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: 585-461-4532

Perinatal Program

**August 8th, 2018 Registrar Meeting Agenda**

1. **Attendance:** Catherine VanDerMeid, Jeanne Brightly, Chris Saur, Amy Burcell, Maureen Herbstrommer, Darlene Waters, Jess, Ernstberger, Liz Rife, Stacey Peers (Audio connection) and Rosemary Varga
2. **Gathering Exercise –** Module 6 Evaluation. This is an ongoing activity (One Module each meeting) and should be done as it is an easy way to review areas that might not occur often. If you weren’t at the meeting, the Module will be found at the end of the Minutes. Please, take a few minutes to complete the Evaluation. As always, continuing education and review of previously learn material enhances our erformance. Let me know if you have any concerns with the information shared.
3. **Social Security presentation –** Charlie Johnson, a Claims Specialist from the Rochester Social Security Office, joined us to review the procedure for obtaining a Social Security number for our babies. It was a wonderfully relaxed and informative encounterBelow are the salient points of Mr. Johnson’s presentation. They, hopefully, are in a reasonable order.
* There is about a two week turn-around for people who request a Social Security # to receive it from the state. If the card doesn’t come within three weeks, the parents should start asking questions.
* If a card is received and the name is spelled wrong, it is a simple correction by going to the Social Security Office. The change is made quickly there. They will need the Birth Certificate to confirm the correct spelling. It needs to be the original or certified copy. Nothing produced can be laminated.
* The preceding item is true for any form needed.
* Cards are mailed with an address and name of the parent with notation that it is for the child.
* There is no connection to the parent through the Social Security number. Once a number is obtained it belongs to the child alone.
* If a parent checks ‘No’ on the birth certificate workbook and then decides that a Social Security # for their child is desired they need to go to a Social Security Office to apply.
* If the parents are applying themselves one of the first things requested is identification. Neither a Birth Certificate (this shows that the child is born not that it is alive) nor a Death Certificate are acceptable. They are supporting documentation but another proof of life with only the child’s name and identifier is acceptable. A health Insurance card, life insurance policy, baptismal certificate, school records, and / or passport is acceptable. The most commonly used is an ORIGINAL note from the pediatrician’s office with the child’s name and date of birth. The hospital discharge paper work is acceptable.
* The names on all documents must be the same.
* If the infant dies before the Certificate of Live Birth is submitted, the parents will need to apply in person. They will need all of the Certificates of proof as for a living child to obtain a Social Security number for income tax purposes. They will need the birth and death certificates as supporting evidence. The medical record is an acceptable form of identification.
* It was emphasized that a Social Security number is not used for identification at any time. Its primary use is to track earnings documentation BUT it is required to submit income tax information.
* If a family decides that they really didn’t want a Social Security # there is a method of archiving the number but is doesn’t ‘go away’. it will be dormant.
* The process of application works fairly smoothly if the mother is applying. If the father is making application it is more difficult. The father needs to prove custody. The father can establish custody through a court order. If the office verifies that there is already a number issued they are automatically refused.
* The section in the New Birth Registration workbook that states that it is mandatory that the parents Social Security # is not followed by the Social Security office. Therefore when our immigrant parents say they don’t have a Social Security #, entering “000-00-0000” for don’t have or “999-99-9999” for don’t know the number is acceptable.
* When the Registrar enters the information from the workbook electronically, the Social Security office receives it only electronically. There is no paper trail so when a parent calls and says that they haven’t received their card it indicates a glitch in the system. Even if you go back and double check that the correct “button” was pushed the result id the same – the parents need to go and reapply.
* If a family comes in for a replacement Social Security card it is important that they sign into the office correctly. If it goes in as “other business” the wait is longer. It is not possible to create an appointment.
* There is no notation of the actual Social Security number in the part of the system that the office workers can access.
* There can be a long wait in the Rochester office. Those seeking can go to ANY office as the information is entered according to zip code and is available on demand anywhere sought.

On a totally different topic – At some point in history the first three numbers of the Social Security number were at one time able to denote the region where a person lived. This has been changed to a random system. One supposition as to the reason for the change is the thought that the number could influence whether or not a person got a loan or a mortgage because race and ethnicity could be inferred.

* Also, a new number can be requested but it will ALWAYS be linked to the original number. There must be extenuating circumstances for this to occur, such as, religious beliefs or identity theft.
1. **Outreach Meetings –** The Outreach meetings have been completed. I hope all of you who attended may have learned a bit on how important you are to the process.
2. **Meeting Frequency –** Is this working for most?? I will remember to post date AND TIME in the future! If you didn’t catch the note on the email, please, refer to it and give me an answer!!!
3. **Data Entry Quality reviews:**

**Concern from Ann Dozier – re: “Pregnancy Intendedness”.** She has frequent contact with Ann Kern, Public Health Program Coordinator, who is primarily involved in statistics from Monroe County. She uses our data production to evaluate where changes in prenatal care may be needed. Ms. Kern has noted a general decrease in the women’s response to the question on “Pregnancy Intendedness”. (That’s Question #5 in the “Interview” portion.) She was unable to find any type of pattern for the absent answers only a global decrease. As this is global in Monroe County, I’m going to assume a generalization across the region. Therefore, I ask that you review the responses you get to the interview question as the results ARE used.

We discussed that this is difficult question for women to answer. Please, continue to offer reassurance that the information is de-identified and that it will only be used to help better the care given to our women who may not know that there is help available in determining the right timing to have a baby.

1. **Registrar questions answered:**

**Who completes the Certificate of Live Birth for a baby born at a non-birthing hospital?** - If the baby is transferred for follow-up care to a birthing hospital. A courtesy completion can be done at the accepting hospital. If this is not possible the birthing hospital can complete a long form and submit it to the Office of Vital Records. The parents can go to the Vital Records office and complete the long form themselves if need be. Rosemary has requested a copy of the “Long Form” so that we can see how it differs from our workbook.

**A woman had IUI and delivered Di-Di twins…this was originally a triplet pregnancy and she reduced it to two.  Does the reduced triplet get recorded under ‘Previous Induced Terminations’ area when coding for TWIN B?** The triplet reduction gets caught in the next pregnancy. It is not acknowledged in this pregnancy. If there is a deceased fetus delivered at the time of the other births it would then be entered as a triplet pregnancy with two living and one deceased

**Medical Records contacted the Registrar. A father was looking for his AOP for his son born in Feb 2014. He is going through a custody battle and they will not accept just the birth cert which his name is on. Upon a little investigation, the Town Clerk says they never rec'd an AOP. I checked through SPDS to see how it was entered. It was entered as if an AOP would be attached**. The father was referred to the Office of Putative Paternity. He will most likely need to go through the court system to achieve proof of paternity.

1. **Scenarios**

 **May 2018**

The woman was a G5P3-0-2-3 admitted for induction of labor secondary to being post due date. She received Misoprostil x3 followed by Pitocin induction 6 hours later, starting at 0800 hr. Her membranes were artificially ruptured at 4cm for clear fluid at 1445 hr. She progressed to full dilation at 1545, began pushing and delivered a viable, cephalic presentation male overran intact perineum at 1615. She did not have a labor epidural.

Her placenta did not immediately follow delivery. After receiving Demerol 25mg IV to help with post-partum relaxation the tip of the placenta was found palpable in the vagina but there was no movement downward despite all approved procedures. After the observation of an appropriate wait time she agreed and was consented for manual removal under general anesthesia. She had lost appox. 700 cc blood by this point. She was typed and crossed for 2units which she received intra-operatively.

She had a “Cephalic” presentation with a “Spontaneous” Delivery, “Without Anesthesia” or “Analgesia”, had an “Unplanned Operating Room Procedure Following Delivery” and a “Maternal Blood Transfusion”

11 0f 31 Registrars responded

 **June 2018**

A 20 yo G1 (now P1) presented to Labor and Delivery in prodromal labor at 4 cm dilation, having been contracting for 2 days. Upon admission, an external heart rate monitor was applied, Pitocin begun for augmentation, and an epidural placed for labor pain relief. Her membranes were artificially ruptured on 1/17 at 1200 for light meconium. An intrauterine pressure catheter (IUPC) was inserted and IV ampicillin begun due to intrapartum fever. After becoming fully dilated and pushing for two hours, the vertex was at +3 station but the patient said she was exhausted. A vacuum was applied and on the next two contractions, traction was applied while she pushed. On 1/18 at 1020, the baby delivered over an intact perineum.

She had “Cephalic” presentation with a “Vacuum” delivery, Indications were “Failure to Progress” or “Other”, There was “Prolonged Rupture of Membranes”. There was, also, “Meconium Staining, Augmentation of Labor”, Antibiotics” administration and “External EEFM”. I accepted Chorioamnionitis as nurses are aware that antibiotics for an intrapartum fever are indicative of this diagnosis even though the term wasn’t mentioned.

16 of 31 registrars responded.

**July 2018**

A mother, who in her first pregnancy, delivers twins on 2/32/1919. What information would you enter in the following for Twin B?

Previous Live Births \_**1**\_

Total Prior Pregnancies \_**0**\_

First Live Birth \_**2/1919**\_

Last Live Birth \_**2/1919**\_

So far 20 of 31 Registrars have responded. *Even if you see the answers before you take the time to respond, please, let me know that you have read the Scenario. Always keep in mind that these are learn/ learn exercises. . I keep track of who responds. It becomes part of the Quarterly Report that Dr. Glantz sends to the Department of Health.*

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, November 14th, 2018 in the Saunders Bldg. Room 3.223 (across from my desk) A ZOOM Conference Line will be available. (I am actually working on my skills as to how to successfully make this process work!) BUT, PLEASE, REMEMBER THAT A PHONE CONFERENCE IS NOT AS PERSONAL AS FACE-TO-FACE, SO, TRY TO ARRANGE YOUR SCHEDULES TO ALLOW ATTENCE IN PERSON! Parking will be available in the Lot attached to the Saunders Bldg. and parking passes will be available at the meeting

**MODULE SIX EVALUATION**

 (Please mark the appropriate response)

1. **If a mother’s pre-pregnancy weight is recorded in the prenatal record as 126 lbs and on the Labor & Delivery admission summary as 130 lbs. Which weight would be the correct weight to enter as the pre-pregnancy weight when entering birth certificate information?**
* Prepregnancy weight found in the prenatal record
* Prepregnancy weight found on the Labor & Delivery summary
1. **There is a difference in the timing of the onset of diabetes between gestational diabetes and pre-pregnancy diabetes.**
* True
* False
1. **“Other Serious Chronic Illness” should be entered for a mother who takes a thyroid pill every day.**
* True
* False
1. **Twins are born at 36 week gestation. “Prior preterm birth” (referring to Twin A’s birth) would be entered in the birth certificate information for Twin B.**
* True
* False
1. **A “Prelabor Referral for High Risk Care” would be entered if the mother was sent for:**
* Ultrasound to determine expected date of delivery
* Consultation to Maternal Fetal Medicine specialist
* Both
1. **If a mother is tested for rubella antibodies during pregnancy you would enter “Rubella” in the “Infections Present or Treated during Pregnancy” field?**
* True
* False
1. **Mother is diagnoses with Trichomonas during her pregnancy. Trichomonas would be entered as:**
* Bacterial Vaginosis
* Trichomonas infection would not be entered
1. **If a mother arrives in labor for a scheduled C-section and terbutaline is given to decrease contraction in anticipation of the C-section, tocolysis** **would be entered.**
* True
* False

9 **MSAFP screening would be entered as “Fetal Genetic Testing.”**

* True
* False
1. **Mother is tested for syphilis (RPR) early in pregnancy and her infant is tested at the time of delivery. Which date is used when entering birth certificate information?**
* Mother’s date from early pregnancy
* Infant’s date at time of birth

See answers next page

**MODULE SIX EVALUATION *ANSWERS***

**1. If a mother’s pre-pregnancy weight is recorded in the prenatal record as 126 lbs and on the Labor & Delivery admission summary as 130 lbs. Which weight would be the correct weight to enter as the pre-pregnancy weight when entering birth certificate information?**

● Prepregnancy weight found in the prenatal record

* Prepregnancy weight found on the Labor & Delivery summary

Answer: When possible, enter data in the prenatal care fields (e.g. pre-pregnancy weight) using information from the prenatal record. (Slide 2)

**2. There is a difference in the timing of the onset of diabetes between gestational diabetes and pre-pregnancy diabetes.**

● True

* False

Answer: Prepregnancy diabetes is diagnosed prior to the pregnancy while gestational diabetes develops during the pregnancy. (Slide 3)

3. **“Other Serious Chronic Illness” should be coded for a mother who takes a thyroid pill every day.**

* True

● False

Answer: Unless there is non-routine or emergency treatment of the thyroid disease would not be entered in this field for thyroid disease. (Slide 4)

**4. Twins are born at 36 weeks gestation. “Prior preterm birth” (referring to Twin A’s birth) would be entered in the birth certificate information for Twin B.**

* True

● False

Answer: “Previous preterm births” refers to a birth from a prior pregnancy. These twins are born as a result of the same pregnancy. (Slide 4)

**5. A “Prelabor Referral for High Risk Care” would be entered if the mother was sent for:**

* Ultrasound to determine expected date of delivery

● Consultation to Maternal Fetal Medicine specialist

* Both

Answer: Ultrasound done for the purpose of dating the pregnancy is considered routine and would not be entered as a “Prelabor Referral for High Risk Care.” A woman who was referred for consultation with a Maternal Fetal Medicine specialist would have data entered as having a “Prelabor Referral for High Risk Care.” (Slide 5)

**6. If a mother is tested for rubella antibodies during pregnancy you would enter “Rubella” in the “Infections Present or Treated during Pregnancy” field?**

* True

● False

Answer: Only enter “Rubella” if mother is sick with rubella (German measles) during current pregnancy. Testing for rubella antibodies does NOT get entered. (Slide 6)

**7. Mother is diagnoses with trichomonas during her pregnancy. Trichomonas would be entered as:**

* Bacterial Vaginosis

● Trichomonas infection would not be coded

Answer: Trichomonas is NOT an infection for which data is requested as part of the birth certificate. (Slide 8)

**8. If a mother arrives in labor for a scheduled C-section and terbutaline is given to decrease contraction in anticipation of the C-section, tocolysis would be entered.**

* True

● False

 Answer: Terbutaline would be entered when used to extend the length of the pregnancy but not when used to decrease contractions prior to a C-section. (Slide 11)

**9. MSAFP screening would be entered as “Fetal Genetic Testing.”**

* True

● False

Answer: First trimester/nuchal translucency screening, MSAFP/quad screening, and cell-free DNA (also known as non-invasive prenatal testing, or “NIPT”) are not considered diagnostic genetic tests. Fetal genetic testing would be entered only when an amniocentesis or chorionic villus sampling is done. (Slide 12) See, also, “Extra Information”

**10. Mother is tested for syphilis (RPR) early in pregnancy and her infant is tested at the time of delivery. Which date is used when entering birth certificate information?**

● Mother’s date from early pregnancy

* Infant’s date at time of birth

Answer: This field relates to testing of the mother. If more than one maternal test has been done, record the earlier date. (Slide 13)