

Licensed Midwife Annual Report
Task Force Report
Submitted by Diane Holzer and Carrie Sparrevohn
Finalized 12-1-2017

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, the task force made 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 as well as the input from the interested parties meeting held November 28, 2017.

This report uses colored type and strike through to delineate between recommendations (blue type) for additions and recommendations for removal of wording. We have purposely not included a discussion on how to implement these changes as the staff writing the code will come up with how, exactly, to make the collection tool work for the recommended changes. We recommend all changes be coordinated with OSHPD and reviewed by the task force prior to implementation 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

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 the 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.
 - ✓ Number of live births after 42 0/7 weeks. 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 Deliveries*: Number of completed breech (live born) deliveries in an OOH setting without subsequent transfer. Number of completed breech (live born) deliveries in an OOH setting with subsequent transfer. Number of breech deliveries (live born) after transfer. Number of breech deliveries (live born) delivered by cesarean section. Collect outcomes for each category using wording from Section O – Birth Outcomes after Transfer of Care.
- 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 twin (live born) deliveries where both infants were delivered in an OOH setting without subsequent transfer. Number of completed twin (live born) deliveries where one infant was delivered in an OOH setting with transfer for delivery of second infant. Number of completed twin (live born) deliveries where both infants were delivered after transfer. Collect outcomes for each category using wording from Section O – Birth Outcomes after Transfer of Care, and include mode of delivery after transfer and whether or not any of the infants were breech presentation delivered vaginally.
- Line 24: *Multiple births other than twin births* - Number of completed multiple (live born) deliveries where all infants were delivered in an OOH setting without subsequent transfer. Number of completed multiple (live born) deliveries where one (or more) infants were delivered in an OOH setting with transfer for delivery of additional infants. Number of completed multiple (live born) deliveries where all infants were delivered after transfer. Collect outcomes for each category using wording from Section O – Birth Outcomes after Transfer of Care, and include mode of delivery after transfer and whether or not any of the infants were breech presentation delivered vaginally.

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 with rupture of membranes.](#)

Section I Intrapartum transfer of care, elective:

- [Add greater than 42 weeks and less than 37 weeks in labor.](#)
- Line 64 *Multiple Gestation*: Remove as situation and outcome will be collected in Section F

Section J Intrapartum transfer of care, urgent:

- [Add greater than 42 weeks and less than 37 weeks in labor.](#)
- Line 76: *Multiple Gestation*: Remove as situation and outcome will be collected in Section F

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.

PROPOSED Section P Vaginal Birth After Cesarean (completely restructured)

- [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 ruptures and outcome \(morbidity only, deaths captured in Section X\)](#)
 - [VBAC after one prior CS and VBAC after more than one prior CS, specifying number of previous CS deliveries.](#)
 - [Number of women who had a prior vaginal delivery, either before or since cesarean delivery](#)
- [Complications leading to death related to VBAC will be captured in Section X](#)

Section X Maternal, fetal and infant mortality completely new section:

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. While LMs should not be intentionally caring for women prior to 37 0/7 weeks gestation and after 41 6/7 weeks gestation there is the possibility that an LM would go check on a woman that meets this criteria and find active labor and/or a demise. Variables re place of death, place of labor and birth, etc. should therefore be collected. Definitions:

Fetal death: lack of fetal heart tones after 20 weeks gestation - OOH by midwife, constitutes fetal death OOH; lack of heart tones discovered only after transfer, constitutes fetal death after transfer.

Neonatal death – World Health Organization (WHO) definition is live birth to day 28 of extra-uterine life. Can be divided into early neonatal death – occurring in first 7 days and late neonatal – day 8 to 28.

Neonatal death rate: is number of infants dying in first 28 days per 1000 live births.

Maternal death: death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes.

Pregnancy related death: (not used here but included for purposes of clarity in this presentation) but a WHO designation to facilitate the identification of maternal deaths in circumstances in which cause of death attribution is inadequate, a new category has been introduced. Pregnancy-related death is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death.

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.
2. Fetal demise(s) prior to onset of labor or after rupture of membranes without labor AND (collect separately) after the onset of 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 AND (collect separately) after the onset of labor, between 37 0/7 weeks gestation up to and including 41 6/7 weeks gestation (term) with a place to enter the exact number of gestational weeks for each demise.
4. Fetal demise(s) prior to onset of labor or rupture of membranes without labor AND (collect separately) after the onset of labor, after (and including) 42 0/7 weeks gestation (post term) with a place to enter the exact number of gestational weeks for each demise.
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. Early Neonatal (presumes live born infant) deaths from birth through the end of the 7th day of extra-uterine life (days 0-6) with a place to enter the exact number of days of life for each death.
7. Late Neonatal (presumes live born infant) deaths from day 7 through the end of day 27 of extra-uterine life with a place to enter the exact number of days of life for each death.
8. Maternal deaths 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 .
10. Whether death of fetus or infant was attributable to diagnosed anomalies incompatible with life.
11. Information on mode of delivery (breech, vertex, cesarean, vaginal, VBAC, multiple birth (twins and higher order multiples).
12. Place of death, OOH or after transfer.
13. County death occurred in.
14. Use coding from Section P for complications leading to maternal and fetal/infant deaths, add uterine rupture to current list.