



## **New York State Birth Registrar Survey Report**

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And

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## EXECUTIVE SUMMARY

Birth records have important legal, administrative, public health, and program uses. Public health applications include the use of birth records to conduct population-based surveillance, research, and program planning and evaluation, to identify risk factors, measure health outcomes, monitor progress toward achieving state and national maternal, infant, and child health goals. In the area of Medicaid managed care, hospital birth data is used to assess risk-adjusted differences in prenatal care and birth outcomes across plans. Thus, the accurate and complete collection of vital birth data is a priority for the New York State Department of Health (NYSDOH).

In order to identify potential barriers in the current practices of birth data collection in New York birth facilities and opportunities for improvement, the New York State Department of Health's Office of Quality and Patient Safety, Vital Statistics Unit, with the support of the Department's Bureau of Vital Records and Division of Family Health and the New York City Department of Health and Mental Hygiene's Bureau of Vital Statistics, collaborated with IPRO to conduct the New York Birth Registrar Survey. The results of this statewide survey are summarized in this report with recommendations based on the findings.

The purpose of the survey was to assess the environment, potential barriers, and current support for birth record reporting based on the experience and expertise of New York State's birth registrars (BRs). This survey represents an initial effort and baseline information to better understand potential areas for improvement across all birthing facilities in the state, in general, and by region. While the extent to which these factors directly affect birth record data quality is not currently known, it is anticipated that these findings will be highly beneficial to state and jurisdictional policy makers and individual birthing facilities as they work to address the staffing, education and training, communication, and electronic and hospital systems changes needed to support data quality improvement.

### Summary of findings

A total of 127 birthing facilities in the state were surveyed. The survey was directed to the individual responsible for collecting and reporting information for electronic birth registration, and referred to as the birth registrar (BR). The response rate was 85%, with 108 BRs submitting completed surveys. Four partial survey responses were also included in the analyses for questions 1 through 18, making the adjusted response rate for this part of the survey 88%. Major findings based on these responses were:

- The hospital department where the majority of BRs reported working is nearly evenly divided between Maternity Ward/Labor and Delivery (45%) and Medical Records/File Room (42%), while the rest reported being a part of a different department in their facility.
- Nearly three-quarters (74%) of BRs stated that a medical/clinical background or training is not required for their position, 70% reported the need for continuing education and training, and a

majority of open-ended responses throughout the survey indicated a substantial need for training for BRs, including in medical terminology relating to births. Almost half (47%) reported that their facility does not provide formal training for BRs.

- Limited steps are taken to improve the accuracy and completeness of information for birth registration. Around one-third of BRs (31%) reported that their facility does not have a single person or unit dedicated to confirming the accuracy or completeness of birth data. Adding to this, open-ended responses indicated that in some institutions no one other than the BR checks the accuracy and completeness of the data collected by the BR.
- Similarly, only 41% reported that BRs meet regularly with medical and clinical staff, 22% conduct audits to compare birth registration data to medical records, 36% provide continuing education and training opportunities to improve data quality, 23% identified the need for improved hospital electronic data systems, and 29% mentioned that prenatal records are unavailable or incomplete. Over one-fifth (22%) of BRs reported that quality control activities to ensure accuracy and completeness of birth data are not performed in their facility.
- Barriers to completing birth registration are common and widespread. For example respondents agreed or somewhat agreed: medical and clinical staff do not provide complete information in their notes and charts (74%); birth data is located across several systems (79%); different data sources contain conflicting data (53%); there is a need for continuing education and training (71%); staff resources are inadequate (30%); recorded information is not legible (54%); prenatal records are unavailable or incomplete (64%); there is a need for improved hospital electronic data systems (42%), electronic birth systems help tables and/or documentation is inaccurate or out of date (19%), and electronic birth systems edits checking features are not effective (27%) .
- An overwhelming majority of BRs (> 90%) use hospital electronic databases, prenatal records, and doctor's notes to gather information to register a birth. An analysis of open-ended responses from BRs suggests that prenatal records and doctor's notes were identified as the main source of inaccurate and incomplete data throughout the survey. The median number of sources utilized by BRs for birth registration was 4.
- BRs reported significant efforts to help the mother fill out the parent's information as well as acknowledgement of paternity (AOP). Moreover, 79% indicated that parents' information is usually or always reviewed for completeness.
- Delivery records and prenatal records (ACOG antepartum record forms) emerged as frequently cited primary and secondary sources of clinical birth data for most clinical elements, while admission history and physical records and newborn admissions and discharge records were often cited as secondary sources.
- Previous low birthweight, date of last menses, previous preterm delivery, and gestational hypertension were identified as the most difficult data elements to capture for birth registration. Date of last menses was also listed as an element for which there are frequent conflicts among data sources.
- The survey indicates that there is the need for improved clinical knowledge and instructions with regard to birth record coding. When asked about coding for fetal presentation, occiput posterior, occiput transverse, and occiput anterior were correctly indicated as Vertex by only 42,

29, and 41% of BR, respectively, while compound and transverse were correctly indicated as “Other” for only 32 and 33%, respectively. Coding as “Unknown” accounted for 28–31% of all coding for the fetal presentation types surveyed.

- Ongoing education for BRs, especially in medical and clinical terminology, as well as increasing the education for and requirement of clinical staff to report complete birth data were identified as the top suggestions from BRs.
- According to the BRs, induction of labor, low birthweight, date of last menses, congenital abnormalities, preterm labor, prolonged labor, and indications for C-section, among others, were identified as specific elements that BRs and clinical staff require more training on.

## Conclusion

Birth registrars in 112 facilities reported significant efforts within their own facility by the NYSDOH to support the collection and reporting of complete and accurate data for electronic birth registration. However, the results of the survey show that barriers and limitations exist on many levels that may impair the ability of NYS birthing facilities to report complete and accurate birth records. Survey respondents identified lack of quality control measures, limited contact with medical and clinical staff, the need to glean clinical information from multiple sources, incomplete and conflicted data sources, and the need for continuing education and training as important areas of concern and opportunities for improvement. Such quality control and assurance measures may or may not directly affect reporting of birth data; however, they can be highly beneficial in ensuring the collection of accurate and complete birth data, suggesting that this is a point of potential improvement at the hospital, or even state level.

## Summary of recommendations

Based on the findings of this survey, IPRO suggests that the NYSDOH encourage facilities to develop and enact policies to improve clinical staff compliance in providing accurate and complete birth data as well as increase interaction between clinical staff and BRs. Findings suggest that NYSDOH should focus on delivery records and prenatal records (ACOG antepartum record forms) to improve accuracy and completeness of birth data. Increasing ongoing education for BRs and Labor and Delivery nurses about the collection of accurate and complete birth data and about medical terminology regarding birth, as well as increasing awareness of coding rules for fetal presentations are also potential areas of improvement based on survey findings.

## INTRODUCTION

In New York State, vital birth records are reported by two separate jurisdictions: the New York State Department of Health (NYSDOH) and the New York City Department of Health and Mental Hygiene (NYCDOHMH). The NYCDOHMH birth registration process has been incorporated into the Electronic Birth Registration System (EBRS) as part of New York City's Electronic Vital Events Registration System (EVERS). The NYSDOH birth registration process is incorporated into the Statewide Perinatal Data System (SPDS) for electronic reporting of births outside of New York City. NYSDOH has the responsibility for annual statewide reporting of vital statistics governed by the terms of a memorandum of understanding between the two jurisdictions.

As an essential part of the monitoring and evaluation of quality perinatal healthcare, the NYSDOH has made the accurate and complete collection of vital records birth certificate data a priority. A study of the validity of New York State birth certificate data reported in 1999 revealed an opportunity for improvement in the accuracy of reporting for some data elements.<sup>1</sup> The New York State and City health departments have developed specific tools, including the NYSDOH-2184E Work Booklet and the NYCDOHMH-VS203 and VS204 Worksheets, to facilitate standardized birth data collection to improve accuracy and completeness of information collected at birthing facilities. Despite efforts to standardize data collection, there is a persistent need to improve the accuracy and completeness of birth data being collected in the state, as evidenced by a recent re-evaluation of New York State birth certificate data accuracy that demonstrated ongoing opportunity for improvement (report in progress).

In order to understand the current birth registration practices in birthing facilities to help create more accurate and complete birth records, the New York State Department of Health's Office of Quality and Patient Safety, Vital Statistics Unit, with the support of the Department's Bureau of Vital Records and Division of Family Health and the New York City Department of Health and Mental Hygiene's Vital Statistics Bureau, collaborated with IPRO to conduct the New York Birth Registrar Survey. The survey was conducted in August 5–23, 2013. The results of this statewide survey are summarized in this report with recommendations based on the findings.

## METHODS

For the purpose of the survey, a birth registrar (BR) was defined as “the person responsible for collecting and reporting information for electronic birth registration, not necessarily the staff who does the actual data entry.” A pilot survey instrument was developed by a committee including representation from New York State Department of Health (NYSDOH) and IPRO, and with input from the New York City Department of Health and Mental Hygiene (NYCDOHMH). The survey instrument was tested with two BRs representing birthing facilities in New York City and two BRs representing facilities in the rest of state (ROS), whose contact information was provided by the NYSDOH, and who were asked specifically to comment on the clarity and relevance of each survey question. Based on the comments received for the pilot survey, the final version of the New York Birth Registry Survey was developed in collaboration with the NYSDOH (**Appendix A**).

A list of facilities with birthing services and their BRs was obtained from the NYSDOH, along with a list of obstetrics (OB) directors, and Regional Perinatal Center Coordinators (RPCs) in the state. Following an email to the BRs, OB directors, and RPCs introducing the upcoming survey (**Appendix B**), the list of BRs was updated to reflect recent changes in the facilities and correct contact information for each facility using the bounced and undeliverable emails. A letter from the NYSDOH Director of Vital Records, in support of the survey was also attached to this introduction email to further inform the interested parties about the purpose of the survey (**Appendix C**).

The finalized list of 127 BRs, each representing a single birthing facility, received an invitation email with a link to the online survey unique to their email address. SurveyMonkey,<sup>2</sup> a third-party online survey service, was used to administer the survey and track responses. BRs were informed that they could opt out of SurveyMonkey correspondence, as per commercial email server requirements, and those who opted out were provided a link to the survey via email to fill out the survey. While the survey was active, at the beginning of each week, BRs who had not responded or had not submitted a complete survey were sent a reminder by IPRO via SurveyMonkey or email. The initial deadline, which was August 16<sup>th</sup>, was extended to August 23<sup>rd</sup> to maximize the response rate. On August 20, 2013, the NYSDOH, with the help of the appropriate RPCs, sent an additional reminder to the facilities and BRs of incomplete surveys. On August 23, 2013, the survey was closed to responses. On August 28<sup>th</sup> and 29<sup>th</sup>, attempts were made to re-contact 12 BRs who completed the survey to clarify some of their responses in the survey for quality control. Eight were re-contacted and they confirmed or revised their responses. The other four BRs did not respond to attempts to re-contact them, and their survey responses were left unchanged. On September 4, 2013, survey data were finalized for analysis taking into consideration the submitted revisions.

## RESULTS

### Survey responses and response rate

A total of 105 completed responses were received by August 23<sup>rd</sup>. New York Presbyterian Columbia University and Weill Cornell Medical Center submitted a single survey, which was given a weight of 2, while all other responses were weighted at 1. Two of the four pilot survey responses were also added to the final sample; the two birth registrars (BRs) were asked to answer an additional question (question 4) via email to complete their responses for the final version of the survey. As a result, the number of complete responses included in the analyses was 108 (**Appendix D**). Accordingly, the response rate was 85%. Four additional institutions responded to the bulk of the survey up to question 19; thus, the responses to questions 1 through 18 from these partially completed surveys were also included in the analyses, bringing the total to 112 for the first 18 questions. The adjusted response rate for the first 18 questions was 88%.

### Location of birth registrars within birthing facilities

In order to understand which hospital departments are most frequently involved in electronic birth registration, the BRs were asked to indicate their departmental location within the birthing facility. As shown in **Table 1**, 45% of BRs indicated that they are located in the Maternity Ward/Labor and Delivery, while 42% indicated that they work in the Medical Records/File Room. None of the BRs indicated the Billing Office as their location, which was the third explicit choice for this question in the survey; however, using the open-ended “Other” choice, 7% of BRs indicated that they are located in Admitting or Patient Admitting, and another 4% in Patient Access or Patient Access Services.

**Table 1. Location of birth registrar**

Q5: In which department in your hospital is the Birth Registrar located? (n = 112)	
Name of department	Percent of facilities*
Maternity Ward/Labor and Delivery	45%
Medical Records/File Room	42%
Billing Office	0%
Other – Admitting	7%
Other – Patient Access	4%
Other – Miscellaneous	3%

\* Percent total is greater than 100% due to rounding.

### Current training for BRs

In order to gauge the current practices in training BRs for electronic birth registration, the BRs were asked whether a medical or clinical background or training was required for their position (Q6). Only 26% of BRs indicated that training was required for the BR position. When asked whether their hospital provides formal training for the BR and other employees directly involved with collecting and reporting information for birth registration (Q7), 53% indicated that a formal training was indeed provided (**Table 2**).

**Table 2. Current training for electronic birth registration**

Q6: Is a medical or clinical background or training required for the Birth Registrar position?	
n = 112	Percent of facilities
Yes	26%
No	74%
Q7: Does your hospital provide formal training for the Birth Registrar and other employees directly involved with collecting and reporting information for birth registration?	
n = 112	Percent of facilities
Yes	53%
No	47%

In open-ended responses, the BRs who indicated that their institution requires a medical or clinical background or training for the BR position in response to Q6 mentioned requirements such as knowledge of medical coding and/or medical/clinical terminology, and computer literacy, as well as training by an RN or as an RN, HIM (Health Information Management)/medical office training or experience, and taking the Civil Service Test. The BRs in institutions that provide formal training (Q7) described the contents of the training as medical coding, periodic medical meetings, official DOH training, EVERS and SPDS training, training on collecting, entering, and retrieving birth information. Most responses described the training as a part of the regular orientation for new hires or on-the-job training usually by previous or existing BRs or supervisors, followed by ongoing training as needed.

### Accuracy and completeness of birth registration data

Accuracy and completeness of birth registration data depends on the resources and activities dedicated to the specific functions of collecting and recording data accurately as well as performing various quality assurance activities that find and correct inaccuracies and incomplete records. For all of these functions to operate smoothly, having a designated unit or individual whose role is to confirm accuracy and completeness of these data may be beneficial. In fact, 69% of BRs indicated that there is a designated unit or specific individual for this purpose in their hospital, while 31% reported that such a unit or person did not exist in their facility (**Table 3**). In open-ended responses, BRs indicated that individuals, such as Admitting staff, Health Information Manager (HIM), clinical staff, and Medical Records staff, confirm the accuracy and completeness of birth information. However, about half of the responses indicated that the BR is the only person checking the accuracy and completeness of the birth registration data.

Regarding various activities that ensure the accuracy and completeness of the information for birth registration, the survey results indicated limited efforts are being made. Less than half (41%) of BRs indicated that meetings are held between medical/clinical staff and the BR to address birth data that are missing or inconsistent, and only 36% confirmed that continuing education and/or training opportunities are provided to improve data quality (**Table 3**). In addition, fewer than one-quarter (23%) of BRs indicated that a supervisor or manager reviews data prior to or following entry into the electronic birth registration system, and only 22% reported that audits are conducted to compare birth registration data with medical record data for a sample of births. Similarly, one-fifth of the BRs (22%) reported that no

quality control and assurance activity was being performed at their institution at the time of the survey (Table 3).

**Table 3. Specific person/unit and activities for accuracy and completeness of birth registration data**

Q8: Does your hospital have a designated unit or specific individual whose role is to confirm the accuracy and completeness of the information collected and reported for birth registration?	
n = 112	Percent of facilities
Yes	69%
No	31%
Q9: Which of the following are performed to improve the accuracy and completeness of the information for birth registration?	
n = 112	Percent of facilities*
Meetings are held between medical/clinical staff and the Birth Registrar to address birth data that is missing or inconsistent	41%
Continuing education and/or training opportunities are provided to improve data quality	36%
Supervisor or manager reviews data prior to or following entry into the electronic birth registration system	23%
Audits are conducted to compare birth registration data with medical record data for a sample of births	22%
None	22%
Other	22%

\* For Q9, respondents were asked to choose all that apply and/or use the open-ended response.

In order to further understand the barriers to completing electronic birth registration, the BRs were asked to indicate their level of agreement with ten statements (Table 4). Reported barriers were common and widespread. Seventy-nine percent of BRs agreed or somewhat agreed that birth data are located in multiple systems and/or obtained from multiple sources, and over half agreed or somewhat agreed that conflicting birth data information is contained in different sources. Regarding specifically these different sources, 74% of BRs agreed or somewhat agreed that medical/clinical staff do not provide complete information in their notes and charts, and 64% agreed or somewhat agreed that data from the mom's prenatal records are unavailable or incomplete. Related to data sources, over half of the BRs agreed or somewhat agreed that the information recorded in the forms is not legible. Not surprisingly, 71% of BRs agreed or somewhat agreed that there is a need for continuing education and training.

**Table 4. Barriers to completing electronic birth registration**

Q10: Please indicate your level of agreement with the following barriers to completing electronic birth registration:					
n = 112*	Agree	Somewhat Agree	Neither Agree Nor Disagree	Somewhat Disagree	Disagree
Medical/clinical staff do not provide complete information in their notes and charts	46%	28%	3%	10%	13%
Birth data is located in multiple systems and/or obtained from multiple sources	58%	21%	4%	9%	9%
Conflicting birth data information is contained in different sources	26%	27%	9%	9%	29%
There is a need for continuing education and training	37%	34%	16%	4%	10%
Staff resources are inadequate	13%	18%	22%	13%	35%
There is a need for improved hospital electronic data systems	23%	19%	21%	13%	24%
Information recorded in the forms is not legible	16%	38%	12%	8%	27%
Data from the mom's prenatal records is unavailable or incomplete	29%	35%	6%	13%	17%
Electronic birth reporting system help tabs and/or documentation are inaccurate or out of date	10%	9%	33%	13%	36%
Electronic birth reporting system edit checking features are not effective	9%	18%	26%	10%	38%

\* Percent total may not equal to 100% due to rounding.

An even distribution of BRs was observed regarding the need for improved hospital electronic data systems, as 42% agreed or somewhat agreed, 21% neither agreed nor disagreed, and 37% disagreed or some disagreed. A similar even distribution was observed regarding the inadequacy of staff resources, although more (48%) BRs disagreed or somewhat disagreed that staff resources are inadequate than the 31% who agreed or somewhat agreed (**Table 4**). In addition, more BRs disagreed or somewhat disagreed that the electronic birth reporting system help tabs and/or documentation are inaccurate or out of date and the edit checking features are not effective. Nineteen percent of BRs agreed or somewhat agreed that the help tabs are inaccurate or out of date, and 27% found the edit checking features ineffective.

Birth registrars were also given the opportunity to describe other barriers to completing electronic birth registration (**Appendix E**). In the open-ended responses that discussed additional barriers, language issues and limited English proficiency (LEP), availability of patients or patient records, existence of prenatal care (e.g., for Amish patients) or access to prenatal care records, or the ability of patients to recall prenatal information were described as barriers. BRs also described SPDS/computer/hospital electronic system downtime and inability to access entered data in a timely manner as a barrier to completing birth registry. A few responses indicated that physicians are not readily available for questions and signatures regarding birth data, and sometimes deliberately choose "Unknown" to avoid liability. Overall, timeliness and language issues were the main barriers to completing the electronic birth registration discussed in the open-ended responses.

As seen in **Table 4**, 79% of BRs indicated that birth registration data are located in multiple sources and over half of them also indicated that these sources contain conflicting information. In order to gain more

insight into birth data collection, the BRs were asked what sources of information are used to gather data for birth registration (Q11) and how many different sources are required to obtain all the birth information needed to register a birth (Q12). BRs indicated that 93% use hospital electronic databases, 91% use prenatal records, and 90% use doctor’s notes and charts areas (**Table 5**). Thirty six percent of BRs also use charts from various clinical program areas for birth information. In addition, in the open-ended responses describing other sources of information, 17% of BRs (n = 112) indicated that information is collected from the parents or mother with direct interviews and/or using Medicaid or facility worksheets and booklets designed for this purpose. Excluding extreme values, the number of information sources, such as databases, charts, and notes varied among institutions, ranging from 1 to 10, with a median of 4. Thirty (27%) facilities use more sources than the median number of sources.

**Table 5. Types and number of sources used for birth data collection**

Q11: What sources of information are used to gather data for birth registration?			
n = 112	Percent of facilities*		
Hospital electronic databases	93%		
Prenatal records	91%		
Doctor's notes and charts	90%		
Charts from various clinical program areas	36%		
Other – Parents, mom, and/or patient	13%		
Other – Medicaid or facility forms, worksheets, booklets	4%		
Other – Miscellaneous	8%		
Q12: How many different sources of information including databases, charts, notes, and other sources are required to obtain all the birth information needed to register a birth?			
n = 112	Minimum	Maximum	Median
Number of different sources:	1	20	4

\* Respondents were asked to choose all that apply and/or use the open-ended response.

### Parents’ information

As obtaining the parents’ information – including demographic information, race/ethnicity, education, and employment – is required to register a birth, BRs were asked about the current practices in obtaining this information and ensuring accuracy and completeness of the obtained information. In response to Q13, 74% of BRs indicated that they are responsible for obtaining the parents’ information (**Table 6**). In addition, 45% indicated that Labor and Delivery staff is responsible for obtaining this information, while 7% indicated other staff (i.e., birth coordinator, OB technicians, unit secretary, Maternity Unit, Vital Statistics staff) in the list of people responsible for obtaining parents’ information for birth registry. Six percent of the BRs indicated that parents are responsible for obtaining and/or reporting parents’ information for birth registry.

**Table 6. Who obtains the parents' information?**

Q13: Who is responsible for obtaining the parents' information?	
n = 112	Percent of facilities*
Birth registrar	74%
Labor and Delivery staff	45%
Other – Other staff	7%
Other – Parents	6%

\* Respondents were asked to choose all that apply and/or use the open-ended response.

Regarding the method BRs use to collect parents' information (Q14), 83% indicated that the parents' information is recorded on the forms provided by the health department in workbook/worksheet format (**Table 7**). Seven percent of BRs reported that their hospital has developed a separate paper form to collect the parents' information, whereas only 8% indicated that the information is entered directly into an electronic system by staff.

**Table 7. Methods used to collect parents' information**

Q14: What method do you use to collect and record the parents' information?	
n = 112	Percent of facilities*
Parents' information is recorded on the forms provided for this purpose by the health department (workbook/worksheet)	83%
Our hospital has developed a separate paper form to collect the parents' information	7%
Parents' information is entered directly into an electronic system by staff	8%
Other	2%
Q15: How is the parents' information collected at your hospital?	
n = 112	Percent of facilities*
The mother reads and completes a form herself or with the help of the father	88%
Translation services are available as needed	82%
Hospital staff is available to assist the mother while she completes the form independently	79%
Family members, including children and extended family, assist the mother with providing the parents' information	35%
Hospital staff reads through the form along with the mother while she fills it out	35%
Hospital staff reads the form to the mother, and she reports the information to the hospital staff, who completes the form	27%
Other way(s) with which information is collected	11%

\* In Q14, respondents were asked to choose only one response or the open-ended "Other" response, whereas in Q15, respondents were asked to check all that apply and/or use the open-ended response.

BRs were also asked to indicate how the parent's information is collected at their hospital in terms of who fills out the forms and types of staff assistance during this process (Q15). Eighty eight percent of BRs indicated that the mother reads and completes a form herself or with the help of the father, and 79% reported that the staff is available to assist the mother while she completes the form independently (**Table 7**). While 35% of BRs indicated that the hospital staff reads through the form along with the mother as she fills it out, 27% also reported that the hospital staff reads the form to the mother, and she reports the information to the hospital staff, who completes the form. In terms of language barriers to completing the parents' information, 82% of BRs indicated that translation services are available as needed, and 35% indicated that family members, including children and extended

family, assist the mother with providing the parent’s information. In open-ended responses (**Appendix E**), BRs also indicated that they interview the mother or parents directly to obtain information, call mothers to make sure they fill out the forms, and ask if mothers have any questions. In general, explaining the forms and/or asking mothers if they have any questions appear to be a common practice. Forrest Hills Hospital also developed a new brochure, titled “Registering Your Newborn’s Birth” to assist parents in providing information.

Birth registrars were asked to qualify how often the parents’ information is reviewed for completeness before the mother is discharged (Q16). Seventy nine percent of BRs indicated that the parents’ information is always or usually reviewed for completeness, 12% indicated that it was sometimes reviewed, and a total of 9% indicated that it was rarely or never reviewed for completeness (**Table 8**).

**Table 8. Review of parents’ information for completeness**

Q16: Please choose the best option to fill in the blank in this statement: The parents' information is _____ reviewed for completeness before the mother is discharged.	
n = 112	Percent of facilities
always	32%
usually	47%
sometimes	12%
rarely	5%
never	4%

One area of difficulty in collecting parents’ information that is required for birth registry is gathering accurate and complete information about the mother’s ethnicity/race. In order to understand if and how this barrier affects birth registration, the BRs were asked whether they have encountered a list of barriers when trying to collect information concerning the mother’s race, especially as it relates to mothers of Hispanic ethnicity (Q17). Sixty-three percent of BRs indicated that the mother leaves the race field blank or chooses “Other” when asked about her race (**Table 9**). While 7% of BRs reported that the hospital staff is not trained on techniques for collecting information on race and ethnicity, 4% also indicated that their hospital policy is not to inquire the mother’s race or ethnicity. About one-quarter (27%) of the BRs indicated that none of these three barriers are currently relevant to their experience in trying to collect information about the mother’s race. In the open-ended responses, a few BRs stated that some patients are averse to giving out any personal information, while one BR indicated that language issues may prevent some patients from accurately filling out race information. Some BRs explained that Latino or Hispanic mothers do not always know what to fill in for race, or disagree about the definition of race versus ethnicity, or fill out Hispanic for race. One particularly insightful response indicates that even though the families are provided with an explanation for race/ancestry from the DOH, this does not help; mothers of Hispanic ancestry most often choose “Other” as their race.

**Table 9. Barriers in obtaining mother’s race/ethnicity information**

Q17: Have you encountered any of the following barriers when trying to collect information concerning the mother's race, especially as it relates to mothers of Hispanic ethnicity?	
n = 112	Percent of BRs*
Mother leaves the field blank or chooses "other" when asked about her race	63%
Hospital policy is not to inquire about the mother's race or ethnicity	4%
Hospital staff is not trained on techniques for collecting information on race and ethnicity	7%
None of the above	27%

\* Respondents were asked to choose all that apply and/or use the open-ended response.

Acknowledgement of paternity (AOP) is also a part of the birth registration process. When BRs were asked specifically about how their hospital fulfills the oral notification requirement included in the AOP process (Q18), 89% indicated that the hospital staff includes the AOP information with the form used to collect parents’ information (**Table 10**). Only 13% of BRs reported that the hospital staff reads the AOP to parents, and 11% indicated that the staff has parents watch the AOP video. Using the open-ended response option (**Appendix E**), 23% of BRs indicated that hospital staff explains AOP and assists parents in the AOP process, 3% indicated that language and translation support is available to parents regarding AOP and 3% indicated that hospital staff is available to witness the signing of AOP.

**Table 10. Acknowledgement of Paternity**

Q18: How does your hospital fulfill the oral notification requirement included in the Acknowledgement of Paternity (AOP) process?	
n = 112	Percent of facilities*
Hospital staff includes AOP information with form used to collect parents' information	89%
Hospital staff reads AOP to parents	13%
Hospital staff has parents watch the AOP video	11%
Other – Hospital staff explains AOP and assists parents	23%
Other – Language and translation support	3%
Other – Hospital staff witnesses signing of AOP	3%

\* Respondents were asked to choose all that apply and/or use the open-ended response.

### Clinical information

In addition to the collection of parents’ information, the accurate and complete collection of clinical information regarding the birth event and the mother is also essential for effective birth registry. In order to understand how clinical information is collected, the BRs were asked to indicate the primary and secondary (if applicable) source of clinical data elements (Q19; **Table 11**). Delivery record emerged as the leading primary source of clinical information, as it was the top utilized source for 6 out of 10 elements (utilized by 32–75% of BRs as the primary source). Prenatal record (i.e., the ACOG antepartum record forms) emerged as the second leading primary source of clinical information, being utilized as the top source for 4 out of 10 elements (utilized by 36–68% of BRs as the primary source), and second choice for primary source for 2 elements. Likely due to different areas of focus, the delivery record and prenatal record (ACOG) complemented each other; together they were utilized as the primary source of information for all 10 elements by 56–80% of BRs. Admission history and physical was utilized by 11–20% of BRs for 5 out of ten elements (previous C-section, previous preterm delivery, gestational hypertension, clinical estimate of gestation, and date of last menses) and was the second most utilized source at 13% for determining previous preterm delivery. MD’s delivery notes were the second leading

primary source of data for method of delivery, fetal presentations, and induction of labor (AROM); 14–18% of BRs used MD’s delivery notes as a source for these three elements. Interestingly, newborn admit/discharge record was not utilized much as a primary source for any of the elements, except for birthweight, for which 20% of BRs used it as a primary source. Nursing documentation in mother’s record was utilized by only 1–5% of BRs as a primary source for all elements, except 9% of BRs used it as a primary source for induction of labor (AROM) information.

**Table 11. Primary and secondary sources for clinical birth data elements**

Q19: Please indicate the primary and secondary (if applicable) sources of each data element.									
n = 108	Primary Source								
Data element:	Delivery record	Newborn admit/discharge record	Nursing documentation in mother's record	Prenatal record (ACOG)	Admission history & physical	MD's delivery notes	Other notes in record	Other	None
Previous C-section	37%	0%	3%	36%	11%	8%	2%	3%	n/a
Previous low-birthweight birth	9%	1%	3%	66%	7%	6%	4%	5%	n/a
Method of delivery	75%	1%	3%	5%	1%	14%	0%	2%	n/a
Previous preterm delivery	8%	0%	1%	62%	13%	8%	3%	5%	n/a
Fetal presentations	69%	0%	2%	4%	4%	17%	2%	3%	n/a
Induction of labor – AROM	59%	0%	9%	2%	6%	18%	3%	4%	n/a
Gestational hypertension	17%	1%	5%	46%	16%	6%	5%	5%	n/a
Birthweight	64%	20%	3%	2%	1%	6%	2%	3%	n/a
Clinical estimate of gestation	32%	2%	4%	23%	20%	11%	5%	3%	n/a
Date of last menses	3%	0%	5%	68%	11%	5%	4%	6%	n/a
n = 108	Secondary Source								
Data element:	Delivery record	Newborn admit/discharge record	Nursing documentation in mother's record	Prenatal record (ACOG)	Admission history & physical	MD's delivery notes	Other notes in record	Other	None
Previous C-section	8%	2%	8%	25%	19%	18%	8%	3%	8%
Previous low-birthweight birth	2%	3%	9%	17%	31%	4%	11%	3%	20%
Method of delivery	11%	6%	10%	4%	3%	44%	5%	3%	16%
Previous preterm delivery	2%	0%	11%	19%	29%	11%	12%	2%	14%
Fetal presentations	15%	4%	10%	3%	6%	39%	6%	2%	17%
Induction of labor - AROM	18%	1%	12%	5%	3%	38%	8%	1%	15%
Gestational hypertension	6%	0%	12%	23%	27%	8%	10%	2%	11%
Birthweight	19%	31%	11%	3%	4%	12%	5%	1%	14%
Clinical estimate of gestation	12%	15%	9%	17%	17%	12%	6%	3%	10%
Date of last menses	9%	0%	13%	16%	27%	5%	13%	2%	16%

n/a: not applicable; "None" was not included as a choice for primary source.

Admission history and physical exam documentation is utilized for five of the ten elements as the leading secondary clinical information source (**Table 11**). For method of delivery, fetal presentations, and induction of labor (AROM), which are elements that admission history and physical exam documentation is not often utilized as secondary source, MD's delivery notes are utilized by 38–44% of BRs instead. Newborn admit/discharge record is also a leading secondary source for birthweight. Interestingly, 20% of BRs indicated that they do not use a secondary source of information for previous low-birthweight, suggesting that many BRs obtained this information solely and mainly from the prenatal record (ACOG).

Birth registrars were also asked about the ease of finding information regarding these ten clinical data elements (Q20) and their ability to report accurate information about the elements (Q21; **Table 12**). Between 94 and 100% of BRs indicated that it was always or usually easy to find information for previous C-section, method of delivery, fetal presentations, induction of labor (AROM), birthweight, and clinical estimate of gestation with 95–100% of BRs indicating that they are always or almost always or usually able to find this information. The most difficult clinical data element to capture was previous low-birthweight, with one-fourth of the BRs indicating that it is always or usually difficult to find this information, and 11% reporting that they are always or almost always or usually unable to report accurate information for it. Date of last menses information is always or usually difficult to find according to 19% of BRs, and 8% report that they are always, almost always, or usually unable to report accurate information for this element. Thirteen percent of BRs also indicated that it is usually or always difficult to find information about previous preterm delivery, and 7% indicated that they are always, almost always, or usually unable to report this element accurately. Nine percent of the BRs indicate that it is always or usually difficult to find information about gestational hypertension, and 7% indicate that they are always, almost always, or usually unable to report this element accurately.

**Table 12. Ease of finding and ability to report accurate information for clinical data elements**

Q20: Please indicate how easy is it to find information for the following birth registration items: (n = 108)				
Data elements:	Always easy to find	Usually easy to find	Usually difficult to find	Always difficult to find
Previous C-section	51%	44%	5%	1%
Previous low-birthweight birth	27%	48%	22%	3%
Method of delivery	78%	22%	0%	0%
Previous preterm delivery	30%	57%	12%	1%
Fetal presentations	61%	36%	3%	0%
Induction of labor – AROM	46%	48%	5%	1%
Gestational hypertension	44%	47%	8%	1%
Birthweight	69%	30%	1%	0%
Clinical estimate of gestation	64%	32%	4%	0%
Date of last menses	30%	52%	16%	3%
Q21: How would you rate your ability to report accurate information during birth registration? (n = 108)				
Data elements:	Always or almost always able	Usually able	Usually unable	Always or almost always unable
Previous C-section	76%	22%	2%	0%
Previous low-birthweight birth	47%	42%	10%	1%
Method of delivery	87%	13%	0%	0%
Previous preterm delivery	49%	44%	7%	0%
Fetal presentations	78%	21%	1%	0%
Induction of labor – AROM	60%	35%	4%	1%
Gestational hypertension	55%	39%	6%	1%
Birthweight	88%	12%	0%	0%
Clinical estimate of gestation	79%	20%	1%	0%
Date of last menses	46%	46%	6%	2%

In order to determine whether the difficulty of reporting these clinical data elements accurately depends on conflicts among various data sources used to obtain the information, the BRs were asked how often data sources conflict for each of the ten elements (Q22). For all elements, 23–54% of BRs indicated that data sources very frequently, frequently, or sometimes contradict each other (**Table 13**). Consistent with the elements BRs reported that they were least able to report accurately (**Table 12**), the elements for which there is conflict among data sources are previous low-birthweight, previous preterm delivery, induction of labor – AROM, gestational hypertension, and date of last menses. In fact, 40–54% of BRs indicated that data very frequently, frequently, or sometimes conflicts for these five elements. Data sources conflict most frequently about date of last menses, for which the most utilized primary and secondary sources are prenatal record (ACOG) and admission history and physical exam (**Table 11**).

**Table 13. Frequency of conflicting data across different sources for clinical data elements**

Q22: How often do data sources (e.g., prenatal vs. delivery record) conflict for the following items? (n = 108)				
Data elements:	Very frequently	Frequently	Sometimes	Rarely or Never
Previous C-section	4%	3%	25%	69%
Previous low-birthweight birth	3%	4%	33%	60%
Method of delivery	3%	2%	19%	77%
Previous preterm delivery	3%	2%	36%	59%
Fetal presentations	3%	2%	25%	70%
Induction of labor – AROM	3%	6%	33%	57%
Gestational hypertension	3%	2%	36%	59%
Birthweight	4%	1%	19%	77%
Clinical estimate of gestation	4%	4%	31%	62%
Date of last menses	5%	8%	41%	46%
When you find contradictory information, how do you decide which source to use? (n = 56)				
	Percent of open-ended responses			
Consult with attending MD and/or OB staff	55%			
Use prenatal record	25%			
Review/double-check everything	11%			
Ask mother/patient	7%			
Use delivery notes/record	4%			
Have consistent data, but missing data is the problem	4%			

When asked how they decide which source to use, when they encounter contradictory information about an element, 55% (n = 56) of BRs who responded indicated that they consult with attending MD and/or OB staff, 11% indicated they review and double-check everything, and 7% reported that they ask the mother (**Table 13**). Twenty-five percent of the open-ended responses also indicated that the BRs choose to use the prenatal record as the source of the correct information for the element, and 4% indicated that they use the information in the delivery record. Four percent also indicated that data incompleteness, and not inconsistency, was the real problem.

Another source of inconsistencies in birth registry data is information regarding fetal presentation. For electronic birth registration according to National Center for Health Statistics guidelines (<http://www.cdc.gov/nchs/data/dvs/guidetocompletefacilitywks.pdf>), fetal presentations – such as occiput posterior (OP), occiput transverse (OT), occiput anterior (OA), brow, face, compound, and transverse – are reported for electronic birth registration using codes “Cephalic,” “Breech, and “Other” where Cephalic includes vertex (OP, OA, OT), brow, and face, and “Other” includes transverse and compound.

In order to understand current practices in coding of fetal presentation data for electronic reporting, BRs were asked to indicate how their hospital instructs staff to code fetal presentation terms (Q23). As shown in **Table 14**, OP, OT, and OA were correctly indicated as Vertex by 42, 29, and 41% of BR, respectively, while compound and transverse were correctly indicated as “Other” for only 32 and 33%, respectively. Most notably, 28–31% of BRs did not know what to code for these fetal presentations. Ten to 17% of BRs indicated that clinicians do not use these terms at their hospital, and 6–8% indicated that clear instructions are not provided by their hospital on coding these terms.

**Table 14. Coding clinical terms regarding fetal presentation**

Q23: The terms below are different ways medical and clinical staff document fetal presentation. These terms can be very difficult to code. How does your hospital instruct staff to code these terms for electronic reporting?							
n = 108	Clinical terms						
Coding:	Occiput posterior (OP)	Occiput transverse (OT)	Occiput anterior (OA)	Brow*	Face*	Compound	Transverse
Vertex	42%	29%	41%	20%	20%	12%	6%
Breech	1%	3%	1%	3%	3%	5%	13%
Other	7%	15%	7%	24%	27%	32%	33%
Unknown	29%	30%	28%	29%	28%	29%	31%
Clinicians do not use this term at this hospital	15%	16%	16%	17%	14%	15%	10%
Clear instructions not provided by hospital on coding this term	6%	8%	7%	7%	8%	7%	6%

\* The survey included “vertex,” a subset of “cephalic” fetal presentation, as a response choice. “Cephalic,” which would be appropriate for brow and face presentations, was not included as a response choice in the survey.

Birth registrars were also asked to describe the other coding in open-ended responses, which some used to explain the “Other” and “Unknown” codes (**Appendix E**). About half of the BRs that responded in this open-ended section indicated that they are not responsible or qualified or aware of coding of fetal presentations. Some of these BRs reported that HIM department staff, labor and delivery nurses, or clinicians are responsible for coding these terms; the BRs simply record these codes in the system. Two BRs indicated that they use SPDS guidelines in coding, and one of these explained that, as per SPDS, brow and face are coded as “Other.” A few BRs indicated that they also use cephalic as a code, which is described in guidelines as presenting part listed as OP or OA. It is also noted in guidelines that cephalic synonyms include vertex. Two BRs specified that compound and transverse are *not* coded as vertex, while one BR indicated that compound *may* be coded as vertex, depending on the presentation, and one BR indicated that they code transverse as transverse lie. Another BR reported that they code a fetal presentation as compound if a hand is presenting. Two BRs indicated that they only code for C-sections, and one of these BRs explained that they use transverse as a code for C-sections.

In order to understand the current practices of hospitals to facilitate birth registration, BRs were asked to indicate whether their facility requires clinicians to complete a single standard form that includes all medical information required for birth registration, uses reports from the hospital electronic data system, educates clinicians on the importance of providing complete and consistent information in the patient medical records, or performs no such activities (Q24). Forty six percent of the BRs indicated that their hospital educates clinicians on the importance of providing complete and consistent information, while 36% indicated that electronic data system reports that include all necessary information for birth registration are generated at their institution (**Table 15**). In addition, 35% indicated that clinicians are required to complete a single paper or electronic form with all the medical information required for birth registration. One-fifth (20%) of BRs indicated that no such activities were performed at their facility. In addition, 10% described these and other activities in their facility to facilitate birth registration using open-ended responses, including two (2%) BRs, who indicated that they did not know or were unsure whether such activities were being performed.

**Table 15. Hospital activities to facilitate birth registration**

Q24: Does your hospital do any of the following to facilitate birth registration?	
n = 108	Percent of facilities*
Clinicians are educated on the importance of providing complete and consistent information in the patient medical records	46%
Reports are generated from the hospital electronic data system that include all necessary medical information for birth registration	36%
Clinicians are required to complete a single standard form (paper or electronic) that includes all medical information required for birth registration	35%
None	20%
Other	10%

\* Respondents were asked to choose all choices that apply and/or use the open-ended response.

When asked whether they use the health department or electronic birth registration system reports to monitor the quality of the data prepared and entered for birth registration (Q25), 88% of BRs responded that they did use such reports, while 12% indicated that they do not (**Table 16**). When asked to explain why they do not utilize electronic database reports for quality control of birth data(Q26), 7 of the 13 BRs (54%) who answered “No” to Q25 indicated that they were unaware of such reports, were not instructed to use such reports, or they did not have access to such reports. Three (23%) BRs indicated that training was needed to be able to utilize electronic database reports, while two (15%) indicated that they use other sources for quality control. One BR indicated that they do not see the value in these reports, as they make sure all birth information is complete before mother/baby is discharged.

**Table 16. Use of electronic reports for birth data quality control**

Q25: Do you use health department or electronic birth registration system reports to monitor the quality of the data prepared and entered for birth registration?	
n = 108	Percent of facilities
Yes	88%
No	12%
Q26: Please explain why you are not using the health department or electronic birth registration system reports to monitor the quality of the data prepared and entered for birth registration:	
n = 13	Percent of facilities
Unaware had access or do not have access	54%
Need training or were not instructed to use reports	23%
Use other sources	15%
Reports not needed	8%

### Suggestions for improvement of birth registration from birth registrars

Birth registrars were also given the opportunity to provide suggestions for the improvement of collection of birth registration data (Q27), assistance by the health department for birth registration (Q28), and training on specific birth registration data elements (Q29) in open-ended response format (**Appendix E**). A total of 71 (66%) BRs responded to Q27 with suggestions for improving the collection of data for birth registration. Suggestions included simpler forms that are easier to fill out with more up-to-date wording, as well as using or creating universal/standardized forms to improve data collection. BRs also suggested that training and education, especially of clinical staff, physicians, and maternity nurses

would improve data collection. In addition, BRs indicated that ensuring physician accountability, involvement, timeliness, and compliance would improve birth data collection. Other suggestions included providing a video that explains the birth registration process to parents, eliminating paper forms altogether, making the paternity acknowledgement deadline the same as the birth certificate preparation deadline, and improving translated forms and language assistance for non-English speaking parents.

When BRs were asked how the health department can assist them with birth registration (Q28), 66 (61%) BRs responded. Depending on their jurisdiction, the health department would either be the NYSDOH or the NYCDOHMH. Many BRs indicated that the health department is already very helpful and the system works seamlessly as it is. Some of these BRs specified that continuing ongoing efforts by the health department will help them in birth registry, such as continuing to provide quarterly progress reports to facilities. Some BRs indicated that the health department can increase its support for BRs – for example, by providing 24-hours support, an online forum or blog for BRs to ask questions, making the workbook available online, etc. – and a few indicated that the health department can help by providing local health department contact information. BRs also indicated that improving the existing electronic birth registration database – for instance, improving searchability of the database, autopopulating certain fields as data are entered, and improving tabbing and printing functions – can help with birth registry. Related to this, they indicated that simplifying and updating current paper and online systems (e.g., EVERS, AOP), or clarifying and updating policies will help them collect more accurate and complete birth data. Specifically, BRs indicated that physicians should be required by official policy to complete birth data needed from them in an accurate and timely manner. Also, some BRs indicated that extending the birth certificate submission deadline would help birth registration. Eight (12%) of the BRs who responded indicated that ongoing and periodic training will help with birth registration. Lastly, 16 (24%) of the BRs who responded indicated that they had no suggestions about how the health department can assist in birth registration.

Sixty eight (63%) BRs responded to the open-ended question asking them to indicate which items collected for birth registration require more training in order to improve accuracy and completeness (Q29). Many BRs indicated specific elements that require more training, such as augmentation vs. induction of labor, AROM, low birthweight, date of last menses, malpresentation, congenital abnormalities, preterm labor vs. preterm contractions, premature rupture, prolonged labor, and indications for C-section. Many also identified general areas of data collection that require more training, such as pregnancy history and newborn information. Medical terminology and coding was identified as another area that requires training, as well as AOP, mother's interview, and collection of demographic information (e.g., middle vs. maiden name, and county of birth). Many BRs indicated that physicians and nurses have to be made aware and educated in the importance of accurate, complete, and timely reporting of prenatal and delivery data. Ethnicity/race reporting and insurance coding were also indicated as potential areas of increased training.

## DISCUSSION

Variations in the accuracy of birth certificate data has been reported in New York and other states, including potential opportunity for improvement in the reporting of important elements such as prior preterm birth, medical risk factors and complications of labor and delivery relevant to evaluating C-section rates.<sup>1,3,4</sup> In order to understand the current practices in birth registry and identify potential areas of improvement of this process, the New York Birth Registrar Survey was conducted. Birth registrars (BRs) representing 127 birthing facilities across the state were invited to complete the survey. A total of 108 complete responses were received, making the response rate 85%. An additional four partial responses were included in the analysis for the first 18 questions of the survey, making the effective response rate for this portion of the survey 88%.

Only 53% of respondents indicated that their facility provides some formal training for BRs, suggesting that a good proportion of facilities have an identified need for training. Education and training of clinical staff in birth data collection was also discussed often in open-ended responses. Training and education of BRs in clinical terminology and coding was also mentioned often. In addition to general areas of data collection, such as mother's interview and AOP, some specific elements were identified by the BRs that require more training, including augmentation vs. induction of labor, AROM, low birthweight, date of last menses, malpresentation, congenital abnormalities, preterm labor vs. preterm contractions, premature rupture, prolonged labor, and indications for C-section. This is in agreement with the findings of this survey regarding coding of fetal presentations and conflicting sources of information for various clinical data elements. It is notable that 74% of BRs indicated that medical background or training is not required for their position in their facility.

Interestingly, over one-fifth (22%) of BRs reported that quality control activities, such as regular meetings with clinical staff to address missing or inconsistent birth data, continuing education or training, or review of data before entry into the electronic birth registration system, are not performed in their facility. Such quality control and assurance measures may or may not directly affect reporting of birth data; however, they can be highly beneficial in ensuring accurate and complete birth data, suggesting that this is a point of potential improvement at the hospital, or even state level. About one-third of BRs reported that their facility does not have a single person or unit dedicated to confirming the accuracy and completeness of birth data. In addition, over half of the BRs who used an open-ended response to elaborate indicated that the BR(s) are responsible for accuracy and completeness, suggesting that the person responsible for collecting the data and the person that checks the data for accuracy and completeness is one and the same in some cases. This is a high percentage of institutions, and may be another point of improvement, especially for those facilities where the personnel involved in quality control of birth data are spread across several different departments. Having a single person, preferably other than the BR(s), responsible for birth data might help consolidate efforts in a more effective and efficient manner. Electronic birth registration system reports can assist BRs in quality control of birth data. In fact, 88% of facilities already utilize such reports. Increasing awareness of such reports or providing access to BRs to generate such reports may be beneficial in increasing this

percentage, as per open-ended responses. It should be noted that although the survey aimed to assess the current environment, barriers, and support for birth registration, errors and sources of error are facility-specific.

A majority of BRs indicated that birth data are located across multiple systems and different sources contain conflicting data. One reason that the source, at least partially, of such conflicting data is the medical/clinical staff, who, according to the BRs, does not provide accurate or complete data in notes, charts, and prenatal records. Such inaccuracies and incompleteness seem to stem from several sources, including lack of prenatal care/information from the mother, loss of information between hospitals, as well as the inability of clinical staff, especially attending physicians, to provide complete data. While 46% of BRs reported that their hospital educates clinicians on the importance of providing complete and consistent data, only 35% indicated that clinicians are required to complete a single paper or electronic form, and 20% indicated no such activities, including the generation of electronic data system reports, were performed at their institution. Considering that clinical information is frequently inconsistent and incomplete, the lack of these activities in one-fifth of the facilities should be rectified. In open ended responses throughout the survey, BRs suggested various reasons to account for the inability of clinical staff to provide accurate and complete data, including lack of time, forms too long and complicated to fill out in available time, and unwillingness of attending physicians to complete or sign forms due to liability issues. As noted in many open-ended responses over the course of the survey, lack of time appears to be a major hindrance for clinical staff to complete birth data, while lack of access to prenatal records is another problem often cited. For example, one BR stated, *"I think our hospital does a great job ensuring accurate information. I think the key to that is educating the nurses and doctors to collect the most information they can. Of course that is also tricky because they don't always have the time."*

Although a majority of BRs did not agree that electronic systems, system help tabs, and edit checking features are inadequate, these problems are cited by some BRs throughout the survey in open-ended responses. It may be beneficial for hospital and DOH training sessions to include a representative from the IT department of the hospital to ensure proper IT support is provided to the BRs with regards to electronic systems, as the problems may not be system-wide, but facility- or even computer-specific.

An overwhelming majority of BRs (> 90%) use hospital electronic databases, prenatal records, and doctor's notes for gathering information to register a birth. Considering that many BRs report inaccuracies and incompleteness with prenatal records and doctor's notes, this may indicate that the improvement of accuracy and completeness of these data sources will have a substantial positive impact for birth registration. The median number of sources utilized by BRs in birth registration across the state is 4, and reducing this number to consolidate information for accuracy and completeness seems to be a worthwhile goal.

A majority of BRs are responsible, solely or partially, for obtaining parents' information required for birth registration. While 83% use health department or hospital forms to collect data, only 8% enter data directly into an electronic system. As discussed above, aggregated data in a single electronic database reduces the problems that arise with multiple data sources that contain contradictory information, which then require the BR to resolve contradictions. On the other hand, electronic

database solutions can be costly, require different training resources, require IT support, and do not automatically resolve the problem of incomplete records. Nevertheless, a needs assessment for each hospital to identify a budget and personnel needs for a fully functional electronic database may be beneficial. The DOH may consider supporting these efforts by providing seamless connectivity to the state birth registration database, if applicable. Such connectivity amongst facilities and with the DOH database was cited by some BRs in open-ended suggestions at the end of the survey.

Birth registrars reported significant efforts in helping the mother fill out the parents' information forms, including reading/explaining the forms to the mother, completing the forms with the mother, making sure the mother's questions are answered, coordinating translation services for the mother, and calling mothers to make sure they fill out the forms. In addition, 89% of BRs indicated that the acknowledgement of paternity (AOP) is included in the parents' information packet.

Despite the thorough efforts to collecting parents' information from the mother, 9% of BRs indicated that this information is rarely or never reviewed for completeness. With an additional 12% indicating that these data are checked for completeness only sometimes, over one-fifth of the facilities do not often perform completeness checks for parents' data. In addition to completeness, accuracy of parents' information remains a problem, especially regarding the mother's race. A majority of BRs indicated that mothers of Hispanic descent either leave the race field blank or choose other, as a result of a combination of reasons, including language issues, refusal to agree with the state's definition of race versus ethnicity, and unwillingness to give out any personal information. For example, one BR reported, *"We have a population of people who are very averse to having personal information reported, and also many who challenge the language/definition of race and ethnicity as presented."* Another BR stated, *"We provide families with a DOH explanation of race/ancestry. It does not help. Those of Hispanic ancestry most often write other."*

Collection, accuracy, and completeness of clinical information appears to be a greater problem for birth registration. Delivery record and prenatal record (ACOG) emerged as the top sources of clinical birth data for most clinical elements. Other sources were used to supplement data collection. A good example is the newborn admit/discharge record, which is not utilized much for any of the elements, except for birthweight. Interestingly, 20% of BRs do not use a secondary source for previous low-birthweight birth, making prenatal record (ACOG) the most utilized and major source of information for this element. It is worth noting that the inaccuracy and incompleteness of delivery records and prenatal records are cited most often as the source of birth data collection problems, suggesting, again, that improvement of data collection at this stage may significantly improve birth registration as a whole.

Reflecting the problems with incomplete or inaccessible prenatal records, the most difficult clinical data element to capture was previous low-birthweight, followed by date of last menses, previous preterm delivery, and gestational hypertension. Improvement in data collection for these elements may be particularly important for monitoring quality, such as for the use of 17-hydroxyprogesterone to reduce recurrent preterm birth in women with prior preterm delivery, and for epidemiologic trends associated with increasing obesity. These same elements were also listed as the elements for which there is conflict among data sources, suggesting that conflicting data in various sources may exacerbate inaccurate

reporting of these elements. Information regarding induction of labor – AROM is also often contradictory among data sources. As would be expected, most BRs resolved data inconsistency problems by consulting with attending physicians and/or OB staff. Overall, the main root of inconsistent and incomplete clinical birth information appears to be the inconsistent and incomplete data collection by clinical staff before/during/and after labor.

Another source of potential inaccuracy in clinical birth data is coding of fetal presentations. It is notable that coding as “Unknown” accounted for 28–31% of all coding for the fetal presentations surveyed here, with some BRs identifying transverse and compound presentations as vertex or breech, and less than half identifying occiput posterior (OP), occiput transverse (OT), and occiput anterior (OA) as vertex presentations. Interestingly, guidance for completing facility worksheets from the National Center for Health Statistics (NCHS), New York State Statewide Perinatal Data System (SPDS) and New York City Electronic Birth Registration System (EBRS) are not entirely consistent in defining fetal presentation. For example, NCHS 2013 guidance includes vertex, OA and OP presentations in the definition of cephalic presentation, but notes OT, brow, face and mentum (chin) presentations as keywords for cephalic presentation. On the other hand, SDPS 2009 guidance identifies vertex as a synonym for cephalic fetal presentation to include OA and OP, and does not address OT, face, brow or mentum presentations. EBRS 2010 guidance defines cephalic presentation as presenting part head down, vertex, OA, OP or OT, while face, brow and mentum are not addressed in EBRS guidance. Both SDPS and EBRS guidance for fetal presentation do not specifically address transverse or compound presentations, while transverse and compound presentations are identified as keywords for “Other” presentation in NCHS guidance.

Correct coding of fetal presentation is particularly important if the State intends to include vital records data in future reporting of the CHIPRA measure Cesarean Rate for Nulliparous, Singleton, Vertex births.<sup>5</sup> Although not included as an item in the survey, both the EBRS and SDPS guidance documents address indications for C-section, which is collected in both systems. One of the C-section indications is non-vertex presentation, and “synonyms” identified in guidance include face, brow, and transverse as well as breech presentations. Of those BRs who used the open-ended responses to explain coding, almost half indicated that they are not responsible for coding. However, it is clear that education and training on coding for the other half responsible for fetal presentation coding may be highly beneficial, particularly for quality initiatives and monitoring regarding C-section rates. This is also clear from the suggestions the BRs themselves made at the end of the survey in the open-ended responses; medical and clinical terminology and coding were often cited as elements for further and ongoing education and training.

Over 60% of BRs utilized the open-ended responses at the end of the survey to provide additional suggestions for improvement for birth registration. Most general suggestions centered on the need for ongoing education and training in collecting accurate and complete birth data of not only the BRs but also the clinical staff and physicians. For example, one BR stated, *“The MDs need to understand the importance of accurate and thorough documentation. When information is missing or incomplete, it is very time consuming to have to go back and try to find form [sic] other sources.”* Current efforts of the DOH, such as providing facilities with quarterly progress reports, were praised by the BRs, while additional support functions, including an online forum for BRs to ask questions and receive input, were suggested. For example, one BR stated, *“it would be great if there was some “continuing education” – or*

*at least refresher classes – offered online. Maybe a blog, or some sort of online community for birth registrars to share information/ask questions/etc.”* It is unclear from the responses whether there is a frequently asked questions section geared towards BR activities on local or state health department websites and whether the BRs are made aware of such information. BRs also had suggestions to improve the existing electronic birth registration database by increasing searchability, making printable forms more user friendly, and improving tabbing functions.

## **Limitations**

There were several limitations in this study. Some limitations were intrinsic to the design of the third-party survey application and the online nature of the study. We were only able to survey BRs with valid email addresses. Although 15 (11.8%) BRs did not complete the survey, this may be due to the fact that some of them never received the survey email, despite the fact that the emails did not bounce back. A detailed analysis of resources allocated to birth registration in relation to the number of births in each facility was not performed, as hospital and maternity department size was not included in the survey; however, such an analysis would be useful in identifying specifically the facilities that have a high volume of births and a particularly low number of employees and staff hours dedicated to birth registration.

## Recommendations

Based on the findings of this survey, IPRO suggests that the NYSDOH:

- encourage the installment and enactment of facility policies to require clinical staff and attending physician compliance to provide accurate and complete delivery and prenatal information;
- encourage hospitals to facilitate coordination between clinicians and birth registrars (BRs) on a regular basis;
- focus on delivery records and prenatal records (ACOG antepartum record forms) for completeness and accuracy;
- increase ongoing education efforts directed at BRs and Labor and Delivery nurses in:
  - acquiring complete and accurate information from the mother using DOH and facility workbook/worksheets, in-person interviews, and the AOP process,
  - understanding medical terminology to aid with accurate interpretation and entry of clinical findings and information, including terminology and knowledge required for:
    - induction of labor,
    - malpresentation,
    - preterm labor vs. contractions,
    - indications for C-section,
  - and collecting complete information for:
    - low birthweight,
    - date of last menses
    - previous preterm deliveries,
    - gestational hypertension,
    - induction of labor;
- increase awareness for existing electronic birth registration rules for coding fetal presentations , provide more education as needed, and ensure that guidelines for electronic birth reporting are consistent with NCHS guidelines;
- encourage and support quality control activities in facilities, potentially using several successful facilities as models to develop similar quality control functions in others;
- devise ways to reduce the time required by clinical staff to complete birth data collection, for example, by simplifying current forms and encouraging hospitals to switch to internal electronic systems for easy and direct birth data entry;
- increase efforts to seamlessly connect the DOH electronic birth registry system to existing hospital birth databases;
- encourage hospitals to include IT personnel in training for BRs to improve IT support for computer-based birth registration functions, such as printing and connectivity;
- require hospitals to review and confirm completeness of birth data before entry to electronic systems;
- require BRs to extract race/ethnicity from mother directly with necessary language and translation support;

- encourage and increase awareness and accessibility of electronic birth database reports to BRs;
- consider developing an online forum where BRs can ask questions that can be answered by a DOH representative in real time, keeping in mind that a collection of such questions and answers can benefit all BRs with similar inquiries and seriously cut down other support efforts via phone.
- develop and disseminate birthing facility-level reports to monitor birth record data quality on an ongoing basis.

## REFERENCES

<sup>1</sup> Roohan PJ, Josberger RE, Acar J, et al. Validation of birth certificate data in New York State. *Journal of Community Health* 2003; 28(5):335–46.

<sup>2</sup> Available at <http://www.surveymonkey.com>.

<sup>3</sup> Hackney DN, Durie DE, Dozier AM et al. Is the accuracy of prior preterm birth biased by delivery characteristics? *Maternal Child Health Journal* 2012; 16(60):1241–6.

<sup>4</sup> Clayton HB, Sappenfield WM, Gulitz E et al. The Florida investigation of primary late preterm and cesarean delivery: the accuracy of the birth certificate and hospital discharge records. *Maternal and Child Health Journal* 2013; 17(5):869–78.

<sup>5</sup> Center for Medicaid and CHIP Services, Centers for Medicare and Medicaid Services. Core set of children’s health care quality measures for Medicaid and CHIP (Child Core Set): technical specifications and resource manual for federal fiscal year 2013 reporting.

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## **APPENDICES**

Appendix A – NY Birth Registrar Survey Print Copy

Appendix B – Email message to BRs, OB directors, and RPCs

Appendix C – Support letter from Guy Warner, Director of Vital Records

Appendix D – List of birthing facilities

Appendix E – Open-ended responses

**APPENDIX A – New York Birth Registrar Survey Print Copy**

## APPENDIX B – Email message to BRs, OB Directors, and RPCs

### Email message to BRs, OB Directors, and RPCs

Dear Doctor, Sir, or Madam,

This information is being sent to birthing facility contacts throughout New York State and New York City including Birth Registrars, OB Directors, and Regional Perinatal Center Coordinators.

The New York State Vital Records Bureau and the Office of Quality and Patient Safety, with the support of the New York City Vital Statistics Bureau, are conducting a New York State Birth Registrar Survey as part of ongoing efforts to improve the completeness and accuracy of the birth data. The goal of the survey is to better understand how each birthing facility gathers birth registration information from multiple sources, including hospital information systems, the Work Booklets (NYSDOH-2184E) or Worksheets (NYCDOHMH-VS203 and VS204) provided by the state or city, and other data sources pertaining to the birth event. The information obtained from this survey will help identify barriers to birth information reporting, training needs, and opportunities for systems improvements.

The New York State Department of Health has contracted IPRO to assist with conducting this survey. An invitation email with a unique link to the survey will be sent to the Birth Registrar at each facility based on contacts obtained through the state and city health departments. The link to the online survey will be emailed shortly, and the deadline for the survey response submission is Friday, August 16<sup>th</sup>, 2013. Responses will remain confidential, though we may contact you if we need further information.

If you have any questions about this survey, please contact Larry Schoen, Director, New York State Vital Statistics, Office of Quality and Patient Safety by phone (518-486-9012) or email ([Ids04@health.state.ny.us](mailto:Ids04@health.state.ny.us)).

Also attached is a letter from Guy Warner of the New York State Department of Health who is lending his support and encouragement to this effort.

Thank you for your cooperation.

Best Regards,

IPRO

**APPENDIX C – Letter from Guy Warner in support of the Survey**

## APPENDIX D – List of birthing facilities

Birthing Facility	Survey status
Adirondack Medical Center - Saranac Lake Site	
Albany Medical Center Hospital	complete
Alice Hyde Medical Center	
Arnot Ogden Medical Center	complete
Auburn Memorial Hospital	complete
Aurelia Osborn Fox Memorial Hospital	
Bellevue Hospital Center	complete
Beth Israel Medical Center (Milton & Carroll Petrie Division)	complete
Bronx-Lebanon Concourse Hospital	complete
Brookdale University Hospital and Medical Center	complete
Brooklyn Hospital Center	complete
Brooks Memorial Hospital	complete
Canton-Potsdam Hospital	
Carthage Area Hospital Inc	complete
Catskill Regional Medical Center	complete
Cayuga Medical Center	complete
Champlain Valley Physicians Hospital Medical Center	complete
Chenango Memorial Hospital Inc	complete
Claxton Hepburn Hospital	complete
Columbia Memorial Hospital	complete
Coney Island Hospital	complete
Corning Hospital	complete
Cortland Regional Medical Center Inc	complete
Crouse Hospital	complete
Eastern Niagara Hospital - Lockport	complete
Ellis Hospital	complete
Elmhurst Hospital Center	complete
F F Thompson Hospital	complete
Faxton - St Luke's Healthcare - St Luke's Division	complete
Flushing Hospital Medical Center	partial*
Forest Hills Hospital	complete
Glens Falls Hospital	complete
Good Samaritan Hospital Medical Center	
Good Samaritan Hospital Of Suffern	complete
Harlem Hospital Center	complete
Highland Hospital	complete
Hudson Valley Hospital Center	complete
Huntington Hospital	complete
Jack D. Weiler Hospital of the Albert Einstein College of Medicine (Montefiore M.C.)	complete
Jacobi Medical Center	complete
Jamaica Hospital Medical Center	complete
Kaleida - Millard Fillmore Suburban Hospital	complete
Kaleida - Women and Children's Hospital of Buffalo	complete
Keller Army Community Hospital	complete
Kings County Hospital Center	complete
Kingston Hospital	complete

Lawrence Hospital Center	complete
Lenox Hill Hospital	complete
Lewis County General Hospital	complete
Lincoln Medical and Mental Health Center	complete
Long Island Jewish Medical Center/Schneider Children's Hospital	complete
Lutheran Medical Center	complete
Maimonides Medical Center	complete
Mary Imogene Bassett Hospital	complete
Massena Memorial Hospital	complete
Memorial Hosp of Wm F & Gertrude F Jones A/K/A Jones Memorial Hosp	complete
Mercy Hospital	complete
Mercy Medical Center	complete
Metropolitan Hospital Center	complete
Mount Sinai Medical Centers	complete
Mount St Mary's Hospital and Health Center	
Nassau University Medical Center	complete
Nathan Littauer Hospital	
New York Downtown Hospital	complete
New York Hospital Medical Center of Queens	complete
New York Methodist Hospital	complete
New York Presbyterian Hospital - Columbia Presbyterian Medical Center	complete**
New York University Medical Center - Tisch Hospital (NYU Langone)	complete
New York Weill Cornell Medical Center	complete**
Newark-Wayne Community Hospital	
Niagara Falls Memorial Med Center	complete
Nicholas H Noyes Memorial Hospital	complete
North Shore University Hospital	complete
Northern Dutchess Hospital	complete
Northern Westchester Hospital	complete
Nyack Hospital	complete
Olean General Hospital	complete
Oneida Healthcare Center	complete
Orange Regional Medical Center	complete
Oswego Hospital	complete
Our Lady Of Lourdes Memorial Hospital Inc	complete
Peconic Bay Medical Center	complete
Phelps Memorial Hospital Assn	complete
Plainview Hospital	complete
Putnam Hospital Center	complete
Queens Hospital Center	
Richmond University Medical Center	complete
Rochester General Hospital	complete
Rome Memorial Hospital Inc	partial*
Samaritan Hospital	complete
Samaritan Medical Center	complete
Saratoga Hospital	complete
Sisters Of Charity Hospital	complete
Sound Shore Medical Center of Westchester	
South Nassau Communities Hospital	complete
Southampton Hospital	complete

Southside Hospital	complete
St Anthony Community Hospital	
St Catherine of Siena Medical Center	complete
St Charles Hospital	complete
St James Mercy Hospital	complete
St John's Riverside Hospital	complete
St Josephs Hospital Health Center	complete
St Luke's Cornwall Hospital/Newburgh	complete
St Mary's Healthcare	complete
St Peters Hospital	complete
St. Barnabas Hospital	complete
St. John's Episcopal Hospital, South Shore	partial*
St. Luke's Roosevelt Hospital Center - Roosevelt Hospital Division	complete
Staten Island University Hospital - North Division	complete
Strong Memorial Hospital	complete
The Allen Hospital	complete
The Unity Hospital of Rochester	
United Health Services Hospital, Inc. - Wilson Medical Center	partial*
United Memorial Medical Center	complete
University Hospital	complete
University Hospital of Brooklyn at Long Island College Hospital	
University Hospital of Brooklyn- SUNY Downstate	
Upstate University Hospital at Community General	
Vassar Brothers Medical Center	complete
Westchester Medical Center	complete
White Plains Hospital Center	complete
Winthrop University Hospital	complete
Woman's Christian Association Hospital WC Hosp At Jones Memorial Health Center	complete
Woodhull Medical and Mental Health Center	complete
Wyckoff Heights Medical Center	complete
Wyoming County Community Hospital	complete

\* Four institutions provided responses to questions 1 through 18, which were included in the analyses.

\*\*A single survey was submitted for the New York Presbyterian Columbia and Weill Cornell Medical Center, which was given a weight of 2. All other responses were assigned a weight of 1.

## APPENDIX E – Open-ended responses

<b>Q5</b>
9th Floor 9E2A
Admitting
Admitting
Admitting
Admitting office
Health Information Services Room
HIM
in between labor and delivery/ post partum unit
In office in OBGYN area below Maternity ward/labor & delivery
labor & delivery
Legal Certificate/Cashiers Finance
MATERNITY ADMITTING
maternity/postpartum unit
Patient Access
Patient Access
Patient Access Dept
Patient Access Services
Patient Admitting
Patient Admitting
post partum floor/separate Office
Warsaw Village Office
<b>Q6</b>
1 year experience in acute HIM or medical office. Medical term preferred. Proficiency & experience with computers and applications.
Background of medical terminology and training is required prior to becoming Birth Registrar
Civil Service Test to get the job in Patient Access Dept, further training is needed to learn how to fill out the workbooklet.
cross training from one employee to another
Extensive Training in coding. Many hours of training in orientation. Acknowledgement of paternity training is ongoing.
It is helpful to know OB medical language.
It would be helpful if the person had some clinical experience
It would help if they did have some clinical or medical background.
Knowledge of medical terminology, medical records experience
medical background very helpful Extensive training required
medicolegal background or medical office management certificate is required
Minimum medical terminology.
must have some clinical judgment and a relationship with the staff filling out the workbook
My training was conducted by the HIM Chart Analyst person responsible prior to myself.
Only the training that was offered in Syracuse a few day classes.
Our birth registrars are RN on the labor floor.
Person is a unit secretary and integrated into the daily operations and charting, forms, etc of labor and delivery. They are trained by me (RN Clinical Instructor, and I am their resource and problem solver.)
Reviewing the EHR for Data which is pertinent to completing the Birth Records is necessary
RN or Certified Medical Records Personnel
Saratoga Hospital has 2 Birth Registrars....each attended training provided by our Medical Records department who previously processed birth certificates
Some training by the previous employee.
some type of medical background is needed if only to find the info in the medical record
Strong medical terminology and understanding required
They need background work in the hospital or medical records school
training
Training is required
We were set up with an HPN account and then trained in the SPDS program

When the job was developed it called for a RN,LPN or medical coder
When there is a new hire, they must be able to understand and comprehend the medical terms used on the forms. Also they must be able to identify what happened during the delivery process.
<b>Q7</b>
4 to 6 weeks of training to do the job, then ongoing training as needed
Attended training in Rochester NY for the last update 10 years ago
Birth Registrar support staff must be oriented and trained for the processing and departmental flow of the birth registry.
director one on one training
Each employee received OTJ training
Employee receives on the job training
Explains the process and reviews the guidelines for SPDS
Hands on training on the EVERS application
I am required to go the Albany med meetings. I am informed of new procedures. My hospital does not have any formal training programs for my position. Seeming I am the only person that does all the birth certificates we communicate by email, face to face and through audits.
I was trained by the person who had my position before me.
in addition to 1 on 1 training from me, birth registrar is sent to DOH trainings as well
It is part of the orientation for these staff members.
New Hires for Birth Registration are given hands on training.
no formal training is provided, it's taught by the previous person occupying that role.
On job training by a supervisor/manager
on-the-job training and review of work.
Orientation
Orientation includes formal Training is Collecting & Reporting of Birth Registration process.
orientation includes review of delivery log, medical records, customer service, record keeping, explanation of medical terms but not medical training
orientation to the process
Orientation would be provided to new employees as on the job training
Policy and procedure review. Shadow the current process. New registrar is observed completing the parent interview, paternity affidavit, record abstracting, workbooklet completion and electronic birth certificate processing for a few weeks.
See above.
shadows employee and reads instruction manual
super user of the data collection will train new data collectors
Team Leader trains each employee
the birth registrar provides the new employee with an orientation followed by ongoing training as the need arises.
The Birth Registrar in training is shown how to collect and input information into the EVERS system by the Administrator.
The current birth registrar trains new staff.
The Maternity Unit Secretary would train new people on SPDS, NYSIS & NYEHD.
The outgoing Birth Registrar trains the incoming. Data is collected by the nurses and no formal training is given.
The people that collects on the weekends only
The supervisor does provide the training on collecting and reporting the information and the IT dept does train employees on the hospital system and the Dept. of Health provided training on the reporting
The Supervisor/Manager of the Department will conduct training for employee involve in the process how to collect data to process and complete a Birth Certificate.
The two employees that are already trained are usually in charge of training new individuals
They are fully orientated to the process of the completion-interviewing the patients, obtaining the information in addition to review from the medical record.
This is done one on one after the person is well established in their other unit responsibilities.
<b>TRAINED ON FORMS INCLUDING PATERNITY PAPERS &amp; TRAINED TO ENTER INFO INTO ELECTRONIC BIRTH CERTIFICATE SYSTEM</b>
trained on how to retrieve the information and any legal matters that may occur
Training is provided on employment.
Very little, mostly how to enter the information.
Vital Statistic Staff provide training to new hires.
we teach each registrar to collect & record birth info when they work I&d
when I was hired my full time co-worker trained me for completing the birth certificates

Yes we have another person was training y reporting to the birth registration
<b>Q8</b>
Admitting
Admitting Administrator
Admitting Unit, Checks for accuracy
birth certificate registrar
Birth certificate Specialist
Birth Registrar
Birth Registrar Coordinator
BIRTH REGISTRAR, COLLECT DATA AND IN-PUT INFO IN THE EVERS SYSTEM
Birth Registrars
Birth Registration Unit, To handout applications to patients and explain the process to the patients. And collect application for processing of the birth certificate.
Birthing Center
Both registrar check each other's work
CECELIA ROBERTS WARD CLERK BETTY COMMANDER NURSE MANAGER
Clerk/Typist serves as Birth Registrar - goes over all info gathered on worksheets by any other employee prior to DOH submission
CNS
Daily review, clarification prior to certification
Done by HIM Department (Birth Registrar or Director)
Gina Garcia Supervisor
H.I.M.
Health Information Manager
HIM EHR Data Integrity Manager
I personally oversee and report
Information provided to Medical Records Clerk to Input in System and check accuracy
Jacqueline Vazquez
I&d lead clerk & managers of unit
Labor & Delivery
Lauren Miller Birth Registrar Coordinator
LEAD REGISTRAR GOES OVER ALL B/C'S ENTERED BY NEW TRAINEES
Lpn to enter data
Maternity
maternity should be validating, we follow up with any questions or concerns with the given info and do rely on the medical record for validity
maternity unit
me and my co-worker are the ones who check for accuracy
me... birth registrar Heidi Tulle
Medical Records/Brenda Nicolazzo, Sr. Clerk
Medical Records
Medical Records
Medical Records, HIM Chart Analyst
Myself
Nurse manager, Ob director, Chief of OB, chief of Peds and Chief of Midwifery
OB coordinator
OB RN director review
obstetrics department
Only me
Registrars
Reviews documentation for completion
RPC Coordinator

Several people, but it's very rarely done and it falls on one person.
That is also me - I have a cross check system for key statistical info.
The Admitting Managers are responsible for reviewing the information prior to submission
The Birth Registrar reviews all information before entering in the Evers System
The Birth Registrar takes care of that in the Maternity Unit
The data entry clerk
The registrar is trained to collect all the information
The same person collecting & reporting double checks their own work.
the title of Certifier allows for the checking and accuracy prior to submission.
unit clerk when doing data submission
Unit Coordinator
Vital records clerk review info when entering
Vital Statistic Staff verify accuracy and completeness.
we are all responsible as birth registrars
We do not have a specific process however with the operational process there are several different reviews by individuals. In addition, spot checks for accuracy are done by me.
<b>Q9</b>
Accuracy and completeness are discussed at staff meetings but medical staff is not involved in those meetings.
Both registrars check each other's work and worksheet is maintained in the department used to reconcile data entry.
Cross checking also considered proof reading is done by the birth registrars prior to managerial sign-off.
DOH webinar for Hep B reporting. AOP inservice
Education comes from Univ of Rochester via coder fax and bi monthly meetings
EMR generated reports for hearing, hepatitis B administration, delivery log
I do this myself if I have any down time when I'm caught up. This has not happened in a while
I double check the workbooklet against the written delivery room record, for the date and time of birth
I make sure myself that every birth certificated gets completed within 5 days of birth. Normally 3 days. I am currently the only birth registrar on the unit. I am currently training a per diem employee on birth certificates.
If issues are noted, education provided to staff in writing or in staff meetings
Informal meetings are held with staff involved with clinical supervisor. City Registrar informs us of inconsistencies.
meetings held 2 times a year
Once a year we have someone that comes around and checks to make sure we are coding correctly and entering correctly. she is a hospital employee with medical background but not in our dept.
Patients fill out the information while in the hospital. If there are any questions I answer them, then information is collected when the patient is d/c from the hospital.
Perinatal Outreach Staff provide a degree of continuing education
Reports are run from the website and anything that is out of the normal is reviewed.
Review of errors listed from the Vital statistic Department. OBGYN also plays a role in collection of data.
REVIEWED BY WARD CLERK, CHARGE NURSE OR MANAGER
SPDS personnel come once a year for chart reviews
The birth registrar does all the data entering with the help of a per diem staff member. She (me) is considered the "manager" who reviews all data entered by the per diem person.
We complete B.C. by doing personal interviews with Mom/parents. We review patients' electronic records to view their delivery records, med records, prenatal records.
We go through the patients chart to make sure our information is as accurate as we can get it. If necessary we will interview the nurse responsible for that delivery.
We use the SPDS Data Report to review at our monthly Perinatal Meeting. When I run that report I check that with my hardcopy of our monthly stats to reconcile the results.
When errors arise the birth registrar will speak to whoever is involved to educate them for the future. If the parents do not fully fill out the workbooklet the birth registrar calls them and asks them for the missing information.
Yearly DOH audits and WCHOB audits are done.
<b>Q10</b>
Again, if we can't read a note we ask the nurse or in some cases the physician.
All of our reporting methods could use a little tweaking but on a whole we give very accurate information
Availability of patients records
Completing Amish mothers' birth certificate can be challenging due to lack of prenatal care and length of stay is sometimes only 24hrs.

Delays in Family deciding the names of the children or waiting for the Paternity forms to be completely filled in correctly
-Don't know what you mean by K above. -Lack of TIMELY availability to see the data entered is biggest barrier to being able to assure accuracy. For instance, if I see (from the monthly report) that a birth was entered as a c/section but was actually a vaginal delivery, I have NO WAY to know which was entered incorrectly and my only recourse is to go through the births in the EBC one by one. I have done this. Ridicules. -A large portion of the data entered has already been entered into our own electronic charting system. It would be ideal if data could flow over.
electronic birth system is to slow or as your typing the system go down.
Having to accept Paternity Ack's for up to 3 months considerably slows down our process since we have to file the birth certificates within 5 days of the baby's birth. Reopening a record to add paternity info is very time consuming. Should be the same amount of time to report the birth to Town Hall as the time required to have parents bring back the Paternity Ack.
I sometimes do have to call the parents at home due to not being able to read their writing, if the OB staff when collecting this information could make sure it is legible
It would be beneficial for the reporting to have some default populated areas, such as the state in which the certificate is being filed.
It would be helpful to see error/or missing info at the end of each page, instead of seeing it at the final review.
Language
Language barriers
LEP
MD's frequently check off "unknown" because of a fear of liability.
Most of our info available is complete and accurate. Main barrier is labor and delivery admitting nurse not always obtaining or documenting some required info. Mainly missing months of other deliveries and other previous pregnancies. Months are rarely documented on prenatal history and often the patients either don't recall the month of missed or induced AB's or have already been discharged when the info is entered.
none
nurses not informing proper way to fill out forms
Parents are not always forth coming with the information needed and require a lot of support to gather what is needed.
Physicians are not also available to sign the birth certificate
Prenatals are missing or incomplete sometimes all there is, the labs with no other information for us to record if the patient is a transfer from another hospital. Hospital/hospital interactions is would be good
SPDS downtime, and Physician signatures are not completed in a timely manner.
Tabbing within the electronic birth registration is not consistent. You cannot tab to some fields.
the barriers are not on every case but we would welcome formal training.
The physicians need to report more data. they do feel some of the questions in the workbooklet are not clear to them.
The Spanish Work Booklets need to be updated.
time and resources to enter data
When calling some Dr offices not helpful or get upset that I call for Information
<b>Q11</b>
All information is contained within the electronic health record including the hospital electronic database, Drs. notes and charts and all pre-natal records.
asking the patient any unclear info or missing info
Booklet form that is filled out
Direct interview with the mother.
Eclipsys
Facility Worksheet
from mothers Worksheet if needed will call mother if more info needed delivery sheet filled in by delivery nurse
I have to call most every Dr office for either visits or AFP information etc.
Interviewing the patient
Labor & delivery logs parents previous births info
Labor and Delivery Report/ Physician's Labor and Delivery Report
Maternity's electronic database (CPN)
NICU staff for PKU #'s not yet available electronically
nurse's and social work notes in EMR
parents
Parents.
Paternity form
Patient

PATIENT
Patient info gathered from completed birth certificate workbook
patient interview
Patient self report
patient.
The parent.
We ask the mom as well
We use Espaces for cin No. for all forms of Medicaid. Also utilize NYS Professions on line verification for accurate Dr's name outside our area and of course for zip code lookup
Workbooklet that parents fill out
<b>Q13</b>
All of above
All staff from admission to discharge
Birth Certificate Office Staff
birth coordinator
Data Entry Personnel
information comes from the mother's worksheet that is supplied by the dept. of health
Labor & Delivery staff hand out workbooks with parents' info to complete & hand into birth registrar
maternity unit
MD
Nurse in charge of patient
Nurses hand out booklets to patients/Registrars follow-up
nursing staff when available
OB Technicians
Our Maternity Staff will be responsible for collecting birth info after I retire in Sept 2013.
parents fill out a worksheet
Parent-Self
Post partum staff
Postpartum nurse
postpartum nurses
Registration area during pre-registration process.
sometimes the nurses
the patients fill out their own work booklet
The Staff gives the workbooklet to the Parents and they fill out there areas and then nursing looks it over.
Unit secretary
Vital Statistic Staff
<b>Q14</b>
Face sheet from the hospital is used initially then confirmed by parents.
Moms are given the BC Workbook pre-admit to complete their info before delivery.
Registration When admitted to hosp
The birth registrar hands out the workbook (provided by the local city hall) to the mother. I then make sure all the information is filled in and correct.
the parents fill out this part if the booklet
The workbooklet is given to the parents after baby's birth to fill out
We do a personal interview with Mom/Dad the day after delivery
We give a mom the workbook when she first goes to the OB if she does not mail in we take one up once baby is born. we have added onto the workbook let info we lack in most prenats i.e. height and pre wgt.
we use the health department workbook that we have separated and modified.
<b>Q15</b>
Again we do a personal interview with Mom/Dad the day after delivery
All forms are explained to the parents
from the medical record if the mother fails to submit her worksheet or provides an incomplete worksheet
if not completed, registrar asks the questions
if we have a patient with barriers or obstacles we do sit down with them and fill it out together.
It all depends on the mom and the level of education or the degree of understanding with a language barrier.
mothers fill out work booklets then unit clerk reviews and obtains any other information mother has left blank to make sure

work booklet is complete and accurate
New brochure created to assist parents. Title of brochure: Registering Your Newborn's Birth.
Sometimes family members help patients; that is usually mothers of teens. Sometimes we set and fill out paper work with patient if health reasons or if patient is unable to read or write.
Telephone calls by birth registrar to parents who have been discharged but omitted various data fields.
We call mother to tell her to fill out form and if need be AOP if mother need help we have translation services available
We provide the packet to the patient as part of our notebook of information presented to pt at 28-32 wks gestation, so she can read and research ahead of time. She brings the notebook and packet with her at delivery. This works well, as we have a large multi-cultural population and many non-English speakers. Our notebook also has a section explaining about the birth certificate process and the paternity acknowledgement process.
<b>Q17</b>
For both parents, If they choose Hispanic origin they do not wish to list anything else for race. IE white
half of the patients that I see are Latino. Since the option of race is whatever the parents see themselves as, most don't consider themselves white and check other.
Hispanic patients usually don't know what race to check
if it is left blank, I would go into our system that shows moms race or I sometimes I would find it in her prenatal
If mom leaves it blank registrar pursues mom to get the information.
In our personal interview we ask what their race is and report accordingly
It is either left blank or boxes are checked accordingly. When the "other" box is checked they don't always write in their specific answer.
Language barrier when blanks are left by parent
Most Hispanic patients do not like to check that they are white or black as there race or ethnicity.
Most patients complete correctly or I help them complete it.
mother doesn't put a race just Hispanic
mother writes in the information
Mothers write "Hispanic" for Race
Often times the patient confuses ethnicity with race...so that need to be explained in detail (One can be Black Race & Hispanic
parents sometimes refuse to fill out many areas they think this information is not needed or any of our business!
Some say they wish to not answer this question
those who are Hispanic continue to argue that Hispanic is not officially a race,
We do not have problems obtaining the race.
We have a population of people who are very averse to having personal information reported, and also many who challenge the language / definition of race and ethnicity as presented.
we provide families with a DOH explanation of race/ancestry. it does not help. those of Hispanic ancestry most often write other.
when patient is registered in I&d this info is recorded also nurses record this info when recording their info
<b>Q18</b>
Ask Questions, Offer an options, explains, answer questions
Before AOP's are given out we confirm marital status' then explain what exactly the AOP is to the parents.
Birth Registrar hands AOP form to parents that are not married, and explains it to them in detail
Birth Registrar verbally explains AOP process when visiting pts and is available for questions.
explains form to parents
Hospital birth registrar alone with other admitting clerks assist the parents in completing the AOP's
Hospital staff explains AOP requirements and procedure for signing/witness'
Hospital staff explains the paternity form to parents
Hospital staff provides AOP upon patient request
Hospital staff/birth registrars are available to assist with AOP's and act as witnesses
I am unsure what the hospital staff does with an AOP before it is signed
I explain to patient about paternity paper o the nurses
If the patient or FOB does not speak English, I print off AOP forms in their language.
information is provided by the birth registrar
Mothers are informed about the AOP and are encouraged to have the fathers fill one out in order to assist the child in getting benefits they are entitled to have.
OB nurses explain AOP and then witness while completing.
OB staff talks with parents regarding need for Paternity if not married and wanting father name on certificate

only video we have is VCR one. We only have DVD player. Also I tell them that it is required to read all info on AOP and if any questions I will stop back and answer all questions. Have read it before to a few patients but not many.
Parents are counseled on all aspects of the AOP
Parents are offered the AOP video, and are always asked if they have read the attachment to the AOP papers before signing, and asked if they have any questions or concerns.
Parents receive Paternity Booklet
Some parents fill out the AOP form themselves so are able to read the form themselves. As for the Hispanic mothers, they are encouraged to ask questions, if they need help.
Staff will ask parents if they are married legally or divorced if applicable and then depending on the response the AOP form is given.
The B.C. coordinator witnesses the completing of paternity papers w/staff member as witness. If coordinator not available, the staff on maternity witnesses the completeness of paternity.
The Birth Registrar does all of this
unit clerk also explains the AOP process to parents and also offers to provide any information the parents may have
Verbal information is given to parents on what The AOP information form contains
VERBAL INSTRUCTIONS, EXPLANATIONS AND OR TRANSLATION ARE PROVIDED FOR ASSISTANCE WITH REGARD TO AOP'S
Verbally explained to parents before completion of form or signatures are witnessed
We ask if they have read the AOP and if they understand what they read and what it means to sign paternity
We explain just some highlights for the AOP then leave for dad and mom to look over. tear off the information page and give to dad if he is still there if not give to mom
we go over the AOP to make sure that the father fully understands what he is signing.
We inform there is an AOP video on our patient channels and strongly encourage them to watch the video before completing the form. We also verbally explain the form and how to complete it.
When I hand the form out I give them a over view of what the form says and answer any questions they have
<b>Q19</b>
Pre-birth is utilized as well
all of this information is supposed to be provided by the physician when they fill out the workbooklet
Birthweight information first hand information
child's records or if mother is a walk in her clinic chart and asking the mother for information.
clinical Estimate of gestation is only found on the pre-natal record
Date of last period is Blank or unknown a lot of the time
Electronic medical record (EMR) Pre-birth
I added a form to the packet we give to the Moms and Dads that was provided by my RPC, in which the mother supplies that information.
I answered "MD Delivery Notes" for all questions that are the responsibility of the doctor to answer. I do not, however, know the source of his information. If the information is not provided primarily, we call the doctor and remind them to do it.
Most of the time if a birth registrar is unsure of the notes in the patients chart, they ask the patient themselves about previous births; low birth weight, premature births, c-sections etc.
Other-our facility has electronic medical documentation.
Previous C/S, Previous low-birthweight birth, Previous preterm delivery - found in MD's dictated History & Physical.
Birthweight is also found on Newborn Identification Record (footprints)
specific form for inductions/augmentation
The Fetal Fibronectin Test -calendar
The New York State DOH booklet that parents/nursing staff fill out
There are times we might have to look in 5 different places in order to get one piece of info. At times the info we need is unclear so we have to make educated guess or they are different from the prenatal to the H & P sometimes the mom does not want the dad to know she has had a TAB so it is one place and not the other.
We have a report that pulls a lot of this information from the entire e-record into one report summary with all the information required to complete the electronic birth certificate
<b>Q22</b>
ACOG record
all of this information is in the physician booklet. A lot of times the information is left out or the wrong information is provided.
ask labor and delivery staff, office prenatal history and patient if it pertains to prenatal information not shown on office prenatal histories
ask the doctor if the doctor is not sure ask the mother.
Attending MD documentation - refer to D/C Summary

Attending MD documentation wins
Attending physician's notes considered most accurate.
By reviewing all records and questioning the MD when necessary.
Call birthing center or patient.
Call the OB Office.
Check to Doctors and Nursing records to see which one matches the birth record.
CHECK WITH MD,OR RN
Clarify with nursing or medical staff
Confirm with Health care provider Review chart further
confirmation by MD or previous medical record
contact ob/gyn for clarification
Delivery record
Delivery Record
depends on the provider and prior experience with completeness of their records
discuss with the clinical staff for clarification
double checking the notes,
go through entire record
I ask questions from doctor, clinical care person, and patient to verify discrepancies
I Go to the patients chart
I look for different ways like the delivery book. notes for the dr or nurses.
I read all resources or ask the providers to find which is accurate
I talk with nursing staff and the delivering doctor to confirm information.
I try to find as many instances I can of the information requested, and see if I can get at least two to agree. For fetal weight, which often varies, I find the PKU form usually has the correct weight on it.
I try to see if two sources agree or sometimes I call the labor room to verify what the correct information is.
I will usually go with the admission info Other things to list mom's pre-pregnancy Wt & Height there could be 3-4 different answers
It depends on the element - check with MD whenever possible.
It depends on which information I'm having an issue with. For last menses I will go with prenatal because that's the start of care. Any other information I will go with Doctors documentation.
Medical Records Clerk/Registrar brings chart to staff to verify correct information
never happens
Physician record or documentation
Refer to Clinician for assistance.
Registrar speaks to MD. on any conflict.
review all info
Review medical chart, refer to OB staff
Sometimes on the labor and Delivery Form that the nurses fill out, the nurses will put conflicting information. We double check the doctor's notes and or the delivery summary for accurate information.
The patient.
These questions would be better answered by the physicians as they are the people obtaining the info. Vital Statistic Staff does not obtain the clinical info; we simply get it from the doctor.
Use information from history & physical.
Use MD documentation/OB prenatal from doctor office.
Usually use documentation collected at the time closest to original date, such as date of menses at first prenatal visit
utilize pre natal charts
We ask the physician for clarification.
We call up to Maternity and ask them to verify the information
We don't compare prenatal vs delivery record.
We go with the prenatal for the most accurate.
We have electronic health system for over a year it is rarely contradictory but sometimes just missing.
We have very consistent information. The only issue is the data that is missing on the prenatals
we speak to pt to get correct info
We utilize all resources that are available to us. If there are too many inconsistencies we ask the nurse, doctor, or patient herself. Nothing is confirmed or recorded unless it is verified by the doctor.
We will confirm with DOH

Which source makes the most sense, or which info is most consistent.
<b>Q23</b>
Birth Registrar not aware of how hospital staff is instructed on these terms.
birth registrars are not responsible for coding. we just look for cephalic, breech, or other.
Brow, face, compound and transverse are coded as such. They are not coded as vertex
Cephalic
Compound and Transverse do not fall under the category of Vertex or Breech
compound could be considered vertex as well it all depends on what is coming out first (e.g., hand,) Transverse is "other" if the baby is sideways coming out.
documented as transverse lie
I am not qualified to answer this question. I am not a labor and delivery nurse
I do not handle this
I do not know how the physicians are instructed to answer these questions.
MD CODES FETAL PRESENTATION
Other is described by clinician
Per our JMH coders; Codes to malposition/malpresentation. Not a normal vertex presentation, but not documented as breech.
Term used if a hand is presenting
The report will generate if the birth was Vertex, Breech, Other, or Unknown and we will check the accuracy by looking into the delivery record which only uses these four terms.
The SPDS help info clearly states that brow and face should be "Other".
They use Cephalic, Breech and Other.
This information is entered by the HIM department at the time of coding.
Transverse is usually used to describe the c-section.
Use the guidelines given in the SPDS program
We are not involved in the coding instructions on these terms. We just take the info & report what we find.
We do not code fetal presentation unless it indicates a c-section
we have specific codes for the ones checked other
<b>Q24</b>
Completeness of the SPDS Work Booklet is usually an issue. This is where a majority of the information is derived from.
I am unsure
if pt is a walk-in try doctor sign form for release of information.
OB and Quality staff are supplied with monthly reports and Non Classifiable Reports
Pt. is given BC Workbook to complete readmit.
reports generated from EMR that include many required fields for birth registration but not all
some reports provide some information
Unit Coordinator completes the birth certificate.
Unknown
Use of birth certificate booklet used to facilitate birth registration
we generally phone the attending's office to obtain incomplete info and stress the importance of having complete info
<b>Q26</b>
DOH system does not have any reports that I can print
I don't see the value -- we always make sure all information entered by the time a baby is discharged
NEVER BEEN INSTRUCTED TO USE THIS SYSTEM
Presently we have a per-diem staffer working in this role. We have not had any formal training since the full time employee resigned.
some physicians do not comply with filling out paperwork, making poor quality of data
The monthly reports are given to the head of the OB department for review.
The NYC EVERS system does not have a reporting option.
training
Unaware we had access to run reports
Unknown
use other sources
We are not able to receive the reports.
we do not receive reports. I can request certain reports but there are no reports available in EBRS for NYC birth certificates
<b>Q27</b>

1) Provide transfer MR from referring hospital when pt is transferred to facility 2) Pre-pregnancy & post-pregnancy weight - remains a challenge to locate in the MR, esp. when pt has been treated elsewhere
Clinics and nurses need to be more accurate with their documentation.
complete documentation of information
completed ACOG's
Consolidation of electronic systems. Better trained registrars
Continue to reiterate the importance of the SPDS work booklet to the nurses and encourage them to complete.
Continued effort to fully complete booklets for registrar and monthly meetings.
Decrease the info needed to be collected. If info is needed for statistics find another way or system to enter the info besides the birth certificate.
Doctor Signature
Doctors filling out forms more timely.
Don't require information from patients that is sensitive. Patients feel it is an invasion of their privacy rights. We cannot force patients to comply with some of your questions.
educate MD office staff on prenatal data collection educate L&D staff on delivery data collection
EDUCATING THE ENTIRE OBSTETRIC STAFF, MAKING SURE ALL INFO IS COLLECTED
eliminate the paper and have one electronic system for the providers to enter the info following delivery
Financial assistance for the registrar
for clinical staff to fill out facility worksheet
For the demand on doctors providing efficiency on the medical information collected
Have one form or source that has all the information needed to complete the birth registration. The form should be completed by one person to ensure accurate information. The birth registrar could use this single form to report all data.
have only a certain few people trained to collect data; right now there are multiple people collecting the data
Have something quick and easy for the doctor/nurse to fill out once the baby is born. Have everything in one tab in the electric chart. Have access to the prenatal instead of it being faxed over. Have access to the other hospitals prenatal so we can record all information.
have the worksheets written on a 3rd or 4th grade level. you would be surprised at how many women (even those with advanced degrees) who write down their delivery weight instead of their pre-pregnancy weight.
Having a form with the needed info to be collected available to the OB offices so they can be sure they are asking all the appropriate questions to the patient at some point during the pregnancy
I don't have any at this time.
I find our doctors tend to be a bit sloppy with their dictations, and I have to be a sleuth to gather all the info that I need, which is time consuming.
I think our hospital does a great job ensuring accurate information. I think the key to that is educating the nurses and doctors to collect the most information they can. Of course that is also tricky because they don't always have the time.
I think that changing the wording of certain things such as Abnormal conditions of Newborns to perhaps something slightly more generic would make the MDs less hesitant to answer for fear of liability.
In service education to maternity & L&D staff on documenting important information for birth certificate reporting
It would help a great deal if the rest of the hospital staff could assist parents with questions when we are not here
Limit the number of clinical information required.
Limit time that the Acknowledgement of Paternity can be added in the hospital to 1 week, and match that time for hospital to file certificate with Town Hall.
Make pending Medicaid numbers easier to obtain.
Mandate Prenatal summaries so every office uses the same one. I said this in 2004. If DOH wants consistency and accuracy, start with the Prenatal summary.
MDs COMPLETE FACILITY WORK SHEET AND ANSWER ALL QUESTIONS ON IT.
More clinician involvement both at the hospital and office level.
More Physicians Education
Multiple forms in different languages, better explanation of the parent worksheet for certain fields, Electronic filing for parents or electronic filing for doctors
my manager suggestion made one video, for the parents see all the process for the birth certificate
N/A
n/a
N/A
No suggestions
NONE

None
none
none
none
none at this time
NYS inform physicians of the importance of accurate records
OB staff should review the mother's booklet before submitting to medical records
omitting the pre- pregnancy weight and report ONLY the current weight
Ongoing reminders of info required in collection of data
People work as a team to collect the information.
Physicians compliance
Physicians to comply
Place infant information first, then mother, then father. Leave remaining pages for staff to complete.
prioritize and simplify data collection, enhance accountability of providers that submit incomplete data
Receiving completed work booklet before delivery for review of spelling and demographics info. Universal prenatal care forms for providers. Now each office uses their own.
Spanish AOP forms will help lower errors lost in translation,
That the Dr's fill out the EBC's forms 100% of the time
The clinicians (PA's and Nurses) completing the hospital worksheets are stating that the form is very time consuming and complicated. Can the form be simplified to allowing the clinicians to provided accurate data?
The collection here at Noyes generally goes very smoothly.
The data elements required to successfully complete and submit the registration is becoming more and more difficult to obtain the information from clinicians/physicians. As an example, we struggle with the breast feeding information being provided in a timely manner to meet reporting deadlines.
the drs complete the workbooklet. the DOH revises the questions that need to be answered.
The information requested is quite clear and the only obstacle in collecting the information is really what the parents are willing to divulge at the time of interview. Demographics are never really a problem.
The method of collection we have in place has been very effective
The packet provided needs more definitions/instructions on what counts as what. We have added our own.
To ensure correct data collection, our nurses should be aware of how important it is to enter accurate data.
training
Update the worksheet to match the entry fields found in the computer software.
We need an updated Spanish workbooklet and one that coincides with the English forms.
We would like to involve the L&D staff in providing most of the clinical information. It is time consuming to look up that data in a non-friendly system such as Quadramed.
<b>Q28</b>
1. Make the AOPs so that they could accept double last names without going into the next column. 2. Enable MDs to electronically sign Birth Certificates. 3. Develop a more concrete policy on unlocking birth certificates so registrars know what is acceptable and what is not.
A formal training CD from the DOH would be helpful for reference. Continue with the help desk phone line.
Accurate phone numbers so when questions arise they can contact someone for answers.
allow for demographic information for multiples to auto-populate the other records. The suffix "Jr" should be in the first screens. Name of county should auto-populate when city entered.
allow for demographic information for multiples to auto-populate the other records. The suffix "Jr" should be in the first screens. Name of county should auto-populate when city entered.
Allowing up to 7 business days to file instead of 5 is not enough time when you have to deal with patients that don't want to complete the paper work until discharge
Annual training sessions for new and current registrars. Clarification of data fields to improve consistency in data collection.
Anytime I've ever needed assistance they have always been more than helpful.
At this time we could use a little more time, due to staffing and the parents not giving back the forms for submission of data.
CONTINUE TO INFORM FACILITY ON QUARTERLY BASIS OF PROGRESS
continues to provide the quality report data
for EVERS to be faster and more support that the clinical staff fill out facility worksheet
Get the tabbing correct and when printing out a full record, have it print in the workbooklet format; this would speed up the time it takes to check for accuracy. Don't mix the parents info with the medical info.
Give us a listing of localities for residence and mailing, courier service to the local health department,

Give us a way to search individual fields, rather than just name, date and number. (So I could find all patients who had intrauterine pressure monitoring, for example - I know I can a year or more later - need ability in real time.)
Give us clear and more accurate definitions in HPN
Heads up on Moms that they might have contact with and they think we should be aware of certain situations
I would like to see some the warning fields updated. Example if a patient VBACS or has her 1st repeat c/s it warns you that they c/s information is inconsistent. Or why can't dad have a field under employment that says not employed. Also the race question is a hard field to get filled in a lot of people feel offended by it. I will call my patients to fill in missing data so I can get the most update correct data.
If there were less data elements required and extension on reporting window
In my opinion, I think the health department should require that attendants/providers complete the worksheet. we have focused on the completeness of the worksheet by providers and that has improved considerably. they certainly are not perfect but much better.
It would be great if there was some "continuing education" -- or at least refresher classes -- offered online. Maybe a blog, or some sort of online community for birth registrars to share information/ask questions/etc.
make a requirement for physicians to complete or answer all questions in workbooklet or prenatal
make customizable reports available, consistently apply regulations and rules r/t registration, acknowledgement of paternity documents in other languages
More Info
More updated and complete tract book info. Ours are VERY OLD and don't always list address' and newer streets as they are constructed.
mothers survey to be omitted
Mothers tend to complained and ask why so much personal questions. What does this have to with Birth Certificate?
n/a
n/a
na
No suggestions
no suggestions at this time
NONE
none
none
none
none at this time
None, the dept. of health has always been helpful when I have concerns.
Not sure many people feel it is not necessary to Provide all their personnel info to the state.
Not sure?
Nothing right now.
Offer periodic training
online courses and onsite training
Physicians Compliance
Possible checking in the practices about the prenats. Explaining to all the facilities that we need all the information completed, accurate and up to date.
Provide a comprehensive pamphlet that tells the parents all of the benefits of accurate reporting in simple language. This will assist the Birth Registrars when they are explaining the process. There are pamphlets now, but some are too rigid. Most refuse to give any information, specifically about the fathers because of the fear of pursuit for child support. The clientele in the caption area are not always cooperative when pushed and often become abusive.
Providing a 24 hour window to make changes, 24 hour support
Reconfigure 14-page packet into an easier format.
Reduce system downtime and computer freezes
reviews, education
some of the questions need to be clear. this is why the drs are not completing the workbooklets because a lot of the time the questions do not relate to their delivery.
Take away "unknown" as an option, when we don't want the doctor to use it. i.e.: Congenital Anomalies, or "Unknown at this time" option on L&D pages. The wording should be "check all that apply, or none."
The AOP form is complicated and not user friendly to the patients. The majority of the time, the registrars have to assist with completion of form. Is there a way to simplify the AOP form? In addition, there are 17 screens in EVERS for data entry, slowing down the registrars when entering the certificates and delay reporting.
The department of health already does a very good job in assisting us with our work.

The health department is available if we ever need assistance.
the possibility of extending the 5 day birth registration submission time.
The SPDS could be more user friendly just by working properly. For example, the tabs don't always work in the correct order.
The system seems seamless and easy to follow.
they are more than helpful as it stands right now always available for questions and trouble shooting
they can not
They could create the form above.
Unknown
Unknown
Update EBC
Update your software system to include more current information. Need ability to over ride information. Electronic signature for physicians is needed. Have workbook on line.
when a need help I call to New York State birth register for any question they help lot.
<b>Q29</b>
All Prenatal information,
AOPs...Especially when fathers are out of the country, incarcerated or when mother is married- not yet divorced but, baby father is someone other than legal husband
AT our hospital probably how to get the most accurate information from our personal interview re: workbook survey
Better clinical documentation from the physicians. That is our most common nemesis.
Cannot say at this moment but the gathering of the information takes the most time. the Evers alerts us to omission and errors, but at times the system is very slow it cut off at 3pm and sometimes difficult to access.
Certain items that don't have clear definitions, such as what constitutes analgesia, when exactly should you check off "fetal intolerance to labor", etc.
Clinicians require training on how to accurately record data timely
collecting and transcribing the info from the work sheet.
Collection of prenatal data which originates with the physicians' private offices could be more complete.
complete ACOG would help
congenital abnormalities, usually marked off on delivery sheet but knowledge of some are vague.
County of Birth
Date of last menses and previous pregnancies.
Definitions of Medical Terms, i.e. Cephalic=vertex
double checking the information that's needed to complete the Birth Certificate with the acknowledgement.
dr's booklet
education for providers regarding data r/t importance and specific prior pregnancy outcomes, a more streamlined process
Education on Augmentation vs Induction, Insurance coding, Indications for C-section
Entire workbook needs to be reconfigured because it takes months to train new staff.
Ethnicity and Race.
ethnicity reporting (race)
Everyone should be using the same definitions for ex: if coding uses different definitions, then the Birth Registration should be using the same definitions and vice versa. SPARCS and SPDS often have conflicting results due to different definitions being used.
everything
Facility Worksheet and AOP
For Vital Statistic Staff we spend some time explaining the Legal Marital Status and whether or not an Acknowledgement of Paternity should be signed.
How to report information that is not available through lack of prenatal care.
I am very lucky where I work to have the nurses and providers at my disposal to help with my questions. I think knowing medical terms is key. I think being informed of changes is key. I also think the meeting that Albany holds in our region is helpful so that we collect the data in the same manner so the data is consistent through the region.
I just think that yearly or 2 a year meeting with other registrars would be helpful. Paternity papers, Obstetric procedures, Risk Factor & pregnancy and Congenital anomalies are areas that could require more training.
induction of labor; malpresentation; preterm labor vs. preterm contractions; timeframe for premature rupture of membranes and prolonged labor. Why is maternal death not included in mortality. Pregnancy History? are "early" losses from multiple gestations in current pregnancy included?
Insurance information, why can't we use EDD to calculate the menses.
initial workbook responses, are sometimes inaccurate or blank.

it is not a matter of more training (at least for Mt. Sinai).it is the fact that many portions of the EMR are not available to birth registrars. this is how the hospital has coded these positions.
Items that require understanding of Medical terms
low birth wt, previous preterm del, hypertension, AROM, previous c/s
make it more clear that parents can use two last names for baby Example: Apellido o Apellidos(Spanish) English - Last name or last names of baby #1 mothers work sheet this will eliminate many corrections
Many areas of the facility form are being left blank by the providers The registrars are constantly going back to the providers for missing information on the facility form.
Medical coding
Medical terminology
Mom's delivery information.
More training on how to record previous live births, twin coding. The characteristics of labor & delivery what is considered induction vs. augmentation. Congenital anomalies what to look for.
Mothers middle name verses maiden name, pediatrician after discharge, training in localities, Interview/Records/Survey of mother in hospital
N/A
n/a
N/A
No problem at this time.
None
None at this time.
None.
PATERNITY PAPERS
Patient knowledge of AOP
Physician / Midwife in-service on required data collection to prepare the record.
Physician documentation accuracy in ACOG/H & P; Definitions for consistency (e.g. augmentation means different things to different people; if a standard definition was used then we would all be on the same page)
pregnancy factors and newborn factors
Race, ethnicity
The collection of medical data
The Labor and delivery sheet page 9 in the SPDS booklet that the nurses fill out after delivery should be completed with extra awareness of accuracy.
The MDs need to understand the importance of accurate and thorough documentation. When information is missing or incomplete, it is very time consuming to have to go back and try to find form other sources.
The types of deliveries and the onset of labor category could use more training.
this way we collect all the birth certificate work booklet in this hospital for medical records is good way
We are always learning about how to code something and the different situations that can cause you to question how you would. This helps in case we have a situation happen like it or similar to.
when our facility can do an unlock to change information, time frame and specific information that can be changed.
Workbooklets and AOP in Spanish to be accepted by DOH