

Other Suggested Reading Materials Summary Table

Source	Sample/Study Description	Purpose	Results
<p>Engle WA, Tomashek KM, Wallman C, and the Committee on Fetus and Newborn. "Late-Preterm" Infants: A population at Risk, Pediatrics. 2007; 120: 1390-1401.</p>	<p>The authors define late preterm and encourage the use of this term, rather than near term. Characteristics of this group of infants that make them more susceptible to morbidities and mortality are also reported. Guidelines for the evaluation and management of these infants are proposed.</p>	<p>To define 'late preterm' and to change the common terminology from near term to late preterm.</p>	<p>It is important for providers to understand that babies born late preterm are immature. Gaps in knowledge, clinical implications, and research implications for late preterm births are identified and a list of the minimum recommended criteria for discharging infants that are born preterm are proposed.</p>
<p>Goldenberg RL, McClure EM, Bhattacharya A, Groat TD, and Stahl PJ. Women's perceptions regarding the safety of births at various gestational ages. Obstetrics and Gynecology. 2009; 114: 1254-1258.</p>	<p>A national U.S. sample of 650 women were surveyed regarding their beliefs about the meaning of full term and when it is safe to deliver a baby at various gestational ages.</p>	<p>To determine women's understanding of the definition of full term and at what gestational age (in weeks) it is safe to deliver a baby.</p>	<p>The majority of women believe a baby is considered full term at 37-38 weeks (51%). An additional 24% think a baby is full term at 34-36 weeks and the other 25% believe this occurs at 39-40 weeks gestation. Approximately 52% of women think the earliest point in the pregnancy it is safe to deliver a baby is 34-36 weeks gestation, an additional 41% reported it was safe at 37-38 weeks, while less than 8% stated 39-40 weeks gestation.</p>
<p>Iams JD, Romero R, Culhane JF, and Goldenberg RL. Primary, secondary, and tertiary interventions to reduce the morbidity and mortality of preterm birth. Lancet. 2008; 371: 164-175.</p>	<p>To explore the primary, secondary, and tertiary interventions that are available to reduce the morbidity and mortality of preterm birth.</p>	<p>To use the results from clinical trials to make recommendations for care of those women who have preterm birth risk factors.</p>	<p>The majority of efforts to reduce preterm birth have focused on tertiary interventions. Advances in primary and secondary care are needed to prevent preterm births and illnesses related to prematurity.</p>
<p>Leveno KJ, McIntire DD, Bloom SL, Sibley MR, and Anderson RJ. Decreased preterm births in an inner-city public hospital. Obstetrics and Gynecology. 2009; 113: 578-584.</p>	<p>Preterm data from an inner-city hospital in Dallas were analyzed, including all singleton births weighing 500 grams or more from 1988-2006 who had received prenatal care (n=260,197). These data were compared to a national dataset, available from the National Center for Health Statistics, for births in 1995-2002 (n=29,366,816).</p>	<p>To compare the preterm rates for Hispanic and black women at an inner-city public hospital in Dallas with national rates.</p>	<p>The preterm birth rate at the inner-city hospital consistently decreased over the 15 year time period, while the rates in the U.S. did not. The racial disparity in preterm birth rates between white women and Hispanics and blacks decreased in the inner-city hospital relative to the U.S. cohort.</p>

<p>Main EK and Bingham D. Quality improvement in maternity care: promising approaches from the medical and public health perspectives. <i>Current Opinion in Obstetrics and Gynecology</i>. 2008; 20:574–580.</p>	<p>Reviewed results from various evidence-based quality improvement activities at multiple levels, including the hospital, regional, community, state, and national level.</p>	<p>To introduce the latest evidence of effective quality-improvement methods to obstetricians to improve the quality of maternity care.</p>	<p>The science regarding quality improvement and the evidence-base for improving the quality of maternal care has increased dramatically over the past several years. However, additional research must be conducted to determine the most effective models.</p>
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ACOG Committee Opinions Summary Table

Topic/Source	Summary of evidence	Conclusion/Committee Opinion	Recommendations
<p>Committee on Obstetric Practice. Cesarean Delivery on Maternal Request – ACOG Committee Opinion. ACOG. 2007; 394: 1-4.</p>	<p>Cesarean delivery on maternal request (CDMR) is defined as primary CDMR in the absence of any medical or obstetric indication. The incidence of CDMR and its contribution to the overall C-section rate is not known, but its estimated that 2.5% of all births in the US are CDMR.</p>	<p>A potential benefit of CDMR is decreased risk of hemorrhage for the mother. Potential risks include an increased risk of respiratory problems for the baby as well as greater complications in subsequent pregnancies.</p>	<p>CDMR should not be performed before gestational age of 39 weeks has been accurately determined unless there is documentation of lung maturity. CDMR should not be motivated by the unavailability of effective pain management [for vaginal birth]. CDMR is not recommended for women desiring several children, given the risks of placenta previa, placenta accrete, and gravid hysterectomy with cesarean delivery.</p>
<p>Committee on Obstetric Practice. Late-Preterm Infants – ACOG Committee Opinion. ACOG. 2008; 111: 1029-1032.</p>	<p>Late preterm births (LPTB), which occur between 34 0/7 weeks-36 0/7 weeks gestation, make up the vast majority of all preterm births (>70%). LPTB are mistakenly believed to be as physiologically and metabolically mature as term infants; however, LPTBs experience higher rates of infant mortality and morbidity, both before initial hospital discharge as well as in the first months of life often resulting in hospital readmission.</p>	<p>Preterm delivery should be limited to those where a clear/accepted maternal or fetal indication for delivery exists.</p>	<p>Collaborative counseling of pregnant women, by both obstetric and neonatal clinicians, about the outcomes of LPTB is warranted unless precluded by emergent conditions.</p>
<p>Committee on Obstetric Practice. Obesity in Pregnancy – ACOG Committee Opinion. ACOG. 2005; 315: 1-5.</p>	<p>Obese women are at increased risk for several maternal and fetal (prematurity, stillbirth, neural tube defect, and macrosomia) pregnancy complications. Research has linked obesity with spontaneous abortion, especially among women undergoing infertility treatment. Obese women are also at risk for emergent C-section delivery.</p>	<p>Preconception obesity assessment and counseling are strongly encouraged. Height and weight should be recorded for all women at the initial prenatal visit. Women with a BMI of ≥ 35 with preexisting medical conditions (hypertension/diabetes) may benefit from a cardiac evaluation.</p>	<p>Obstetricians should: provide preconception counseling and education about possible complications associated with maternal obesity; encourage obese patients to reduce their weight before conceiving; and consider screening for gestational diabetes upon presentation or in the 1st trimester, with repeated screening if results are initially negative. Specifically, obese women should be encouraged to follow an exercise program and offered nutrition consultation. Women who have undergone bariatric surgery should be assessed and possibly supplemented with Vitamin B12, folate, iron and calcium.</p>

<p>Committee on Health Care for Underserved. Psychosocial Risk Factors: Perinatal Screening and Intervention – ACOG Committee Opinion. ACOG. 2006; 343: 1-9.</p>	<p>Screening for psychosocial risk factors for adverse maternal, fetal, and infant outcomes may help predict a woman’s use of prenatal services. Research suggests that women who are screened for psychosocial issues once each trimester are half as likely as women who are not screened to have a low-birth-weight or preterm baby.</p>	<p>An effective system of referrals will be helpful in augmenting the screening and brief intervention that can be carried out in an office setting.</p>	<p>To increase the likelihood of successful interventions, psychosocial screening of all pregnant women should be performed on a regular basis (at least once each trimester) and documented in the medical record. Screening should include assessment of barriers to care, unstable housing, unintended pregnancy, communication barriers, nutrition, tobacco and/or substance use, depression, safety, intimate partner violence, and stress.</p>
<p>Committee on Health Care for Underserved Women and Committee on Obstetric Practice. Smoking Cessation During Pregnancy – ACOG Committee Opinion. ACOG. 2010; 471: 1-4.</p>	<p>Smoking is one of the most important modifiable causes of poor pregnancy outcomes in the US and is associated with maternal, fetal, and infant morbidity and mortality. An office-based protocol that identifies pregnant women who smoke and offers treatment/referral has been shown to increase quit rates.</p>	<p>A short counseling session with pregnancy-specific educational materials and a referral to the smokers’ quit line is an effective smoking cessation strategy.</p>	<p>Provider knowledge and use of the 5A’s (an office-based intervention developed to help pregnant women quit smoking), health care support systems and pharmacotherapy can support perinatal smoking cessation.</p>

AAP Policy Statement

Topic/Source	Summary of evidence	Conclusion/Committee Opinion	Recommendations
<p>Stark AR; American Academy of Pediatrics Committee on Fetus and Newborn. Levels of neonatal care. Pediatrics. 2004 Nov;114(5):1341-7.</p>	<p>No standard definitions exist for the graded levels of complexity of care NICUs provide, making it difficult to compare outcomes of care. Development of uniform definitions of levels of care offers many advantages. Standard definitions will permit comparisons for health outcomes, resource utilization, and costs among institutions. This will also provide information to high-risk maternity patients that will be helpful in selecting a delivery service. Finally, uniform definitions will facilitate the development and implementation of consistent standards of service provided for each level of care.</p>	<p>Facilities that provide hospital care for newborn infants should be classified on the basis of functional capabilities, and these facilities should be organized within a regionalized system of perinatal care.</p>	<p>(1) Regionalized systems of perinatal care are recommended. (2) The functional capabilities of facilities providing care for newborn infants should be classified as follows: Level I (basic), Level II (specialty), and Level III (subspecialty). Level II care is subdivided into two categories. Level III care is subdivided into three categories. (3) Uniform national standards such as requirements for equipment, personnel, facilities, ancillary services, and training, and the organization of services (including transport) should be developed for the capabilities of each level of care. (4) Population-based data on patient outcomes, including mortality, specific morbidities, and long-term outcomes, should be obtained to provide level-specific standards for volume of patients requiring various categories of specialized care, including surgery.</p>

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