Licensed Midwife Annual Report
Task Force Report
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Following are recommendations from the Midwifery Advisory Council Task Force for adjustments to the Licensed Midwife Annual Reporting (LMAR) Tool.

The overall recommendation of this task force is to seek legislative change to permit moving data collection for Licensed Midwives to the Midwives Alliance of North America (MANA) Department of Research statistical database. Reasons for this move have been delineated in former reports to this council and to the Board as a whole, however, it is important to review the main advantages of the MANA system. First among them is that the MANA Stats reporting tool was designed by those with knowledge of how to collect data from midwives. Additionally, it has a dedicated staff of researchers, computer coders and others working to make sure it continues to be the best tool of its kind. MANA employs 'data doulas' to verify data reported to them when the data reported includes a death of a mother or a baby. This is done, not to change what is reported, but rather to verify that the midwife reporting the data did in fact, intend to report a death. The information is verified by phone and the data is changed only if it is an error. However, the original data remains and can be accessed should a researcher want to further verify what has been reported. A number of other states have already made the choice to capture data using MANA Stats and that number is growing. It is a good fit because the MANA data collection is gathered in a prospective manner rather than a retrospective (how the LMAR functions) one. Prospective data collection is the gold standard in scientific research and should be what is used in California.

Unfortunately, a move of this nature cannot be accomplished without legislation. So in order to expedite the improvement of the data we are gathering, this task force submits the following items for review and incorporation, either in part or in total, into the current LMAR.

General Recommendations:

- Confine all information regarding deaths in a separate section (see Section X 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
- Recommend delineating number of transfers of care by primip and multip; since primips will have a higher rate of transfer, especially intrapartum.
- 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. Recommendation: allow zeros to be inserted and remove the button. This would require that reporters read each definition 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. Recommendation: allow 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. Those comments should be included in the final report unless they could identify either the reporter or the client.

- ✓ Midwives should be encouraged to enter data as it occurs, over the course of the reporting year. The reporting device would need to be changed to accommodate this.

Specific Recommendations, by section, as follows:

Section D Client Services:

- Line 14 *Number of clients who left care for non-medical reasons.*
  - Recommendation: Change wording to "Number of clients who were either lost to care or who left care for non-medical reasons (definition of lost to care: clients who never returned for appointments despite efforts to contact them)"
- Line 15 *Total number of clients served whose births were still pending on the last day of the year.*
  - Recommendation: Remove. It serves no purpose, is not required by statute, and confuses the numbers
- Line 16 *Collaborative Care.*
  - Recommendation: Change (secondary to change made by AB 1308) to number of times referrals were made (acknowledge that it might be more than one referral per client) and include the reasons for each referral from the list currently being developed in regulation. This may need to be incorporated in coming years pending the adoption of the regulation implementing AB 1308.
- Line 17 *Supervision.*
  - Recommendation: Remove this line secondary to change made by AB 1308

Section E Outcomes per county in which 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 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) delivered after transfer of care
  - ✓ Number of low birth weight, term, infants (Definition: under 2500 grams/5# 8oz). Delineate between Out of Hospital Births (OOH) and in hospital after transfer.
  - ✓ Number of live preterm births completed out of hospital (before 37 0/7 weeks gestation)

Section F Outcomes of Out of Hospital Births (OOH)

- Line 19 and 20 no change
- Line 21 *Breech*: split to delivered OOH and delivered after transfer (it should be recognized that occasionally breech babies will be born with an LM in attendance secondary to precipitous, undiagnosed breech) Include mode of delivery after transfer and outcome and collect data for each individual breech.

- Line 22 *VBAC*: Remove and create a separate section for VBAC. See notes for Section P
- Line 23 *Twins*: collect individual data on both delivered OOH along with outcome and mode of delivery after transfer, one delivered OOH and outcomes for both, and transferred for both with outcomes
- Line 24: *Higher Order Multiples*: collect individual data on all delivered OOH along with outcomes and mode of delivery after transfer, one delivered OOH and outcomes, more than one delivered OOH and outcomes, and transferred for all with outcomes.

Section G Antepartum Transfer, elective: no changes currently but may need to be adjusted based on the upcoming regulations for consultation with a physician.

Section H Antepartum Transfer of Care, urgent

- Line 52 *Fetal Demise* - Recommendation: remove to Section X

Section I Intrapartum transfer of care, elective

- Line 64 *Multiple Gestation* - Recommendation*:* Remove, data captured in Section F (this eliminates duplicate data)

Section J Intrapartum transfer of care, urgent

- Line 76: *Multiple Gestation* - Recommendation*:* Remove, data captured in Section F (this eliminates duplicate data)

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. Data in this section relates only to morbidity. 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. Deaths will be captured **ONLY** in Section X.

Section P Vaginal Birth After Cesarean (completely restructured) *(naming/numbering of this section can be changed if desired. Suggested section name:Section V for VBAC)*

- Eliminate current questions in favor of Section X
- Use this Section to capture VBAC information only, as follows
    - Enter information on each VBAC/attempted VBAC individually. This will allow for better understanding of which VBACs are more likely to be successful out of hospital.
    - This section only applies to women planning OOH VBAC at onset of term labor or term rupture of membranes
    - Number of prior cesareans for this woman
    - Number of prior vaginal births for this woman

    - Completed VBAC OOH or after transfer to hospital
    - Cesarean section after transfer to hospital
    - Diagnosed uterine dehiscence and outcome (morbidity only, deaths captured in Section X
    - Diagnosed uterine rupture and outcome (morbidity only, deaths captured in Section X)
- Complications leading to death related to VBAC will be captured in Section X

Section X Maternal, fetal and infant mortality *(naming/numbering of this section can be changed if desired)* 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, 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 7^{th} 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. Consider collecting mode of delivery if delivered prior to death.
9. Fetal demise(s) (of any category) diagnosed prior to labor by a physician where the woman subsequently delivered OOH, attended by the LM, on maternal request (*This information is captured for each death, rather than as an aggregate eliminating duplicate data entries*)
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 uterine dishesience or uterine rupture.
12. Complications contributing to deaths of mother or infant
13. Place of death, OOH or after transfer