Finger Lakes Region

**Regional Perinatal Center Dept. Of Health Sciences**

U of R Medical Center **Data Coordinator**

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Perinatal Program

**July 12th, 2017 Registrar Meeting Minutes**

1. **Attendance:** Nicole Hancock, Amanda Roach, Shelley O’Brien, Jeanne Brightly, Michelle Tuohey, Rosemary Varga
2. There were several open discussions:

Adding a suffix to the father’s name on the AOP: The Guidelines say that the father’s name should be the same as on his birth certificate. Therefore, a suffix should not be added but as usual, do not get into ‘arguments’ with the parents. If they insist on adding a suffix let it happen keeping in mind that the signers not the witnesses are responsible for what is on the form. There is no space for a suffix to be added on the AOP form.

Additionally, with mother/ mother relationships, the 2nd parents name is entered on the AOP if they are married. As above, don’t get into ‘arguments’ if they are domestic partners. And with father / father, if one is the biologic father his name can be on the birth certificate. The 2nd needs to adopt the baby.

We reviewed how log books are maintained and their importance.

Also, touched on was the process of getting an ‘unlock’. Amanda (G .Corning) says she has been more successful in not having to repeat the request submission process by calling Kyriako shortly after requesting the unlock and giving the reason on his message machine.

Re: access to Medicaid numbers – Jeanne (Unity) shared that access to eMedNY thru your hospital administrator and/or IT dept. You might start with your billing Dept. and ask for guidance. This is through the Dept. of Health under the Medicaid umbrella. While the space can be left blank every effort should be made to obtain the number.

Using eMedNY can help in two ways – If you have a number you can validate that it is active. If not you can enter the first and last name, date of birth, social security number and gender, it leads you to a response page which will either give you the number of a reason why there is not one available

1. Training Modules Review. Our “gathering Exercise” was the Evaluation for the 2nd part of Module I. For those of you who weren’t able to attend the meeting, I attached the evaluation immediately followed by the answers. ***I would like to know if you answered any incorrectly and which they were. I would then consider addressing them in future Scenarios.***
2. **Annual Registrar reviews:**

We have completed the 2017 annual review. We reviewed information collected and submitted during 2016. As the birth information continues to change different topics arise. The most frequent issues this year were around one of our favorites – genetic screening vs testing.

1. **Outreach Meetings:** A reminder note re: Outreach Meetings – It is to yours and your supervisors benefit to attend at least the 1st ½ of the meetings during which Dr. Glantz shares Regional data derived from your entries. In the past changes in how the data is provided to you have changed because of your input in these sessions.

This year’s Meetings are: Highland, March 2nd

Unity, March 29th

FF Thompson, April 10th

Corning / Elmira, April 28th

Strong May 24th, review only, no Outreach meeting

Rochester General, June 15th, Weiner Conf. room

Noyes, June 20th

Newark-Wayne, June 27th

1. **Data Quality:**

* Re: the baby’ pediatrician. I noticed that the hospitalist was sometimes entered. This is not the baby’s pediatrician. I checked with Pam Parker. She responded, “I believe that information is used by the Newborn Screening Program (PKU testing) and should be as accurate as possible. The best option is to ask the parents at discharge since a follow up appointment is generally made at that time.” The consensus at the meeting was to seek the name listed on the PKU and enter that provider on the C of LB.
* Are any of you responsible for reporting fetal deaths? Last time on this one – It is different for each hospital. It is an add on task if done as the C of LB is for live births.
* I looked into the C of LB submission time limit re: entering Birth Certificate information into the SPDS. There are indeed limits set by both the SPDS and Medicaid. Medicaid does have the ability to levee a fine but never has and doesn’t foresee a practice change. There is significant flexibility from the state.
* Who can certify? The certifying physician does not need to be the attending physician and writing the certifiers’ name is acceptable.- Deborah Madaio
* I attended the annual Association of Perinatal Programs (ARPP) in Albany. The Upstate and Long Island Coordinators are going to try to set up a face to face meeting with the NYS officials. If this happens I will ask for your questions and concerns, such as what happens to the information submitted. Who has access to it? Is there any type of recommended training for new registrars?
* Re: data access: Joe Duckett, the U of R data analyst created an Access program that you can download into your system. It will allow you to easily download and ‘read’ the information sent to you by the state. It will give you as immediate access as possible to the information you entered into SPDS. Highland created this system years ago. They use a double entry system and their data IS immediately available to Highland personnel. If this is something you would like to explore, get back to me and I’ll help facilitate.
* The state hass not released any 2017 data yet. It slipped by all of us. The Regional Coordinators have begun to ask why.
* *I have given the digital Training Modules and the HELPER Guidelines to all who attended the meeting. The remainder will be mailed. Ann Dozier’s suggestion was to have them installed on your hospitals permanent drive.*
* With Dr. Glantz I am exploring Registrar certification. This would entail the completion of modules, either from NCHS or the Finger Lakes before the Registrar begins collecting information and entering it in SPDS. I’ll let you know progress.
* Highland has an abundance of SPANISH A o P. Would you like some? I will be picking up several copies – Unity and Noyes have asked for some
* Alice asked about Syphilis testing. When a Mennonite patient comes in as a failed home delivery and there is no Serology test on record before the birth what should be marked in the “Reason” box \_\_\_ Mother refused

\_\_\_ Religious reasons

\_\_\_ No Prenatal Care

\_\_\_ Other

\_\_\_ No time before del.

The general consensus was ‘no time before delivery’

* A question was asked after an Outreach meeting re: the sharing of specific patient identified information with re: HIPPA violations. As the meeting is considered an M&M (Mortality and Morbidity) it is covered and expected that what happens in the meeting stays in the meeting and all participants will respect the HIPPA regulations.

1. **Coder questions answered:**

* *5/16/2017 RGH* - When a baby is transferred to the SCN at a level 2 hospital, is it a NICU admission?

Yes, when it’s in the same hospital, you don’t do “transferred out” you use the “Abnormal Conditions…>Admit to NICU”, for Discharge it’s transferred out at the date it went to the SCN and the feeding is followed for the 5 day rule. N.B. Remember, that if you are a Level I hospital and the baby goes to SCN, it is not a NICU. A NICU must provide the ability for surgery and ventilator support.

1. **Scenarios:**
2. **May scenario**

**A 36 yr old mother accepts NIPT (Non-Invasive Prenatal Testing); when the test results came back her provider recommended CVS (Chorionic Villus Sampling)**

How would you code this, as prenatal screening or prenatal testing?

Was the MSAFP / triple screen offered?

\_X\_ Yes \_\_ No

\_\_ No, too late

Was the MSAFP / triple screen done?

\_X\_yes \_\_No

If the woman was over 35 yr was the fetal genetic testing offered?

\_X\_yes \_\_no. too late \_\_No, other reason

**A 20 year old mother accepts the recommendation to have MSAFP/ triple screen and NIPT (Non-Invasive Prenatal testing). The results are in her prenatal record.**

How would you code this, as prenatal screening or prenatal testing?

Was the MSAFP / triple screen offered?

\_X\_ Yes \_\_ No

\_\_ No, too late

Was the MSAFP / triple screen done?

\_X\_yes \_\_No

If the woman was over 35 yr was the fetal genetic testing offered?

\_\_yes \_\_no. too late \_\_No, other reason

**Which of the following are Fetal Genetic testing?**

\_\_\_ NIPT

\_X\_ CVS sampling

\_\_\_ Harmony Test

\_X\_ Amniocentesis

\_\_\_ Quad Screen

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Number of Registrars who participated** | **Offered** | **Given** | **>35** | **Offered** | **Given** | **>35** | **Testing / srceening** |
| **17 / 31** | **16** | **17** | **17** | **17** | **17** | **16** | **15** |
|  |  |  |  |  |  |  |  |

**2017 June Scenario**

**The woman is a G2P0. Her first pregnancy ended at 24wks with an intrauterine fetal death (IUFD). The fetus weighed 780 gm.**

**Pregnancy History**

Previous Live Births Previous Spontaneous Previous Induced Total Prior Terminations Terminations Pregnancies

Now Living Now Dead Less than 20 weeks 20 weeks or more

None or Number None or Number None or Number None or Number None or Number None or Number

\_**X**\_ \_**X**\_ \_**X**\_ \_\_\_ **1** \_**X**\_ \_\_\_ **1**

**Prenatal Care**

**Risk Factors in this Pregnancy**

\_\_\_None \_\_\_Unknown at this time

**Select all that apply:**

\_\_\_ Prepregnancy Diabetes \_\_\_Gestational Diabetes \_\_\_Prepregnancy Hypertension

\_\_\_ Other Serious Chronic Illness \_\_\_Abruptio Placenta \_\_\_Gestational Hypertension

\_**X**\_ Other Poor Pregnancy Outcome \_\_\_Other Vaginal Bleeding \_\_\_Eclampsia

\_\_\_ Prelabor Referred for High Risk Care \_\_\_Previous Low Birth Weight Infant

\_\_\_ Previous Preterm Births

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Number of coders who participated** | **>20 loss** | **Total Prior Preg** | **Poor Outcome** | **Prev. Preterm** | **Prev. LBW** |
| **21** | **21** | **19** | **19** | **21** | **21** |

Dr. Glantz says that a baby born at 20 weeks is a birth whether born alive or dead but as the Guidelines very clearly state “live” birth. Therefore, we will adhere to the Guidelines.

1. **Web Page:** [**https://www.urmc.rochester.edu/finger-lakes-regional-perinatal-program.aspx**](https://www.urmc.rochester.edu/finger-lakes-regional-perinatal-program.aspx)This address will stay on the Minutes as a reminder that it is there. I will note in the minutes when items change.

The HELPER Guidelines are available as are all Scenarios and previous meeting minutes. I will be adding the Training Modules within the next month.

Of note re: the web page – Besides having a Registrars section there are also forms available for maternal transfers and for requests for access to the SPDS data.

1. Any else for the good of the nation???
2. **Twilla Dillon, one of the researchers who uses our data will be joining our next meeting to talk about how she uses it, and the positives and negatives of the information entered!**

##### The Registrar Meeting is on *September 6th, 2017* in the Saunders Research Bldg., 265 Crittenden Blvd. on the Strong Hospital Campus, room 3223 (near the cubicles – signs will be posted) Parking passes and a Conference Line will be available.

**MODULE ONE - INFANT EVALUATION**

*(Please check the appropriate response)*

1. **How many hours of the infant’s life do the NYSDOH Guidelines specify are to be captured on the NYS birth certificate?**
   * 24hours
   * 48 hours
   * 72 hours
2. **If the infant’s weight is recorded in the delivery record as 2.5 kg what value do you enter?**

* 2.5
* 25.0
* 2500

1. **True or False, when the infant’s 5 minute Apgar is below ‘6’ you are required to also enter the infant’s 10 min Apgar score?**

* True
* False

1. **When the infant is transferred at <24 hours of age (less than 24 hours old) do you report the infant’s status as:**

Alive:

* Yes
* No
* Infant transferred / status unknown

1. **Gestational age is stated in the mother’s record as 39 -4/7 weeks what value do you enter?**

* 39 weeks
* 40 weeks

1. **When determining gestational age is the Ballard Score considered to be the best estimate of clinical age?**

* Yes
* No

1. **If the infant received one feeding of breast milk 30 minutes after delivery and subsequently only received formula, what would be coded in response to the infant feeding question?**

* Breast milk only
* Formula only
* Both Breast milk and Formula
* Other
* Do not Know

1. **Check the respiratory therapies listed below, that if used would indicate infant required ‘Assisted ventilation required immediately following delivery?’**

* O2 positive pressure
* O2 (Blow by)
* CPAP
* PPV
* Bag and Mask

1. **If your hospital is designated a Level 1 hospital ( in Finger Lakes region all but SMH, AO & RGH are level 1) and the infant is transferred to your hospital’s Special Care Nursery (SCN) would you note this transfer as a ‘NICU Admission’ (Abnormal conditions of Newborn)?**
   * Yes
   * No
2. **If an infant fails their hearing test in one or both ears how would you enter the response to the hearing screen question?**

* Pass
* Refer
* Not performed- Medical Exclusion

**MODULE ONE - INFANT EVALUATION *ANSWERS***

1. **How many hours of the infant’s life do the NYSDOH Guidelines specify are to be captured on the NYS birth certificate?**

* 24hours
* 48 hours

● 72 hours

Answer: Infant fields relate to the 1st 72 hours of an infant’s life. (Slide 1) The only exception relates to the coding of infant feeding when information up to the 5th day of life (or at time of discharge whichever comes first) is required. (Slide 14)

1. **If the infant’s weight is recorded in the delivery record as 2.5 kg what value do you enter?**

* 2.5
* 25.0

● 2500

Answer: If birth weight is recorded as grams (gm), enter weight in grams (if recorded as kilograms (kg) move decimal 3 places to the right and enter weight as grams, e.g. *3.390kg = 3390 grams*) (Slide 4)

**3. True or False, when the infant’s 5 minute Apgar is below “6” you are required to also enter the infant’s 10 min Apgar score?**

● True

* False

Answer: Record 1 min and 5 min Apgar scores for all infants and the 10 min score if the infant’s 5 min score is less than 6. (Slide 9)

4. **When the infant is transferred at <24 hours of age (less than 24 hours old) do you report the infant’s status as: Alive:**

● Yes

* No
* Infant transferred / status unknown

Answer: Coding should reflect the infant status at the time of transfer. This means that the coding for “is the infant still alive?” for transferred infants would be “Yes” (alive). *If infant were no longer alive infant would not be transferred.* (Slide10)

**5. Gestational age is stated in the mother’s record as 39 -4/7 weeks what value do you enter?**

● 39 weeks

* 40 weeks

Answer: Enter the weeks of gestation only. DO NOT enter “Days” (do not round upward). (Slide 11)

6. **When determining gestational age is the Ballard Score considered to be the best estimate of clinical age?**

* Yes

● No

Answer: Use Dubowitz or Ballard scores ONLY if best OB estimate (determined by LMP or Ultrasound) is not available. (Slide 11)

1. **If the infant received one feeding of breast milk 30 minutes after delivery and subsequently only received formula, what would be coded in response to the infant feeding question?**

* Breast milk only
* Formula only

● Both Breast milk and Formula

* Other
* Do not Know

Answer: The intent of the question (as of Jan 1, 2011) is to capture information regarding how the infant was fed during his/her hospital stay. The actual question in the work book has not changed (how is infant being fed at discharge) but the information the NYSDOH is looking for has changed. Breast Milk only” and “Formula only” are exclusive fields; if any combination of the two were used enter “Both Breast Milk and Formula” (Slide 13)

8. **Check the respiratory therapies listed below, that if used would indicate infant required “Assisted ventilation required immediately following delivery?”**

● O2 positive pressure

* O2 (Blow by)

● CPAP

● PPV

● Bag and Mask

Answer: Assisted ventilation includes all forms of positive pressure ventilation (PPV) such as bag and mask, positive pressure mask, CPAP (Continuous Positive Airway Pressure), O2 pos. pressure or Neopuff. It does NOT include administration of O2 w/o pressure (Blow by). (See slide 22).

**9. If your hospital is designated a Level 1 hospital ( in our region all but SMH, AO & RGH) and the infant is transferred to your hospital’s Special Care Nursery (SCN) would you note this transfer as a “NICU Admission” (Abnormal conditions of Newborn)?**

* Yes

● No

Answer: Code infant transferred to the NICU or special care nursery (SCN) either within your hospital (if your hospital is a Level 2 or 3) or to a NICU or SCN at a hospital which is designated as a Level 2 or Level 3 hospital. Transfer to a SCN at a Level 1 hospital is not coded as a “NICU admission”. (Slide 23)

**10. If an infant fails the hearing test in one or both ears how would you enter the response to the hearing screen question?**

* Pass

● Refer

* Not performed- Medical Exclusion

Answer: The word “refer” in regard to hearing screenings is a failed result (or a “did not pass” result), not a referral for consultation with a specialist. Coder should report the final inpatient hearing screening results in SPDS. (Slide 20)