

HERC Coverage Guidance – Induction of Labor Disposition of 2nd Round of Public Comments

Stakeholder	#	Comment	Disposition
Oregon Perinatal Collaborative <i>Suzanne Lubarsky, MD, NW</i> Permanente <i>Megan Bird, MD,</i> Tuality Healthcare <i>Mark Tomlinson, MD,</i> Providence Health and Services, Oregon <i>Aaron Caughey, MD,</i> Oregon Health and Sciences University <i>Laurel Durham, RN,</i> Providence Health and Services <i>Katherine Criswell, RN,</i> Providence Health and Services <i>Duncan Neilson, MD,</i> Legacy Health <i>Helen Philips, RN, MS,</i> Legacy Health <i>Richard Lowensohn, MD,</i> March of Dimes <i>Yvonne Gordon, RN,</i> March of Dimes <i>Patrice Chatterton,</i> Kaiser Permanente	1	We agree that making policy decisions regarding the clinical practice of labor induction at term should be based on optimal data. We assert that the best and most relevant data are only relatively recently available. We wish to point out two considerations which complicate interpretation of prior studies: 1) Accurate determination of gestational age (only available with sufficient resolution since the routine practice of first trimester ultrasound) and 2) The tendency to group spontaneous labors with induced labors in comparing delivery outcomes at a given gestational age.	Thank you for your comment. EbGS agrees that grouping spontaneous and induced labors results in potentially biased results.
	2	With regard to the first of these points, high resolution gestational age vs. overall perinatal mortality (stillbirth plus neonatal death) curves now show that the nadir of the curve (lowest risk of perinatal death) is at 39-40 weeks, and overall mortality increases by 41 weeks. Studies which include less accurate gestational dating (menstrual plus clinical indicators) will systematically overestimate gestational age, as the distribution of ovulation times relative to last menses is not Gaussian, but skewed toward the longer times. Including such studies in the policy-making will falsely overestimate the safety of longer gestation (beyond 40 weeks). Thus only the most recent large scale studies employing first trimester ultrasound dating should be used for determining optimal delivery time. We have previously supplied several such studies to the HERC committee demonstrating this curve.	Thank you for providing these articles (see comments in the 2 nd Round of Expert Comments disposition).
	3	Secondly, the clinical decision to induce labor only applies if a patient hasn't delivered spontaneously at a given gestational age. The question is, if a patient hasn't delivered by a given gestational age (e.g., 39 or 40) what is the relative risk of induction vs. expectant management? This issue has only recently been addressed carefully in the OB literature (reference below) and the conclusion is that induction may actually be favored over expectant management for patients who have reached that nadir of perinatal mortality which occurs at 39-40 weeks in the otherwise uncomplicated gestation.	Only one study provided was in low risk women (a second study was provided that addressed optimal age for delivery in women with gestational diabetes). The study of low risk women had some limitations that could result in significant bias (differing inclusion criteria between spontaneous labor and IOL groups).
	4	An additional consideration is that our Oregon Perinatal Collaborative (including the major health systems, payors, and the March of Dimes) has recently successfully implemented a hard-stop policy virtually State-wide, preventing elective delivery of uncomplicated pregnancies prior to 39 weeks. There is a large national consensus on the validity of this practice. If a State policy board attempts to change that date to 41 weeks without strong data to validate that change, the validity and credibility of the Collaborative, which continues to have potential to improve Obstetric practice state wide, will certainly be damaged, and we would risk losing the ground we've gained to date.	EbGS is aware of the statewide collaborative efforts.

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<p><i>Diane Waldo RN,</i> Oregon Association of Hospitals and Health Systems</p> <p><i>Shelora Mangan,</i> RN, Legacy Health</p>	5	<p>For these reasons we request that HERC acknowledge the data supporting induction of labor beginning at 39 weeks of gestation when the clinical setting is appropriate rather than the currently proposed 41 week gestational age.</p> <p>Cheng YW, Kaimal AJ, Snowden JM, Nicholson JM, Caughey AB. Induction of labor compared to expectant management in low-risk women and associated perinatal outcomes. Am J Obstet Gynecol. 2012 Dec;207(6):502.e1-8. doi: 10.1016/j.ajog.2012.09.019. Epub 2012 Sep 22.</p>	<p>The previous IOL Coverage Guidance recommended non-coverage for elective induction of labor < 41 weeks, but was not implemented for OHP. The rationale was that this was thought to increase harms (cesarean sections, and neonatal outcomes in earlier gestations) and also increase costs. Data available now suggests that harms are not increased, and in select populations may result in decreased risk of CS and rare improvement in composite indicators (see comment #4 in the 2nd Round of Expert Comments disposition).</p> <p>Guidance language changed to “Induction of labor is recommended for coverage for the following indications (<i>weak recommendation</i>): Elective purposes, >39 weeks 0 days to <41 weeks 0 days (without a medical or obstetrical indication) with a favorable cervix (e.g., bishop score ≥6).</p>