Finger Lakes Region

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

U of R Medical Center **Data Coordinator**

601 Elmwood Ave. Box 668 65 Crittenden Blvd. Box CU420644 Rochester, NY 14642 Rochester, NY 14642-0644

Phone: 585-275-4930 Phone: 585-276-8737

Fax: 585-4614532

Perinatal Program

**January 10th, 2018 Registrar Meeting Minutes**

1. **Attendance:** In person: Catherine VanDerMeid, Jeanne Brightly,Rosemary Varga By phone conf.: Jan Bubel, Amy Burchell, Maureen Herbstsommer, Nicole Egan, Stacey Peers, Darlene Waters
2. **Gathering Exercise –** Module 4 Evaluation. Found at the end of the Agenda. Please, take a few minutes to complete the Evaluation. As always continuing education and review of previously learn material enhances our production. Let me know if you have any concerns with the information shared.
3. **Outreach Meetings –** My understanding is that the Spring Outreach Meetings have been scheduled except for G. Corning and Arnot-Ogden. As soon as I have the dates I will pass them on. Things to keep in mind on this topic are that I would like you to attend at least the 1st ½ of the meeting. And, I would like to schedule chart reviews on the same day if possible. As usual, I will set another date if you are not available for the chart review on the day of the Outreach.

For the chart reviews, I would like to have at least two Registrars with me, preferable one of them being the newest kid on the block. I will be completing a workbook with the person who is using the chart to help me most efficiently find the information. The other person will hold the copy of the workbook from which the Certificate of Live Birth was created for comparison.

You will choose the record. It should be one of your more difficult to code.

1. **Meeting Frequency –** I continue to believe that face to face meetings are important. As a result I would like to find ways to make attendance easier. There will always be folks who cannot make the meeting and for them I strongly encourage the use of the provided conference call availability.

The general consensus was to move to a tri-monthly schedule excluding December and January and to move the meeting slightly later in the day.

The way that will work best is February, May, August, and November. *There will be NO meeting February 2018.* They will continue to be held on the 2nd Wednesday and will start at 3PM to 4 PM

1. **Data Entry Quality reviews:**

* **A better Discrepancy Report explanation** – I think a better title would be “Potential Challenges”. The Office of Vital Statistics has access to some data produced by SPARCS and Medicaid. In their effort to have SPDS be the best it can be, they use a percentage number selected by them to determine if the responses given match each other or require a 2nd look to see who may have made an incorrect entry. On the chance that it’s an SPDS error they ask us to double check our information. Sometimes it is our fault. Most of the time the error is with the others. The Vital Stats Office has no influence in either of the two whose data they review. They just use them as a measuring tool because they are available.

The goal is to make us the best we can be.

* **Medicaid-SPARCS-SPDS** A large number of the “discrepancies” seem to be around correct entry of CIN #’s. In discussion with those present I learned that each hospital has their own way of checking for The CIN #. This was a questioned asked to help me formulate a response to the DOH when I’m asked.
* **Next – an apology –** In November I found a letter from Mark Sharp, that was sent is September, saying that the discrepancy file was in your inboxes for download from early September. I forgot that I had received it.

Brian sent me another notice in November asking that I remind you to make the potential corrections.

I apologize for the confusion I caused in November as I was trying to figure out what was being asked of me!

I may have actually sent out a note in September and forgotten that I did so. Barb Suter used to save everything. I probably err on the opposite side of the coin and delete too much. I’ll try to do better.

* **Fetus at Risk –** Barb Burns pointed out an error in the Infant portion. – The clarification for this is that same as with “Labor & Delivery- C-sect Indications”. The only place that fetus at risk is questioned with the infant is in regard to the preterm delivery and the criteria are clear in the Guidelines. But let’s discuss that a bit further
* **Electronic Death Registration (EDRS) –** Last year we were invited to take part in a EDRS Webinar. This may not affect many hospitals in our region as only Unity currently enters the spontaneous fetal deaths that occur in their hospital onto fetal death certificate paperwork. But, each hospital determines who enters the information. The hospitals may wish to make changes. This process is being rolled out to all NYS hospitals over the next 12 – 15 months. I’m sure we’ll hear if it is to affect us any further.

1. **Coder questions answered:**

**Certifier** – When the child is born at an unattended home birth, the mother signs as attendant. The Guidelines are quite confusing on the Certifier. So, I checked it out with Deb Madaio’s office. Kristy said that the “Certifier” is the person who validates that the baby has been born and that a Certificate of Live Birth is appropriate. As I read the guidelines it feels as if the certifier is validating the contents of the workbook. From Kristy’s response that is not so. Therefore, the mother CAN be the certifier by leaving the space blank at completion and having the mother sign OR the attending physician provider can sign as the verifier. For the majority of hospitals, the 2nd choice will be the most efficient. Remember that a midwife can only sign for deliveries that she attended.

**Discharge location** – If the mother is giving up custody to the father the baby can be listed as “discharged to home”

**Cigarettes** – Hookahs and Vapes continue on the DO NOT list re: nicotine consumption

**Another question –** This came up as I was reviewing potential Coder Faxes left by my predecessors that I am exploring for use as future scenarios.

The issue of: *Vanishing Twin* – Unless the mother insists on having the twin recognized tis should be ignored, (no type of entry made) as the Guidelines state baby BORN alive or dead and a vanishing twin may not be discernable in the products of the birth

*Molar Pregnancy* – no type of entry possibility is possible. Its’ presence may be captured in the prenatal history.

*Early Reduction* – This question arose because you are asked to enter how many eggs were implanted if there was invitro fertilization. As the current system has no way for us to capture this information we should make no entry.

1. **Scenario**

**November**

The birth occurred at home. It was unattended. The mother delivered her own child. She is the “Attendant”. At the hospital, the placenta was delivered by the Midwife who was on duty as provider.

How is the “Certifier” portion completed?

Choose all correct answers; (HELPER Guidelines may be of help here)

\_\_\_Enter the mother as “certifier” and mark “Other” in the title section. *This can work if “9999999” is entered in the license space*

\_\_\_ The Midwife signs as “Certifier”

\_**X**\_The covering Physician Provider signs as certifying that the birth actually took place.

\_**X**\_The “certifier” is left blank. The mother signs the Certificate of Live Birth after it is printed.

21 of 33 Registrars and Abstractors responded

**January Scenario** – 11 of a possible 32 Registrars have responded. Please, try to find a few minutes to complete the questions.

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.

##### Our next meeting will be Wednesday, April 11th, 2018 in the Saunders Bldg. Room 3.223 (across from my desk) A ZOOM Conference Line will be available. BUT, PLEASE, REMEMBER THAT A PHONE CONFERENCE IS NOT AS PERSONNAL AS FACE-TO-FACE, SO, TRY TO ARRANGE YOUR SCHEDULES TO ALLOW ATTENCE IN PERSON!

**MODULE FOUR EVALUATION**

*(Please mark the appropriate response)*

1. **If, upon admission to L&D, the physician ruptures the amniotic sac to induce labor but labor does not begin until Pitocin is given, what would you enter in the *Characteristics of Labor & Delivery* field?** 
   1. Induction of Labor- Medicinal
   2. Induction of Labor- AROM
   3. Induction both Medicinal and AROM
2. **The physician ruptures a pregnant woman’s membranes when she is 8cm dilated. This would always be considered augmentation of labor.**

* True
  1. False

1. **Terminal meconium would not be entered in the *Characteristics of Labor & Delivery* section of the birth certificate.** 
   1. True
   2. False
2. **If a mother doesn’t have a tubal ligation until the day after she delivers, “Sterilization” would not be entered in the *Other Procedures Performed at Delivery* field.**
   1. True
   2. False
3. **If during labor membranes are artificially ruptured (AROM) so an IUPC can be inserted the following would be entered:**

* Induction of Labor
* Augmentation of Labor
* Internal Electronic Fetal Monitoring
* None of the above

1. **If a 2nd degree laceration is repaired following delivery you would enter:**

* Episiotomy and Repair
* Perineal Laceration
* Neither of the above

1. **If a woman is given an epidural containing fentanyl but receives no other analgesics during labor, *Analgesia* would be entered as ‘No’.**

* True
* False

1. **A pregnant woman who was 3 cm dilated when she saw her physician last week is admitted to the hospital without contractions at 4 cm dilation. She is given Pitocin soon after admission. What would you enter in the *Characteristics of Labor & Delivery* field, induction or augmentation?** 
   * Induction of Labor- Medicinal
   * Augmentation of Labor
2. **If Tylenol is given to a woman who had a headache during labor this would be entered as *Analgesic*=’Yes’*.***

* True
* False

1. **If general inhalation *Anesthesia* is used during the delivery, general intravenous anesthesia will also almost always be used.** 
   1. True
   2. False

See next page for answers

**MODULE FOUR EVALUATION *ANSWERS***

1. **If, upon admission to L&D, the physician ruptures the amniotic sac to induce labor but labor does not begin until Pitocin is given, what would you enter in the *Characteristics of Labor & Delivery* field?**

* Induction of Labor- Medicinal
* Induction of Labor- AROM

● Induction both Medicinal and AROM

Answer: Without the start of labor (no cervical change) following AROM, adding oxytocin would be entered as induction. (Slide 5)

1. **The physician ruptures a pregnant woman’s membranes when she is 8cm dilated. This would always be considered augmentation of labor.**

* True

● False

Answer: AROM may be done for many reasons other than augmentation (Slide 6)

1. **Terminal meconium would not be entered in the *Characteristics of Labor & Delivery* section of the birth certificate.**

* True

● False

Answer: All types of meconium (including terminal meconium) should be entered as “Meconium Staining”. (Slide 9)

1. **If a mother doesn’t have a tubal ligation until the day after she delivers, “Sterilization” would not be entered in the *Other Procedures Performed at Delivery* field.**

* True

● False

Answer: Sterilization that occurs at anytime during the birth hospitalization should be entered. (Slide 15)

1. **If during labor membranes are artificially ruptured (AROM) so an IUPC can be inserted the following would be entered:**

* Induction of Labor
* Augmentation of Labor
* Internal Electronic Fetal Monitoring

● None of the above

Answer: AROM is done for many reasons other than induction/augmentation of labor including insertion of pressure catheter (IUPC). An IUPC is not an internal fetal monitor but can be used with one. (Slides 6 & 10)

1. **If a 2nd degree laceration is repaired following delivery you would enter:**

* Episiotomy and Repair
* Perineal Laceration

● Neither of the above

Answer: Only 3rd & 4th degree Perineal Lacerations are entered in the Maternal Morbidity section of the birth certificate. (Slide 11) Episiotomy and Repair is entered only when an episiotomy is performed (Slide 15)

1. **If a woman is given an epidural containing fentanyl but receives no other analgesics during labor, *Analgesia* would be entered as ‘No’.**

* True

● False

Answer: Fentanyl is an analgesic and all analgesics are entered in the Analgesia section of the birth certificate even when given as part of the anesthesia. (Slide 14)

**8. A pregnant woman who was 3 cm dilated when she saw her physician last week is admitted to the hospital without contractions at 4 cm dilation. She is given Pitocin soon after admission. What would you enter in the *Characteristics of Labor & Delivery* field, induction or augmentation?**

● Induction of Labor- Medicinal

* Augmentation of Labor

Answer: If a woman not in labor and is given Pitocin to get labor started induction of Labor- Medicinal would be entered. (Slide 4)

1. **If Tylenol is given to a woman who had a headache during labor this would be entered as**

***Analgesic*=’Yes’*.***

● True

* False

Answer: Any analgesic (narcotic or non-narcotic) used during labor and delivery is coded in the Analgesia section of the birth certificate. (Slide 14)

**10. If general inhalation *Anesthesia* is used during the delivery, general intravenous anesthesia will also almost always be used.**

● True

* False

Answer: General inhalation anesthesia will almost always be preceded by general intravenous anesthesia. (Slide 13)