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

**November 13th, 2019, Registrar Meeting Agenda**

**Attendance**: Sarah McKinney, Chris Saur (SMH), Darlene Wates (SMH), Jeanne Brightly (Unity) Lisa Santos (Unity), by phone: Catherine VanDerMeid (Noyes), Amy Burchell (HH), Liz Rife (HH), Rosemary Varga

1. **Gathering Exercise –** Module 2 (Birth Anomalies) 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 learned material enhances our performance. Let me know if you have any concerns with the information shared.
2. **Introducing Sarah –** Sarah has accepted the position as SPDS Coordinator. (I will be phasing out over the next few months). She comes to us from FFThompson. She will be maintaining her per diem position there. Sarah is a mom of 18 mo. old Gracelyn, an LPN and back-up for the FFT Lead Registrar. She is comfortable with IT. We welcomed her with dessert from Cheesy Eddie’s
3. **New Birth Entry System** – I spoke with Deb Madaio on Oct. 16th asking about the progress toward the intended Birth Entry System. She told me that it is still in the earliest of thought processes. She foresees one to two years before real work can begin. I’ve attached the list of suggested updates that have come from Registrars. Please, take a look at it and send potential additions to me.
4. **An interesting point**. This is why we have a HELPER Guidelines.

The November Scenario had two areas where the answers are different from what I thought they should be. When I consulted the Guidelines, I felt the need to correct myself. 1st. Anesthesia – The spinal would not be entered as it was not administered in the intra-partum period

And, 2nd, Transfer to a higher level of care is only for a Hospital transfer or for a planned home delivery needing admission after the delivery.

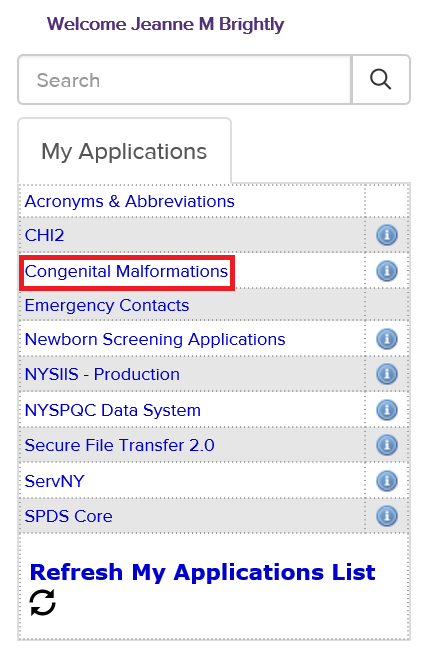
1. **Discussion point** - Who notifies the Congenital Malformations Registry (CMR)? We enter the limited few anomalies that are required into our workbook. Does this info go to the CMR? Or, is it, as I believe, that billing “catches” anomalies and it is their responsibility to inform the CMR? - Rosemary

I'm not sure.  I think it may be a combination of both. – Pam

Those present said that none of them notifies the Congenital Malformation. Each said that it is handled by their billing department.

1. This triggered a discussion on “Discrepancies” – Most are not receiving notification of this practice being continued after Larry Schoen left. Then Jeanne noted that there is a way to view these. In the Congenital Anomalies Application there is a sidebar with options to “add a new confidential report, look at all the reports that have been entered by your facility, and Headings” One of them is congenital anomalies queries and SPARCS report. There is not always a report under the heading but if there is, there will be another line that tells what the time line is.

On your HCS main page under My Applications you can add the Congenital Malformations application. Below is a screen shot of Jeanne’s “My Applications” tab with the Congenital Malformations highlighted in red so you can reference it to your HCS homepage if you need to add it. (Sarah)



1. **Discussion point 2** - We FedEx'ed a package in September to Canandaigua City Clerk with 12 birth certificates.  It was a busy few weeks, so this package was not noticed as missing because I was sending them more frequently to the clerk than usual.  A patient called 4 weeks after birth checking in on her birth cert and we realized that a whole package was missing. FedEx had documented the package as delivered, so our receiving department who prepares the envelope did not think anything went wrong.  The package was tracked and was reportedly delivered to the address of the clerk, but a signature and name of the person who received it was not recorded.

FedEx only requires drivers to retrace their steps if the package is thought to be missing within 8 days of delivery.

At this point the package is declared lost, and I have unlocked the certificates to be re-issued, as well as contacted the 3 sets of parents who need to re-do acknowledgment of paternity.

I have issued an incident report for a breach of information, and hopefully either FedEx or our hospital will compensate these families with identity theft monitoring.

Do other hospitals have this process already in place?  It's a situation that is probably all a coincidence, but also seems suspicious and I wanted others to be aware.  Thanks, Alice

HH and Noyes use the US Postal Service. SMH delivers the Certificates to their in-house post office. A courier from the Vital Records Office comes and picks it up. Unity has an in-house courier who takes the Certificates to the Vital Records Office. It was suggested by the FFT legal dept. that they begin signature on receipt process.

Understandably this has happened only once but a suggestion is to explore how your Certificates are being cared for between you and the Vital Records Offices

1. **Redesignation Process –** This is a lengthy process in which committees review each of the regulations used to determine our hospital levels. Very few actual changes are expected but there may be a tightening of the need to follow the regulations. This process started in 2017 and may be completed by early to mid-2020.
2. **Registrar Questions Answered –** I realized that I had omitted this section starting in May of this year. Well, it’s back!

Baby born to a single, surrogate mother. The Biological parents were present for the birth. How is the work book completed?

- The surrogate mother is listed as the mother. If the mother is not married she can use an AOP for the biological father. The biological mother needs to adopt the baby through family court. If the surrogate mother is married, the "Father" section remains blank and both biological parents need to adopt the child. The baby will be d/c'd to "Home" if the biological father is on the Certificate of Live Birth.

A transgender father (male) wants to be listed as "Father" on the Birth Certificate. The couple is not married.

* If both parties agree that the person in question is the father of the baby and sign the AOP, he will be listed as "Father". This is a place where the teaching re: the responsibilities that are assumed by signing this form become so very important.

The mother is separated but still married. She does not want the father on the Birth Certificate. He wants to be on the Birth Certificate.

* He can fill out and have witnessed "Father" portion of the AOP and mail it himself to the Office of Putative Paternity. He will be acknowledged as having no financial responsibility for the child and will not be listed on the Birth Certificate. He will be notified if any adoption proceedings should be initiated and the child may be eligible for death benefits from him when he dies.

Serious Chronic Illness - Cholestasis of Pregnancy - Is there a way to document this?

* It's a gray area. Dr. G. feels that if an illness is serious enough to need treatment or hospitalization in the pregnancy then it should be acknowledged. But, the word "chronic" can make not documenting it acceptable.

Can the unmarried female partner in a same sex relationship complete an AOP and be entered on the Birth Certificate?

* No, she will need to go to Family Court and adopt the baby.

The mother wanted the baby's first name changed. The Registrar was able to unlock and make the correction. The mother has been asking when she'll receive an updated Social Security Card.

* I was reminded at the meeting that there can be no changes to the baby’s name after the Certificate has been sent to Vital Records except through Family Court. No one is permitted to alter the baby’s name if an AOP or Social Security (SS) card has been requested. If neither of these were completed there is a 90 day grace period that allow for a change in the first and middle names BUT not the last or surname. Please, see the HELPER Guidelines under AOP.
* The mother will need to go to her local Social Security (SS) Office to change anything on the SS card. She will need two forms of identification and the Birth Certificate cannot be one of them. I’ve attached notes from the meeting where we had a visitor form Social Security. **PLEASE**, make a copy and put it in your HELPER Guidelines section 5 - Attestation. Darlene also recommended that the parents call the Social Security office before they go to learn which forms of identification are acceptable. The phone wait can be VERY long but it does get answered.

Mother/mother certificate. Married couple. The birthing mother now wants to remove her spouse from the certificate. I’m guessing family court or no chance at all. It was filed 2 weeks ago.

* Yes, the birthing mother will need to go to family court.

1. **Scenarios –** *Please, note how many are responding to the Scenarios*

**May –** Anesthesia

The G1P0 at term enters the hospital in labor. EFM is placed. She receives an epidural at 5cm dilation. Her membranes ruptured spontaneously at 7 cm. After 20 hours she is fully dilated. After pushing for 2 hours is there is no descent of the fetal head. The baby begins to have increasing variable decelerations. The decision is made to deliver the baby by urgent C-sect. Due to the fetal distress the mother receives general anesthesia.

Presentation – Cephalic

Route – Cesarean

C-sect Hx – 0

Indications – Failure to progress

Characteristics – EFM, Fetal Intolerance

Anesthesia – Epidural, General Inhalation and Intravenous

*10 of 27 Registrars responded to this Scenario.*

**June –** Surrogate mother

We have a surrogate mother, Jane Doe (BD 1/1/2001), a single woman, whose baby was born 5/30/2019. She had a fertilized embryo implanted in her uterus. The biological parents. John Smith (BD 1/1/1992) and Mary Smith (1/1/1994), are at the birth as well with the surrogate mom. How do we fill out the parent sections? How is the “mother” / “father” question answered? If you decided that it is Jane, what does Mary need to do? How is the “Father” question answered? What if the gestational mom is married?

Jane Doe is in her first year at the local Community College. She was born in Chicago, FL. Both She and the biological parents are African American. Jane lives at 123 First St. Chicago FL. 12345, Infant County. Phone #123-456-7890. She was not employed during the pregnancy. While in High School she was a sales clerk in the clothing industry. She declined to name the company.

Mary Smith is working on her PhD on English and teaches at her local Community College. She was born in San Francisco NY. After marrying John they moved to his birth place, Hometown Alaska and reside at 456 Seventh St., 67890

John Smith has his PhD and is also working as a teacher in their Community College.

Risk Factors – Assisted Reproductive technology

Mother –

Education - Some College, Hispanic Origin – No

City of Birth – Chiago, FL

Race – African American

Residence – 123 First St., Chicago FL, 12345, Infant County, Phone-(123)456-7890

Employment Hx – While Preg. – No, Most recent - Sales clerk – clothing industry

Father –

Name- John Doe

DOB – 1-1-1992

Education – Doctorate

City of Birth – Hometown Alaska

Hispanic – No

Race – African American

Residence – 456 Seventh St., Hometown AK, 67890

Employment – Teacher, local Community College

*An added note - In EPIC there is a field that would be selected when the delivering mother is admitted that will indicate “surrogacy”, so that the baby’s chart is not connected to the mother’s chart.  Surrogacy was one of the choices in that field that otherwise is left blank at admission.*

*12 of 27 Registrars responded to this Scenario.*

**July – AOP (read only)**

Question sent – June 25th, 2019

Monique, This question has popped up several times over my time here. To start the discussion, I remember, from your 2016 visit, that we are not legally allowed to ask for identifications before the putative father/second parent signs the AOP and that we cannot ask if the putative parents are married.

I think we have the “Identity” part under good control.

But, regarding the marital status it’s a different story. What if we know that the woman is married and she demands to fill out an AOP? Can we deny her? What if the AOP is filled out and when given back to the Registrar she learns as she is reviewing the chart that the woman is married. (This information is in the prenatal and on face sheets completed by Admissions offices). Should the AOP be destroyed? Or, should the Registrar answer “yes” to “Will the mother and Father be executing an AOP?”

Thank you in advance for taking the time to help us. – Rosemary

***First reply –*** June 25th, 2019

Hi Rosemary, I just need to confirm my answers w/our legal office.  More soon. Thank you. - Monique

***Second reply –*** June26th, 2019

Rosemary, you cannot deny parties from completing the AOP or processing an AOP once you have it in hand after the parties have completed and have witnessed – unless there is a reason it needs to be rejected, such as, missing or crossed out information, wrong information, changes in child’s name, etc.

If the parties fraudulently sign the form then it is up to the court to resolve the matter – if ever it is raised.

Please let me know if you have any additional questions.  Thank you.- Monique

*12 of 27 Registrars responded to this Scenario.*

**August – C-sect**

The woman was scheduled for an elective C-section.  Her previous vaginal delivery was a bad shoulder dystocia and child went to NICU. This child is larger by ultra sound. After careful discussion with her provider the C-Sect. was scheduled for 39 1/7 wks. gestation. She arrived in Triage at 38 5/7 wks. gestation with irreg. contractions.  After monitoring for 2 hrs. she was sent home with no cervical change. She came back 5 hours later stronger contractions. She had progressed from 3 to 5 cm. and was determined to be in labor. The delivering team proceeded with the planned C-sect.

Trial Labor - NO

Indications for the C Section were: - Elective, Other

Onset of Labor – None

External Fetal Monitoring - -Could be yes or no

Maternal Morbidity - None

Other responses were “Refused VBAC” and “Maternal Condition-Preg. Related”

**September - Serious Chronis Illness**

The woman, with husband and two year old, presented to Labor & Delivery at 35 wks. gestation with her 2nd pregnancy. She c/o severe left upper quadrant pain. She was placed on EFM as the team worked on determining the cause of her pain. After blood work and an ultrasound she was diagnosed with Cholestasis of pregnancy.  She was given pain relief and discharged home.

She returned to L & D Triage three more times in the next two weeks for help with pain control.

Due her gestational age and the risk of surgery at this stage in pregnancy her provider decided to schedule a C-sect.

She delivered a baby with cephalic presentation by C- sect at 37 2/7 wks. She had her gall bladder removed the next day.

Presentation – Cephalic

Route – C-sect

C-sect Hx - ?

Attempted Proc. - No x 2

TOL – No

Indications – Maternal Condition – not pre. Related, Other, Elective

Characteristics – none

Maternal Morbidity - None

Preg. Hx – 1 Living, 0 Dead, Terminations – none, Total Prior Preg. – 1

Prenatal Care –

Risk Factors - None

*12 of 27 Registrars responded to this Scenario.*

**October**

Twins born prior to hospital admission – They were 30 wk. 2da. as documented in her prenatal record. Mary Smith was home alone when she went into premature labor.  Before the ambulance arrived the 1st baby, a girl, was born at home with only Mary, in attendance. The 2nd baby, a boy, was born in the ambulance with assist from EMT, Jeff Brown, lic # 678390. He also delivered the placentae.  The NICU team at the Level III hospital met the family in the Emergency room. Both babies were assessed, found to be breathing on their own and transported to NICU due to prematurity. All immediate care was done after the NICU admission. There was documentation that the babies had received eye meds and Vit K. They’re hearing was not tested and they did not receive the hepatitis vaccine before day 5 of life. The NBS was completed, 987654321.

Attendant - Mary Smith –Other for Baby A

Attendant - Jeff Brown License # 678390 –for Baby B

“Doc in the Box” as Certifier

# Live Births - 2

Not transferred

*Question asked about the ability to enter Jeff Brown. Can it be done??*

Alive - Yes

Gestation – 30 NB Treatment – both

Feeding – don’t know

NB Blood-Spot – 987654321

Hepatitis and Immunoglobulin – No

NB Hearing Screen – Not performed-medical exclusion

Abnormal Cond. of the NB - NICU admission *11 of 27 Registrars responded to this Scenario.*

***With regard to completing the Scenarios - Even if you see the answers before you have 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 is included in the report I write to your supervisors after our Annual Reviews so it has the possibility of affecting your yearly evaluation. It, also, 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. When you have a free minute, you might take a look at it, especially the section referring to Registrars. I am open to needed corrections and possible additions!

##### Our next meeting will be Wednesday, February 12th 2020, room TBA.

**MODULE TWO EVALUATION**

(Please check the appropriate response)

1. **Which of the following congenital malformations is least likely to be identified prenatally?**

* Anencephaly
* Meningomyelocele/Spina Bifida
* Congenital Diaphragmatic Hernia
* Omphalocele
* Gastroschisis
* Limb Reduction Defect
* Cleft Palate

1. **For a congenital malformation that is likely to be identified prenatally, which of the records below would be the best source of information related to testing & diagnosis?** 
   * Infant’s record
   * Hospital record (L&D)
   * Mother’s prenatal record
2. **If a diagnosis is suspected or discussed for one of the anomalies listed in the Birth Certificate work book, but is not diagnosed what should you enter?**

* ‘Unknown at this time’
* ‘None’
* ‘Yes’ next to the suspected anomaly
* ‘No’ next to the suspected anomaly

1. **If the anomaly is not listed in the Birth Certificate work book you should enter all ‘None of the listed’**

* True
* False

1. **A Level II ultrasound can be used to identify any of the congenital anomalies listed in work book.**

* True
* False

1. **Accurate entry of congenital malformations provides which of the following information (check all that apply)**

* Establish the need for services
* Identify causal links
* Track changes in incidence over time

1. **The MSAFP/ triple screen testing involves getting urine from the expectant mother and looking at levels of various proteins**

* True
* False

1. **Which of the genetic tests listed below can be done within the 1st trimester of pregnancy?**

* Chorionic Villus Sampling (CVS)
* Amniocentesis

1. **If a significant birth defect not listed on the birth certificate is identified, is it reported?**

* It is not reported
* It is reported by the hospital to the NYS Congenital Malformations Registry
* It is identified on the birth certificate

1. **Downs syndrome is often diagnosed prenatally**

* True
* False

**MODULE TWO EVALUATION *ANSWERS***

1. **Which of the following congenital malformations are likely to be identified prenatally? (check all that apply)**

* Anencephaly
* Meningomyelocele / Spina Bifida
* Congenital Diaphragmatic Hernia
* Omphalocele
* Gastroschisis
* Limb Reduction Defect
* Cleft Palate

Answer: Cleft palate may be diagnosed prenatally but is most often diagnosed after the infant is born. (Slides 5, 6, 8, 9, 10, 11, 12, 13)

1. **For a congenital malformation that is likely to be identified prenatally, which of the records below would be the best source of information related to testing & diagnosis?**

* Infant’s record
* Hospital record (L&D)

● Mother’s prenatal record

Answer: Check the mother’s prenatal record for tests and diagnoses made during pregnancy (Slides 3, 17)

**3. If a diagnosis is suspected or discussed for one of the anomalies listed in the Birth Certificate work booklet, but is not diagnosed what should you enter?**

● Unknown at this time

* None
* ‘Yes’ next to the suspected anomaly
* ‘No’ next to the suspected anomaly

Answer: If a diagnosis is suspected or discussed (for one of the anomalies listed) but is not diagnosed, enter ‘Unknown at this time’ (Slide 4)

**4. If the anomaly is not listed in the Birth Certificate work booklet you should enter all ‘No’s”**

● True

* False

Answer: If no anomalies listed are present enter ‘None’. (Slide 4)

**5. A Level II ultrasound can always be used to identify any of the congenital anomalies listed in work booklet.**

* True

● False

Answer: Only those anomalies that can be identified prenatally will benefit from ultrasound. Cleft palate is often identified at birth (Slides 5, 6, 8, 9, 10, 11, 12, and 13)

**6. Accurate entry of congenital malformations provides which of the following information (check all that apply)**

● Establish the need for services

● Identify causal links

● Track changes in incidence over time

Answer: Accurate coding of Congenital Anomalies provides information which can help establish the need for services, causal links and changes in the incidence of the defect. (Slide 2)

7. **MSAFP/ triple screen testing involves getting urine from the expectant mother and looking at the levels of various proteins.**

* True

● False

Answer: MSAFP/ triple screen testing involves drawing blood from the expectant mother and looking at the levels of various proteins and then comparing these levels with the established norms. (Slide 19)

**8. Which of the genetic tests listed below can be done within the 1st trimester of pregnancy?**

● Chorionic Villus Sampling (CVS)

* Amniocentesis

Answer: Amniocentesis uses chromosomes taken from cells in amniotic fluid in second/ third trimester (Slide 20) while CVS uses chromosomes from cells taken from chorionic tissue early in pregnancy (Slide 21)

**9. If a significant birth defect not listed on the birth certificate is identified, is it reported?**

* It is not reported

● It is reported by the hospital to the NYS Congenital Malformations

Registry

* It is identified on the birth certificate

Answer: A significant birth defect that is not currently coded on the birth certificate will be reported by the hospital to the NYS Congenital Malformations Registry by the Health Information Departmant(Slide 22)

10. **Downs syndrome is often diagnosed prenatally?**

● True

* False

Answer: A suspected diagnosis of Downs can result from abnormal prenatal ultrasound and triple marker screen which can be confirmed by amnio or CVS (Slide 14)