enough to make up for revenue lost due to healthier babies. NICUs are a major profit center for hospitals. Main said some hospitals complained that when they cracked down on early elective deliveries, their NICU revenues dropped. “People don’t want to complain about that publicly,” he said. (Those who do should fire their P.R. advisers; those who complain even in private need some serious soul-searching.) “They know that at the end of the day. But they’re still trying to take care of their bottom line.”

*** Collaboration.** Transparency and payment reform create incentive for change. But they are not a strategy. South Carolina created a strategy through its monthly meetings to share and support best practices. Obamacare is trying to do something similar across the country with two programs. Partnership for Patients funds and supports networks of hospitals to improve safety. These networks get hospitals to agree to standards, provide model policies, training, technical assistance and monitoring. And Strong Start funds hospitals as they test ways to reduce early elective deliveries and spread those practices.

What was most important in reducing early elective deliveries? All these pieces together. Plus strong public advocacy, good tools to help hospitals improve quality, and local leadership. “Many improvement efforts don’t get such a good response because they’re approached from one dimension or direction,” said Main. “It really comes down to having multiple different strategies at the same time.”

Note: An earlier version of this article got the name of The American College of Obstetricians and Gynecologists wrong. This has been corrected.

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