

Licensed Midwife Annual Report
Task Force Report
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The Midwifery Advisory Council task force on the Licensed Midwife Annual Reporting (LMAR) Tool met on August 11, 2017. At the meeting staff shared the results of the survey that was done in March of this year. The purpose of the survey was to determine if licensed midwives (LM's) desired to continue reporting data accumulatively at the end of each calendar year, or prospectively throughout the year. The survey was asked in conjunction with the LMAR reporting this year resulting in 182 LMs responding. The questions and results were as follows:

OPTION #1 (135 out of 182 chose option #1) which is:

Continue to report data accumulatively at the end of each calendar year, as has been done since 2007. If this option is favorable to the midwifery community, Board staff will begin revising the system to add additional questions, prompts, and formatting, to allow for more reliable reporting and better ease of use. Data would continue to be submitted to the Office of Statewide Health Planning and Development (OSHPD) who would then provide the Board with the annual summary at the end of the reporting period. Feedback from all interested parties would be welcomed prior to revising the system to ensure the reporting tool would meet the needs of all entities utilizing the summary of data available each year.

OPTION #2 (47 out of 182 chose option #2) which is:

Report data prospectively throughout the year by entering client data as it becomes available. If this option is favorable to the midwifery community, Board staff will begin creating a new reporting system, similar to current nationally recognized research data registries like MANA Stats. Data would continue to be submitted to OSHPD who would then provide the Board with the annual summary at the end of the reporting period. Feedback from all interested parties would be welcomed prior to revising the system to ensure the reporting tool would meet the needs of all entities utilizing the summary of data available each year.

Given that licensed midwives overwhelmingly chose option #1, this task force makes the recommendation to adopt it as well, continuing to collect data from LMs after the end of the reporting (calendar) year.

This report shares our input as to corrections, additions, and revisions, and advise an interested parties meeting to give input regarding these revisions and/or to suggest others as relevant. Additionally, we have included notes on areas that need further clarification and discussion/decisions regarding inclusion – (these areas are noted in red in this report).

While all areas of change are up for discussion at the interested parties meeting, the task force has used colored type to distinguish between our recommendations (blue type) and those that we are not yet recommending and need further discussion (red type). We have purposely not included how to implement these changes as that will come from the interested parties meeting and discussions with staff. We recommend all changes be coordinated with OSHPD so the reporting tool can be updated in time for collecting 2018 data.

The Midwifery Advisory Council Task Force recommendations for adjustments to the Licensed Midwife Annual Reporting (LMAR) Tool are as follows.

General Recommendations:

- Remove the by county reporting from the publically and legislatively released reports. The Public Records Act will still allow that data to be accessed, but due to the small midwifery and out-of-hospital birth community the identity of an individual midwife or client could be gleaned from knowing which county a death took place in.
- Confine all information regarding deaths in a separate section (see below), removing the collection of data relating to deaths from all other sections.
- For each item that has a definition, have a pop up box with the definition that is not one you scroll over to select but one that automatically comes up when the cursor is put into the answer box
- General workings of the on-line tool
 - ✓ The 'No Data to Report' button is confusing. If you are filling in the form with zeros as you go down a column and then notice the 'no data' button at the bottom you have to remove the zeros before you can select that button. Recommend allowing zeros to be inserted and removing the button. This would mandate reporters reading each item before answering.
 - ✓ Zeros are allowed to be entered in some sections and not in others and then do not show on the final form, including print view. Recommend allowing zeros in all fields if that is the answer and have the zeros print on the saved form.
 - ✓ Comments made in each section do not show on the finalized form, including the print view. This should be corrected, with all comments made by the reporter showing on both their copy and on what is sent to the OSHPD and ultimately to the Medical Board. Those comments should also be included in the final report released by the board and given to the legislature unless they could identify either the reporter or the client.

Specific Recommendations, by section, as follows:

Wording changes are in blue type

Wording noted in red needs further discussion

Section D Client Services:

- Line 13 *Total number of clients served as primary caregiver, for birth related care, during this calendar year.* Add definition (in a pop up box) for birth related care, noting that it includes antepartum, intrapartum and post-partum but does not include clients seen for family planning during the inter-conceptional years.
- Line 14 *~~Number of clients who left care for non-medical reasons:~~* Change wording to: Number of clients who were either lost to care or who left care for non-medical reasons (Add definition of lost to care: clients who never returned for appointments despite efforts to contact them and LM doesn't know if they left for medical or non-medical reasons)
- Line 15 *Total number of clients served whose births were still pending on ~~the last day of this reporting year~~* the first day of the new year.
- Line 16 *Collaborative Care: ~~Enter the total number of clients served who also received collaborative care.~~* remove secondary to change made by AB 1308 and change to total number of women covered in this LMAR (= Line 13 – (line 14 + line 15))
- Line 17 *Supervision: ~~Enter the number of clients served under the supervision of a licensed physician and surgeon~~* remove entire line secondary to change made by AB 1308

Section E Outcomes per county in which a live birth, fetal demise, or infant or maternal death occurred

General recommendations:

It is desired that more in-depth information be captured regarding the nature of all deaths. Therefore we recommend having a separate Section X for reporting of all deaths.

Change Section E to capture information on live births only:

- Column A [change to county in which live birth occurred](#)
- Column B keep the same
- Column C [move to Section X](#)
- Column D [move to Section X](#)
- Column E [move to Section X](#)

Specific recommendations for additional fields of data:

- Retain Columns A & B
- [Add the following Columns:](#)
 - ✓ [Number of live preterm births \(before 37 0/7 weeks gestation\) Delineate between Out of Hospital Births \(OOH\) and after transfer, in hospital.](#)
 - ✓ [Number of low birth weight, term, infants \(Definition: under 2500 grams/5# 8oz\). Delineate between Out of Hospital Births \(OOH\) and after transfer, in hospital.](#)

Section F Outcomes of Out of Hospital Births (OOH)

- Line 19 and 20 no change
- Line 21 *Breech*: Number of completed breech (live born) deliveries in an OOH setting without subsequent transfer. Deliveries where a death happened will be recorded in a separate section as will breech deliveries completed in a hospital. [Discussion needs to be had on whether to collect data on breech deliveries in an entirely separate section.](#)
- Line 22 *VBAC*: Remove and create a separate section for VBAC. See notes for Section P in this report.
- Line 23 *Twins*: Number of completed (both twins, live born) deliveries in an OOH setting without subsequent transfer. Deliveries where a death happened will be recorded in a separate section as will twin deliveries where one or more infants are live born in a hospital. [Discussion needs to be had on whether to collect data on twin deliveries in an entirely separate section.](#)
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- Line 24: *Multiple births other than twin births* - Number of completed deliveries (all infants, live born) in an OOH setting. Deliveries where a death happened will be recorded in a separate section as will deliveries where one or more infants are live born in a hospital. [Discussion needs to be had on whether to collect data on multiple deliveries in an entirely separate section.](#)

Section G Antepartum Transfer, elective:

- [Add greater than 42 weeks and less than 37 weeks.](#)

Section H Antepartum Transfer of Care, urgent

- ~~Line 52 *Fetal Demise*~~: remove to Section X
- Add [Less than 37 0/7 gestation in active labor or with rupture of membranes.](#)

Section I Intrapartum transfer of care, elective

- Line 64 *Multiple Gestation*: Remove wording “NO BABIES DELIVERED PRIOR TO TRANSFER”
Note: We need to capture the outcomes in the outcomes section. Discussion needs to be had on whether to collect data on twin deliveries in an entirely separate section.

Section J Intrapartum transfer of care, urgent

- Line 76: *Multiple Gestation*: Remove wording – “AT LEAST ONE BABY HAS BEEN DELIVERED OUT-OF-HOSPITAL” Note: We need to capture the outcomes in the outcomes section. Discussion needs to be had on whether to collect data on multiple deliveries in an entirely separate section.

Sections K, L, M, N no recommended changes

Section O Birth Outcomes after transfer of care:

- Wording change in directions “Lines 116-131: For any mother or infant who transferred care as reported in section I, J, K, L, M and N, from the licensed midwife to another healthcare provider, please provide the outcome information regarding the mother and the infant in the spaces provided. Deaths will be reported in a separate section”.
- Lines 119 *Death of mother*: Capture data in Section X
- Line 126 *Fetal demise diagnosed prior to labor*: Capture data in new Section X
- Line 127 *Fetal demise diagnosed during labor or at delivery*: Capture data in new Section X
- Line 128 *Live born infant who subsequently died*: Capture data in new Section X
- Make it clear that this Section O is for morbidity only. Mortality will be captured **ONLY** in Section X.

The following categories need to be added to Section O (or perhaps separate sections) to capture information on multiple gestation and breech deliveries

- Multiple gestation deliveries Discussion needs to be had on whether to collect data on multiple deliveries in an entirely separate section.
 - Columns for
 - Number of infants
 - Number born prior to transfer (needs pop up that says if all infants born OOH without transfer this section should be skipped)
 - Number born after transfer
 - Presentation for each infant (Note: one may be vertex and another breech)
 - Mode of delivery for each infant
 - Retain wording from lines 117, 118, 120, 121, 122, 124, 125, 129, 130, 131 for outcomes
- Breech deliveries Discussion needs to be had on whether to collect data on breech deliveries in an entirely separate section.
 - Columns for
 - Number of infants (needs pop-up that says if greater than 1 report a multiple gestation)
 - Mode of delivery
 - Retain wording from lines 117, 118, 120, 121, 122, 124, 125, 129, 130, 131 for outcomes

PROPOSED Section P Vaginal Birth After Cesarean (completely restructured) *(naming/numbering of this section can be changed if desired) (how do we record a VBAC that was breech or multiple gestation?)*

- Eliminate current questions to be reported in Section X
- Use this Section to capture VBAC information only, as follows
 - Number of planned OOH VBACs at onset of term labor or term rupture of membranes
 - Number of completed VBACs OOH
 - Number of completed VBACs after transfer to hospital
 - Number of cesarean sections after transfer to hospital
 - Number of diagnosed uterine dehiscence and outcome (morbidity only, deaths captured in Section X)
 - Number of diagnosed uterine ruptures and outcome (morbidity only, deaths captured in Section X)
 - Consider capturing data on: VBAC after one prior CS and VBAC after more than one prior CS, specifying number of previous CS deliveries.
- Complications leading to death related to VBAC will be captured in Section X

Section X Maternal, fetal and infant mortality completely new section

The entirety of this section requires discussion and fine tuning of questions to capture all of desired data

This new section will capture all deaths; fetal, neonatal and maternal. **Each death will be recorded individually**, not as an aggregate. This allows for all of the details of each death to be individually gathered. No data regarding the death of a mother or an infant will be entered elsewhere on this form. A summary of captured data is included here, all components (cause, OOH, after transfer) are collected as they have been previously. (A pop-up definition of fetal death OOH: lack of heart tones, OOH by midwife, constitutes fetal death OOH; lack of heart tones, discovered only after transfer, constitutes fetal death after transfer)

1. Pregnancy losses (from any cause) prior to 20 completed weeks of gestation with a place to enter the exact number of gestational weeks for each demise. *(could be separated into SAB/TAB/TAB for medical indication or fetal anomaly if desired, though not necessary).*
2. Fetal demise(s) prior to onset of labor or after rupture of membranes without labor, from 20 0/7 weeks gestation up to and including 36 6/7 weeks gestation (pre-term) with a place to enter the exact number of gestational weeks for each demise.
3. Fetal demise(s) prior to onset of labor or rupture of membranes without labor, after 37 0/7 weeks gestation (term) with a place to enter the exact number of gestational weeks for each demise.
4. Fetal demise(s) during labor between 20 0/7 weeks gestation and 36 6/7 weeks gestation (pre-term) with a place to enter the exact number of gestational weeks for each demise. *(While LMs should not be intentionally caring for these women there is the possibility that an LM would go check on a woman that meets this criteria and find both active labor and a demise. Variables re place of death, place of labor and birth, etc. should be collected).*
5. Fetal demise(s) during labor after 37 0/7 weeks gestation (term) with a place to enter the exact number of gestational weeks for each demise.
6. Neonatal (presumes live born infant) deaths prior to the 7th day of extra-uterine life with a place to enter the exact number of days of life for each death.
7. Neonatal (presumes live born infant) deaths from day 7 to day 28 of extra-uterine life with a place to enter the exact number of days of life for each death.

8. Maternal deaths (*Definition: death of mother as a result of pregnancy; while pregnant or within 42 days of the end of a pregnancy*). Collect cause of death and age of mother as well as age of gestation if still pregnant at time of death or number of days after end of pregnancy if mother is not pregnant at time of death.
9. Fetal demise(s) (of any category) diagnosed prior to labor by a physician who were subsequently delivered OOH by the LM on maternal request (*This information is captured for each death, rather than as an aggregate eliminating duplicate data entries, as woman enters data for the demise*).
10. Whether death of fetus or infant was attributable to diagnosed anomalies incompatible with life.
11. Information on VBAC that resulted in the death of a mother or an infant, specifically, but not limited to, uterine rupture leading to death.
12. Complications contributing to deaths of mother or infant.
13. Place of death, OOH or after transfer.