

Birth Certificate Optimization Initiative

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Illinois Perinatal Quality Collaborative
Meeting
11/10/2014

Overview

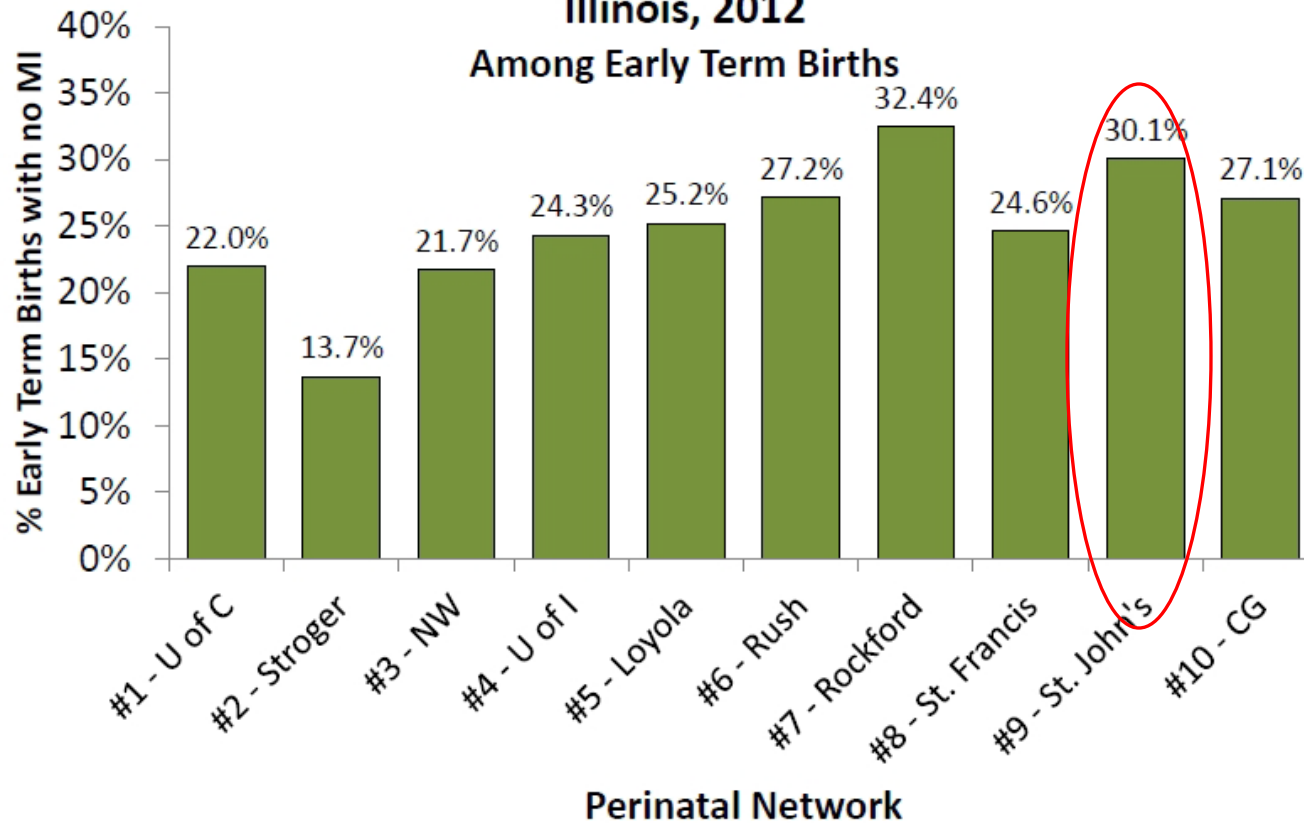
- Birth Certificate Optimization Initiative Pilot at South Central Illinois Perinatal Center
 - Why improve birth certificate accuracy?
 - What we did
 - Pilot results
- Birth Certificate Optimization Initiative 2015 partnership IDPH / IHA / ILPQC
 - Approach
 - Next steps
 - Discussion

How this Initiative Began:

- ❖ 2013 ILPQC Kickoff Conference
- ❖ IDPH released provisional birth certificate data for EED to all hospitals
- ❖ Our network data appeared different than what we had been collecting

NMIED by Network

**Non-Medically Indicated Early Delivery
(37-38 Weeks Gestation) by Perinatal Network In
Illinois, 2012**



- ❖ Hospitals received the reports generated from the birth certificate for non-medically indicated deliveries between 37 0/7 – 38 6/7
- ❖ Hospitals and Networks were surprised with their reported rate and variability across hospitals
- ❖ Concern raised that portion of variability across Hospitals / Networks secondary to birth certificate inaccuracy

What can we do to fix this:

- ❖ Conversations began
- ❖ Rolled out network survey
- ❖ Audits to identify where to focus our efforts

Survey and Discussion Findings:

- ❖ Variables were defined differently by the network hospitals
- ❖ There are no official programs from Illinois Vital Statistics that train individuals on the specific information they are looking for or where to find it
- ❖ There is training available on how to enter data into the system

Network Initiatives Completed:

- ❖ Survey done
- ❖ Audits completed on clinical record vs. completed birth certificate



IVRS to Patient Medical Record Audit Checklist



Hospital: _____

Month: _____

IVRS	Variable		Chart 1		Chart 2		Chart 3		Chart 4		Chart 5		Total Y	Total N	Total Y+N
			Y	N	Y	N	Y	N	Y	N	Y	N			
Pregnancy tab: Risk Factors	Pre-pregnancy and Gestational diabetes	Does the data documented in IVRS <u>MATCH</u> the data found in the patient record													
IVRS	Variable		Chart 1 Y N	Chart 2 Y N	Chart 3 Y N	Chart 4 Y N	Chart 5 Y N	Total Y	Total N	Total Y+N					
Pregnancy tab: Risk Factors	Pre-pregnancy and Gestational hypertension	Does the data documented in IVRS <u>MATCH</u> the data found in the patient record													
IVRS	Variable		Chart 1 Y N	Chart 2 Y N	Chart 3 Y N	Chart 4 Y N	Chart 5 Y N	Total Y	Total N	Total Y+N					
Labor & Delivery tab: Characteristics of Labor and Delivery	Induction of Labor	Does the data documented in IVRS <u>MATCH</u> the data found in the patient record													
IVRS	Variable		Chart 1 Y N	Chart 2 Y N	Chart 3 Y N	Chart 4 Y N	Chart 5 Y N	Total Y	Total N	Total Y+N					
Labor & Delivery tab: Characteristics of Labor and Delivery	Antenatal corticosteroids (ANCS)	Does the data documented in IVRS <u>MATCH</u> the data found in the patient record													
IVRS	Variable		Chart 1 Y N	Chart 2 Y N	Chart 3 Y N	Chart 4 Y N	Chart 5 Y N	Total Y	Total N	Total Y+N					
Newborn tab: Other	Obstetrical estimate of gestation at delivery	Does the data documented in IVRS <u>MATCH</u> the data found in the patient record													
												Total Y	Total N	Total Y+N	
		Total "yes" responses divided by total "yes" + "no" responses =													
															%

Audit Results:

Month	Q 1	%	Q 2	%	Q 3	%	Q 4	%	Q 5	%
January	45/45	100	42/45	93	40/45	88.8	39/40	97.5	42/45	93
February	45/45	100	43/45	95.5	44/45	97.7	39/40	97.5	44/45	97.7
March	35/35	100	35/35	100	30/35	85.7	25/25	100	32/35	91.4
Overall %	125/125	100	120/125	96	114/125	91.2	103/105	98.1	118/125	94

9 out of 15 Hospitals reported Jan and Feb

7 out of 15 reported March

1 Hospital did not record steroids each month

1 hospital did not record steroids for one month

Birth Certificate Optimization Initiative Roll Out

- ❖ Birth Certificate project will be the next state wide project similar to that of the OB Hemorrhage program
- ❖ Partnership established with IDPH/IHA/ILPQC
- ❖ Birth Certificate initiative workgroup
 - ❖ consultation from Ohio
 - ❖ developed key variables, accuracy data form, revised birth certificate guidebook
 - ❖ feedback from State Quality Council and OB Advisory Workgroup
- ❖ Aim: Obtain 95% accuracy on key birth certificate variables

Approach: establish teams

- ❖ Identify Hospital Teams: physician lead, nurse lead, quality lead, birth certificate clerk
 - ❖ Each team confirms has ILPQC REDCap data system access
 - ❖ Forms to report Birth Certificate Team roster and ILPQC data system request available at www.ilpqc.org

- ❖ Collect baseline accuracy data
 - ❖ Team will review 10 charts per month for 3 months (retrospective)
 - ❖ Will review completed birth certificate against actual medical record and record if 17 selected variables are accurate (yes/no)
 - ❖ Accuracy data reported in ILPQC REDCap data system

Approach: team education

- Birth certificate accuracy education for hospital teams
 - Webinar(s) national / state speakers
 - Discussing face to face team training spring meeting?
 - Monthly ILPQC Hospital Team Calls
- Focus on QI at hospital level
 - Support PDSA cycles to improve system for completing birth certificates
 - Support education on improving collection of each key variable

Approach: data collection & QI

- Hospital teams review 10 charts per month for accuracy on 17 key variables
 - Enter data into ILPQC REDCap data system
- Monthly accuracy data available to hospitals via secure ILPQC data system portal
 - Tracks improvement in hospitals birth certificate accuracy rate for each key variable and overall
 - Comparison across time and across all hospitals
 - Teams implement PDSA cycles based on data
- Monthly ILPQC OB Team Calls
 - Review accuracy data
 - 3 teams / month report on PDSA cycles, challenges & successes to share across hospitals
 - Identify focus areas for ongoing education

IVRS to Patient Medical Record Checklist Instructions

Background:

The Department of Public Health recognizes the importance of birth certificate data, as these data are used to identify prevention strategies and determine funding for state, local and national maternal and child health programs, among other important uses. The Department is committed to proactively helping hospitals improve the accuracy of this information. As a first step, hospitals are asked to assess the degree to which the information in the medical record supports the information on the birth certificate, by auditing a sample of 10 records per month, beginning with a 3-month "baseline" audit. IDPH will use the results to target items that should be the subject of further education. The goal shared by the ILPQC and the SQC is 95% consistency between the birth certificate and the medical record. This checklist will help you assess current consistency as well as subsequent improvement.

Data collection process:

Who:

Identify members of your Improvement team, consisting of a *nurse, physician (or provider), QI administrator, and/or birth certificate abstractor* to complete medical record reviews each month. One of these individuals will need to have access to IVRS to open and review the past IPHIS/birth registry submissions.

When:

1. **Initially**, we request that you collect a data sample from *July, August and September 2014* as a baseline for monitoring change in patient medical record to IVRS consistency
2. Thereafter, once the education has been implemented we request that you monitor patient medical record to IVRS consistency on a monthly basis. Please include the results of your chart reviews in your monthly report.

What:

AS A TEAM, review **10 patient medical records** for accuracy of information submitted into IVRS. 17 variables are listed on the tool. **You are verifying that the information entered into IVRS is supported by documentation found in the patient's medical records.** If there is a blank or an unknown value in IVRS, you are checking whether it is also unknown or not documented in the patient medical record.

For both baseline and subsequent reviews, Level II+ and III facilities must select 2 additional charts per month for deliveries that occurred prior to 34 weeks if there were not at least 2 of these early preterm births in the original 10 charts selected.

How:

1. Print out the IVRS to Patient Medical Record Audit Checklist; (it consists of 2 pages.)
2. Select a sample:
 - a. **Initially**, select 10 records from July, 10 from August, and 10 from September, 2014 from IVRS records with a status of completed
 - b. **Thereafter, for subsequent reviews**, select 10 records for the current month from IVRS records with a status of completed.

3. Select the first IVRS record completed for the month, then select every 3rd chart after that until 10 records are selected. If your hospital has fewer than 30 births per month, select the first 10 completed IVRS records for the month.
4. Obtain patient medical records for each of the charts audited. **Be sure to include any and all electronic and paper medical records to be used for data abstraction. This is likely to include both mom's and infants' medical records.**
5. Using the IVRS to Patient Medical Record Checklist, check to see if the data element submitted into IVRS matches or is substantiated by the documentation in the patient's medical record. If documentation in the medical record matches or substantiates, circle "Y". If documentation in IVRS does not match what is in the medical record, or is not substantiated by information in the record, then circle "N".

For example, variable #6 does not ask if the mother received antenatal corticosteroids (ANCS.) Instead it asks if the IVRS submission under the Pregnancy tab accurately reflects the data that is found in the patient medical record regarding ANCS. If the mother DID NOT receive ANCS and that data is supported in the patient medical record, the correct response would be "YES." Meaning the data in the medical record matches the data submitted into IVRS. If according to the patient medical record the mom DID receive ANCS, but it was not checked in IVRS, the correct response to the question would be "NO."

- Total up each variable's "yes" and "no" answers. Totals for all answers are at the bottom of the page.
- Once the checklist is complete, transfer your results into the Birth Certificate data form in the REDCap database. The REDCap database will have a report you can run to compute and view your accuracy percentage and compare your results to participating (de-identified) hospitals based on the number of yes and no replies submitted.

Child Info	Parent Info	Certifier	Demographics	Mother Medical Info	Mother Med(Cont'd)	Newborn Medical Info	Complete	Flags	Amend
System									
State File Number	Local File Number	Date Created	Created By	User Group Code	Date Modified	Modified By	User Location		
		//	PIPPIN, DAN	CENTRAL	//		CENTRAL		
Record Status	Amendment Flag	Correction Flag							
	<input type="checkbox"/>	<input type="checkbox"/>							
Reg Type	Court-Ordered Reg Type	Case Number	Index Update Requested	Paper or Electronic Filing					
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>					
Child									
First	Middle	Last	Suffix						
JUDITH		BURKETTE							
Time of Birth	Time Unit	Sex	Date of Birth						
02:33	PM	F	05/13/2014						
Birth Facility									
Place Where Birth Occurred	State of Birth								
HOSPITAL	ILLINOIS								
County of Birth	City of Birth								
COOK	CHICAGO								
Facility Name									
CHICAGO LYING IN HOSPITAL									
Place of Birth Address	Zip Code								
5815 SOUTH MARYLAND	60615								

STATE OF ILLINOIS
CERTIFICATE OF LIVE BIRTH WORKSHEET

CHILD	1. CHILD'S NAME (First, Middle, Last, Suffix) ST JOHN'S HOSPITAL		2. SEX M	3. DATE OF BIRTH (Month/Day/Year) 05/18/2011
MOTHER/CO-PARENT	5. FACILITY NAME (If not institution, give street and number) ST JOHN'S HOSPITAL		6a. CITY OR TOWN (Location of Birth) SPRINGFIELD	6b. ZIP CODE 62769
MOTHER/CO-PARENT	6a. MOTHER/CO-PARENT'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		7. COUNTY OF BIRTH SANGAMON	
MOTHER/CO-PARENT	6c. MOTHER/CO-PARENT'S NAME PRIOR TO FIRST MARRIAGE/CIVIL UNION (First, Middle, Last, Suffix)		8b. DATE OF BIRTH (Month/Day/Year)	
MOTHER/CO-PARENT	6d. BIRTHPLACE (State, Territory, or Foreign Country) ILLINOIS		9a. RESIDENCE OF MOTHER/CO-PARENT-STATE ILLINOIS	
MOTHER/CO-PARENT	9b. COUNTY SANGAMON		9c. CITY OR TOWN SPRINGFIELD	
MOTHER/CO-PARENT	9d. STREET AND NUMBER		9e. APT. NO.	9f. ZIP CODE
MOTHER/CO-PARENT	9g. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
FATHER/CO-PARENT	10a. FATHER/CO-PARENT'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		10b. DATE OF BIRTH (Month/Day/Year)	
FATHER/CO-PARENT	10c. FATHER/CO-PARENT'S NAME PRIOR TO FIRST MARRIAGE/CIVIL UNION (First, Middle, Last, Suffix)		10d. BIRTHPLACE (State, Territory, or Foreign Country) ILLINOIS	
CERTIFIER	11. CERTIFIER'S NAME (Type or Print) TITLE: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> HOSPITAL ADMIN. <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify)		12. DATE CERTIFIED MM DD YYYY	
CERTIFIER	13. LOCAL REGISTRAR'S SIGNATURE		14. DATE FILED BY REGISTRAR (Month, Day, Year)	
THIS WORKSHEET SHOULD BE RETAINED BY THE ORIGINATOR FOR REFERENCE PURPOSES				
INFORMATION FOR ADMINISTRATIVE PURPOSES				
15. MOTHER/CO-PARENT'S MAILING ADDRESS: <input checked="" type="checkbox"/> SAME AS RESIDENCE IN ITEMS 5A-9G				
16. MOTHER/CO-PARENT MARRIED? (At birth, conception, or any time between) OR: MOTHER/CO-PARENT IN A CIVIL UNION? IF NO, HAS VOLUNTARY ACKNOWLEDGEMENT OF PATERNITY BEEN SIGNED IN THE HOSPITAL?		17. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD?		18. FACILITY ID (NPI)
19. MOTHER/CO-PARENT'S SOCIAL SECURITY NUMBER		20. FATHER/CO-PARENT'S SOCIAL SECURITY NUMBER		
INFORMATION FOR STATISTICAL PURPOSES ONLY				
MOTHER/CO-PARENT	21. MOTHER/CO-PARENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input checked="" type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LL.M., JD) <input type="checkbox"/> Unknown		22. MOTHER/CO-PARENT OF HISPANIC ORIGIN? (Check the box that best describes whether the mother/co-parent is Spanish/Hispanic/Latino. Check the "No" box if mother/co-parent is not Spanish/Hispanic/Latino) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify)	
MOTHER/CO-PARENT	23. MOTHER/CO-PARENT'S RACE (Check one or more races as identified by mother/co-parent) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the ancestor or principal ancestor) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> Other (Specify)			
FATHER/CO-PARENT	24. FATHER/CO-PARENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input checked="" type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEd, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LL.M., JD) <input type="checkbox"/> Unknown		25. FATHER/CO-PARENT OF HISPANIC ORIGIN? (Check the box that best describes whether the father/co-parent is Spanish/Hispanic/Latino. Check the "No" box if father/co-parent is not Spanish/Hispanic/Latino) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify)	
FATHER/CO-PARENT	26. FATHER/CO-PARENT'S RACE (Check one or more races as identified by father/co-parent) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the ancestor or principal ancestor) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input checked="" type="checkbox"/> Other Asian (Specify) LAOS <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> Other (Specify)			
FATHER/CO-PARENT	27. PLACE WHERE BIRTH OCCURRED (Check one) <input checked="" type="checkbox"/> Hospital <input type="checkbox"/> Free-standing birthing center <input type="checkbox"/> Home Birth: Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Other (Specify)		28. ATTENDANT'S NAME, TITLE, AND NPI NAME: _____ NPI: _____ TITLE: <input checked="" type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify)	
FATHER/CO-PARENT	29. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:			

Informant: _____
 I verify that the personal information in this certificate is correct to the best of my knowledge.
 Mother/Co-Parent's Signature: _____
 Father/Co-Parent's Signature: _____
 Other: _____

		INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY			
MOTHER	30a. DATE OF FIRST PRENATAL CARE VISIT MM / DD / YYYY <input type="checkbox"/> No Prenatal Care	30b. DATE OF LAST PRENATAL CARE VISIT MM / DD / YYYY	31. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY (If none, enter "0")		
	32. MOTHER'S HEIGHT (feet/inches)	33. MOTHER'S PREGNANCY WEIGHT (pounds)	34. MOTHER'S WEIGHT AT DELIVERY (pounds)	35. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	36a. Now Living Number _____ <input type="checkbox"/> None	36b. Now Dead Number _____ <input type="checkbox"/> None	37a. Other Outcomes Number _____ <input type="checkbox"/> None	38. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day Three Months Before Pregnancy _____ or/_____ or/_____ or/_____ First Three Months of Pregnancy _____ or/_____ or/_____ Second Three Months of Pregnancy _____ or/_____ or/_____ Third Trimester of Pregnancy _____ or/_____ or/_____	
36c. Date of Last Live Birth MM / YYYY	37b. Date of Last Other Pregnancy Outcome MM / YYYY	40. DATE LAST NORMAL MENSES BEGAN MM / DD / YYYY		41. MOTHER'S MEDICAL RECORD NUMBER	
MEDICAL AND HEALTH INFORMATION	42. RISK FACTORS IN THIS PREGNANCY (Check all that apply) Alcohol Alcohol use during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No Average number of drinks per week _____ Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Pregnancy resulted from infertility treatment-if yes, check all that apply. <input type="checkbox"/> Fertility-enhancing drugs, Assisted insemination or In vitro fertilization (IVF), gamete intralipid transfer (GIFT) <input type="checkbox"/> Mother had a previous cesarean delivery if yes, how many _____ <input type="checkbox"/> None		44. OBSTETRIC PROCEDURES (Check all that apply) <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolytic <input type="checkbox"/> External cephalic version <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the procedures listed above		47. METHOD OF DELIVERY A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Fetal presentation at birth (Check one) <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other D. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No
	43. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the infections listed above		45. ONSET OF LABOR (Check all that apply) <input type="checkbox"/> Premature rupture of the membranes (prolonged, >12 hrs.) <input type="checkbox"/> Precipitous labor (<3 hrs.) <input type="checkbox"/> Prolonged labor (> 20 hrs.) <input type="checkbox"/> None of the above		
	46. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply) <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or Maternal temperature >38°C (100.4°F) <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid <input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions were taken, including resuscitative measures, further fetal assessment, or operative delivery <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above characteristics		48. MATERNAL MORBIDITY (Complications associated with labor and delivery) (Check all that apply) <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedure following <input type="checkbox"/> None of the above		
NEWBORN	49. NEWBORN MEDICAL RECORD NUMBER		55. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply) <input type="checkbox"/> Resuscitation at delivery <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skull/rib fracture(s), peripheral nerve injury, and/or soft tissue/visceral organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above conditions		56. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply) <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastrochisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and charring syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> Other congenital anomalies <input type="checkbox"/> None of the congenital anomalies listed above
	50. BIRTHWEIGHT (grams preferred, specify unit) _____ grams <input type="checkbox"/> lb/oz		57. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____		
	51. OBSTETRIC ESTIMATE OF GESTATION _____ (completed weeks) _____ (completed days)		58. HOW IS INFANT BEING FED? _____		
	52. APGAR SCORE Score at 5 minutes _____ Score at 10 minutes _____ If 5 minute score is less than 6, Score at 10 minutes _____		59. IS INFANT LIVING AT TIME OF REPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Deceased, status unknown		
	53. PLURALITY - Single, Twin, Triplet, etc. (Specify) _____		54. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____		

Note: The Father/Co-Parent has my consent to review this worksheet. Yes No

Mother/Co-Parent's Signature: _____

Note: The Father/Co-Parent cannot review this worksheet without consent from the Mother/Co-Parent.

MEDICAL AND HEALTH INFORMATION

Note: The Father/Co-Parent has my consent to review this worksheet. No Yes

Note: The Father/Co-Parent cannot review this worksheet without consent from the Mother/Co-Parent.

Note: The Father/Co-Parent cannot review this worksheet without consent from the Mother/Co-Parent.

42. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Alcohol

Alcohol use during pregnancy Yes No

Average number of drinks per week _____

Diabetes

- Prepregnancy (Diagnosis prior to this pregnancy)
 Gestational (Diagnosis in this pregnancy)

Hypertension

- Prepregnancy (Chronic)
 Gestational (PIH, preeclampsia)
 Eclampsia

Previous preterm birth

Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

Pregnancy resulted from infertility treatment. If yes, check all that apply.

- Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
 Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))

Mother had a previous cesarean delivery
 If yes, how many _____

None

43. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

- Gonorrhea
 Syphilis
 Chlamydia
 Hepatitis B
 Hepatitis C
 None of the infections listed above

44. OBSTETRIC PROCEDURES (Check all that apply)

Cervical cerclage

Tocolysis

External cephalic version:

- Successful
 Failed

None of the procedures listed above

45. ONSET OF LABOR (Check all that apply)

Premature rupture of the membranes (prolonged, >12 hrs.)

Precipitous labor (<3 hrs.)

Prolonged labor (> 20 hrs.)

None of the above

46. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Induction of labor

Augmentation of labor

Non-vertex presentation

Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery

Antibiotics received by the mother during labor

Clinical chorioamnionitis diagnosed during labor or Maternal temperature >38°C (100.4°F)

Moderate/heavy meconium staining of the amniotic fluid

Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery

Epidural or spinal anesthesia during labor

None of the above characteristics

47. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?

Yes No

B. Was delivery with vacuum extraction attempted but unsuccessful?

Yes No

C. Fetal presentation at birth

- Cephalic
 Breech
 Other

D. Final route and method of delivery (Check one)

- Vaginal/Spontaneous
 Vaginal/Forceps
 Vaginal/Vacuum

Cesarean

If cesarean, was a trial of labor attempted?

Yes No

48. MATERNAL MORBIDITY

(Complications associated with labor and delivery)

(Check all that apply)

- Maternal transfusion
 Third or fourth degree perineal laceration
 Ruptured uterus
 Unplanned hysterectomy
 Admission to intensive care unit
 Unplanned operating room procedure following
 None of the above

Elements to Audit:

- ❖ HTN
- ❖ Diabetes
- ❖ Previous Preterm Birth
- ❖ Augmentation of labor
- ❖ Induction of labor
- ❖ ANCS (Antenatal Corticosteroids)
- ❖ Fetal intolerance to labor
- ❖ Antibiotics received during labor
- ❖ Gestational age
- ❖ Assisted Ventilation
- ❖ NICU Admission
- ❖ Infant Feeding
- ❖ Mother's Social Security number
- ❖ Date of first prenatal care visit
- ❖ WIC participation
- ❖ Source of Payment
- ❖ Date of last menstrual period

IVRS	Variable		1 Y/N	2 Y/N	3 Y/N	4 Y/N	5 Y/N	6 Y/N	7 Y/N	8 Y/N	9 Y/N	10 Y/N	Total Y	Total N	Total Y+N
"Mothers Medical Info" tab	WIC Participation during Pregnancy														
IVRS	Variable		1 Y/N	2 Y/N	3 Y/N	4 Y/N	5 Y/N	6 Y/N	7 Y/N	8 Y/N	9 Y/N	10 Y/N	Total Y	Total N	Total Y+N
"Mothers Medical Info" tab	Source of Payment for Delivery														
IVRS	Variable		1 Y/N	2 Y/N	3 Y/N	4 Y/N	5 Y/N	6 Y/N	7 Y/N	8 Y/N	9 Y/N	10 Y/N	Total Y	Total N	Total Y+N
"Mothers Medical Info" tab	Date of Last Menses														
													Total Y	Total N	Total Y+N
															%

Child Info	Parent Info	Certifier	Demographics	Mother Medical Info	Mother Med(Cont'd)	Newborn Medical Info	Complete	Flags	Amend
System									
State File Number	Local File Number	Date Created	Created By	User Group Code	Date Modified	Modified By	User Location		
		//	PIPPIN, DAN	CENTRAL	//		CENTRAL		
Record Status	Amendment Flag	Correction Flag							
	<input type="checkbox"/>	<input type="checkbox"/>							
Reg Type	Court-Ordered Reg Type	Case Number	Index Update Requested	Paper or Electronic Filing					
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input checked="" type="checkbox"/>					
Child									
First	Middle	Last		Suffix					
JUDITH		BURKETTE							
Time of Birth	Time Unit	Sex	Date of Birth						
02:33	PM	F	05/13/2014						
Birth Facility									
Place Where Birth Occurred				State of Birth					
HOSPITAL				ILLINOIS					
County of Birth			City of Birth						
COOK			CHICAGO						
Facility Name									
CHICAGO LYING IN HOSPITAL									
Place of Birth Address				Zip Code					
5815 SOUTH MARYLAND				60615					

Guidebook Currently Available

National Vital
Statistics System



Updated March 2012
March 2003

Yellow Highlights indicate updated text.

Guide to Completing The Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death (2003 revision)

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
NATIONAL CENTER FOR HEALTH STATISTICS



CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL VITAL STATISTICS SYSTEM

Page 1 of 51

<http://www.cdc.gov/nchs/data/dvs/guidetocompletfacilitywks.pdf>

Next Steps:

- ❖ Establish hospital teams: turn in roster and confirm have ILPQC REDCap data system access at www.ilpqc.org
- ❖ Collect baseline data: accuracy rates for 17 variables
- ❖ Identify topic areas for more focused education, develop materials
- ❖ Teams collect ongoing monthly data and participate in webinar and ILPQC monthly teams call
- ❖ Teams use monthly data to implement PDSA cycles to drive QI in birth certificate accuracy for 17 key variables & overall
- ❖ Aim: Obtain 95% accuracy on birth certificate variables

Discussion

