CT Department of Public Health

**SUMMARY FACT SHEET**

**Medical Provider Training Course**

Connecticut’s New Certificate of Live Birth, 2003 Revision

**Introduction**

*Beginning January 1st, 2016*, each live birth born in Connecticut will be registered using Connecticut’s New Live Birth Certificate. The New Birth Certificate contains many modernizations that improve the content and quality of the birth data collected. At the same time, Connecticut’s new Vital Records System, ConnVRS, will be implemented at all birth facilities.

To prepare medical providers for this transition, the Connecticut Department of Public Health and the State Office of Vital Records developed a training course for physicians, prenatal care providers, and hospital staffs with comprehensive information on why the birth data and its quality are important and how to properly collect and report birth certificate data.

Providers are encouraged to view the course in its entirety for a comprehensive overview of Connecticut’s New Live Birth Certificate. The Training Course and additional resources can be accessed through the Connecticut Vital Records webpage at [www.ct.gov/DPH/VitalRecordsTraining](http://www.ct.gov/DPH/VitalRecordsTraining). This summary sheet highlights the most important points of the Medical Provider Training Course.

**The Birth Certificate Serves Two Primary Purposes**

**Legal Documentation**

The certificate serves as legal documentation to the facts of the birth, such as where or when he or she was born and who the child’s parents are. The child will need it to prove age and citizenship, enter school, obtain a driver’s license, apply for a passport, and many other purposes.

**Public Health Resource**

The birth certificate is a major public health resource for the surveillance and promotion of maternal and newborn health at national, state, and local levels. The birth certificate provides detailed health and medical information about the mother, the prenatal period, the delivery, and the newborn that supports public health surveillance and initiatives. Birth data are used to identify maternal and infant health needs, allocate resources, drive health policy, and measure results of health policies and programs.

**We Are Part of a National System**

**National Vital Statistics System**

NVSS is the Nation’s system for collecting and reporting official statistics on births, deaths, fetal deaths, marriages, and divorces. Collection of vital event data, such as live births, occurs through 57 independent registration areas (the 50 states; New York City and Washington, D.C.; five U.S. territories). Each registration area maintains and operates its own vital registration system which captures the vital event data.

**National Center for Health Statistics**

NCHS is a branch of the CDC and serves as the Nation's principal health statistics agency. Its mission is to provide statistical information that will guide actions and policies to improve the health of the American people. NCHS is mandated by law to collect and disseminate national vital statistics birth data. It achieves this by compiling the data from all 57 registration areas into a national data file. NCHS then produces a variety of annual and special reports at state and national levels.

***State vital***

***statistics office***

**Standard Certificates and Revisions**

**U.S. Standard Certificate**

The US Standard Certificate of Live Birth is the principal means by which uniformity of birth data collection is achieved across the 57 jurisdictions. Through inclusion of demographic and health information, the birth certificate provides a valuable public health resource for our Nation.

**Revisions**

Periodic revisions of the US Standard Certificate of Live Birth serve to modernize the information collected by the certificate and afford our Nation the opportunity to make substantive improvements in the content, procedure, and quality of the birth information collected.

**New Standardizations Improve Consistency and Quality**

**Standardizations**

A cross-cutting criticism of the 1989 Revision was that the lack of standardization undermined data quality. To address this issue, the CDC’s NCHS collaboratively developed sets of detailed specifications for collecting and reporting the items on the birth certificates.

Connecticut has incorporated most of the recommended standardizations into our collection worksheets – making the worksheets themselves a comprehensive tool for quality data collection.

* Separate worksheets (the Mother’s Worksheet and the Facility Worksheet) effectively parse apart the information by best source for the information.
* Worksheets provide as stable resource for collecting the birth information which supports consistency by providing a uniform resource from one hospital/physician/midwife to another throughout the country and maintaining that consistency across time and through staff turnover.
* Our worksheets serve as a comprehensive tool for the collection process by integrating definitions and supplemental guidance into the worksheets themselves.
* Our worksheets are designed to facilitate efficient data entry into the electronic registry system, ConnVRS.

We expect that the quality of Connecticut’s birth certificate data will be greatly improved as a result of implementing these standards.

*Remember, it is critical that all medical providers and hospital staff follow these standards as closely as possible to promote quality data collection throughout Connecticut and throughout the United States.*

**The Facility Worksheet**

**Overview**

The Facility Worksheet collects the birth information for which the mother’s and newborn’s medical records are the preferred source. Connecticut’s new Facility Worksheet includes added documentation which has increased the length of the worksheets to 7 pages, yet the amount of information being collected by the new Facility Worksheet is comparable to the old worksheets. A copy of the Facility Worksheet is available for download at [www.ct.gov/DPH/ConnVRS](http://www.ct.gov/DPH/ConnVRS).

**Administrative Updates**

Connecticut’s New Live Birth Certificate, 2003 Revision, will go into effect on January 1, 2016. The 1989 Revision worksheets are not valid with the 2003 Revision of the birth certificate.

A title box on the front page of the Facility Worksheet provides a summary of the Connecticut General Statute §7-48 requirements for completing a live birth certificate.

* The birth attendant and prenatal care provider are to provide the information required on the birth certificate within 72 hours of the birth.
* The hospital is responsible for completing the birth certificate and filing it within 10 days of the birth.

It is the policy of the Connecticut Department of Public Health that the birth attendant is the preferred hospital staff person to complete the Facility Worksheet.

* If the Birth Attendant or other Attending OB is not completing the Facility Worksheet, these providers must support the rest of the birth certificate team to ensure that the birth information is complete and correct.
* Incompleteness and/or uncertainty are both valid reasons for pushing the Facility Worksheet back to the attending physician or other clinical provider for review.

**Medical Certification**

The certifier is legally certifying to the facts of the birth: “I Hereby certify that the child was born at the hour, date, and place stated above.”

* In a hospital, the Certifier should be a licensed provider present at the delivery who can certify to the place, date, and time of the birth to that mother.
* In a home birth, the Certifier should be a licensed physician or licensed midwife, or in absence thereof, the Mother.
* The Certifier may or may not be the Birth Attendant.

**Birth Attendant**

The attendant at birth is the person *physically present at the delivery room who is responsible for the delivery even if they do not themselves deliver the infant*. Thus, the birth attendant is the attendant at birth responsible for the delivery. The Birth Attendant may or may not be the Certifier, although it is preferred that they are the same person.

**Prenatal Items**

This section of the Facility Worksheet represents the perinatal events that would occur or be diagnosed prior to labor, such as prenatal care usage, pregnancy history, and maternal risk factors.

Prenatal care providers are the originating stewards of this information.

* Connecticut General Statute §7-48 states that the prenatal care provider shall provide the medical information required by the certificate within 72 hours of birth.
* Since this section of the birth record is abstracted from the prenatal care record, the quality and completeness of the prenatal care records have a direct impact on the quality and completeness of the birth record.
* Prenatal care providers should strive to properly document all information required for the birth record. For example, recording both the month and year of the last live birth in the mother’s prenatal care record so that it is available for the Facility Worksheet.

**Unknowns**

When information cannot be ascertained because a record is unavailable, the information should be reported on the worksheet as “unknown”. No attempt should be made to report information that cannot be validated using the mother’s or newborn’s records.

When information cannot be ascertained because the record is unclear or ambiguous, the medical provider or hospital birth registrar should not make assumptions. When in doubt, seek clarification from the primary medical provider for the mother or from the pediatrician for the infant.

**Notable Changes**

The revisions to Connecticut’s Live Birth Certificate are substantial – fields have been added, deleted, and wholly revised. The form used for reporting the birth data, the Facility Worksheet, has been modernized to collect the new fields as well as modified to support collection of quality birth data. An abridged list of the notable changes to individual items can be found at the end of this document.

**Summary**

The Facility Worksheet is a standardized collection tool specially designed to improve the quality and completeness of birth certificate data.  Providers are *required* to use the new Facility Worksheet to collect the health and medical information for Connecticut’s New Live Birth Certificate.  To support Medical Providers with this transition, Connecticut developed a Medical Provider Training Course that covers each item in the new Facility Worksheet.   Providers are encouraged to view the course in its entirety for a comprehensive overview of Connecticut’s New Live Birth Certificate.  The Training Course and additional resources can be accessed through the Connecticut Vital Records webpage at [www.ct.gov/DPH/VitalRecordsTraining](http://www.ct.gov/DPH/VitalRecordsTraining).

**Thank you for taking the time to review the revisions and**

**preparing to complete the new birth certificate.**

**Contact Us**

For questions or concerns, please contact the Connecticut State Office of Vital Records at (860) 509-7896 or via our dedicated ConnVRS email at ConnVRSSupport.DPH@ct.gov.

**2003 Revisions in Detail**

PRENATAL SECTION

**Date of first prenatal care visit** is now required; effectively replacing the item “month prenatal care began”

**Date last normal menses began** should be the exact LMP date self-reported by the mother. Unsure or unknown portions of the date should be reported as “unknown”.

* Prenatal care providers should not substitute estimates for any part of the date (such as day=1 or day=15) when the mother is uncertain about the exact date. Substituting parts of the date imposes systematic bias into the calculation of gestational age at the time of delivery that can impact estimates of preterm versus full-term rates.
* Do not use the wheel to reverse calculate LMP from the estimated date of delivery or the actual delivery date.
* Do not calculate the LMP date in any way if it is not specified in the prenatal care record.

**Method of determining Estimated Due Date** is a state-added item used to ascertain the methods used for dating gestation.

* With the ACOG and NCHS adoption of the obstetric estimate of gestation as the primary measure of gestational age, Connecticut added this item to monitor this paradigm shift and to aid ourselves in understanding the impact of LMP, ultrasound, and ART dating in the estimation of gestational age for Connecticut babies.
* The item asks for the method (ultrasound, LMP, ART) used by the prenatal care provider to establish the Estimated Date of Delivery (EDD) and offers 7 mutually exclusive options. The respondent should check only one option.

**Other pregnancy outcomes** collects the total count of pregnancy losses of any gestational age and for any reason. These may be spontaneous losses (miscarriages), induced losses (abortions), and/or ectopic pregnancies. It includes losses prior to 20 weeks gestation as well as fetal deaths occurring after 20 weeks.

* Some physicians have expressed concern about the reporting of abortions on the birth certificate. Please remember that this item collects all types of losses and is not specific to abortions. The reporting of a count for this item does not specifically indicate an abortion was received, but rather that a mother had a pregnancy that did not result in a live birth. The child’s legal certificate of live birth document does not include any of the mother’s health or medical information.

**Positive tests for Syphilis** has been improved by defining the item as “Did mother’s blood test positive for syphilis during this pregnancy?” Previously, the item asked if and when the test was performed with no information about the test result. The exact test date is available on the lab work and is required for any positive result. The CT DPH Infection Diseases program uses these test dates to perform surveillance and outreach. The second test date is optional but allows the reporting of a second, confirmatory test. For “No” responses, no test date is required because the result was negative.

**For diabetes and hypertension**, notice the terms used in the 2003 Revision are now “pre-pregnancy” and “gestational” rather than chronic or pregnancy-associated. This is an important distinction as the definitions have changed to fit those terms.

**Pregnancy resulted from infertility treatment** collects information on whether an assisted reproduction technique was used to initiate the pregnancy and includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).” It is a two part item. The first part indicates whether pregnancy resulted from infertility treatment. The second part indicates the types of treatments used to initiate the pregnancy.

**Previous Cesarean delivery** is now reported in this section using a 2-part response. First, indicating whether the mother had a previous cesarean delivery. Second, indicating the number of previous cesareans deliveries.

**Mother used tobacco cigarettes or alcohol during this pregnancy** are two items added to help identify unreported cases of smoking and alcohol consumption in mothers. They are defined as “Prenatal care record indicates that mother used [tobacco cigarettes / alcohol] during pregnancy.  Include any reported use during  this pregnancy, *even if mother reported cessation upon learning of her pregnancy*, as documented in her prenatal care record. Electronic cigarettes, known as e-cigs, and other vapor products are not tobacco cigarettes and should not be included in this item.

**“None of the above” and “Unknown”**

* None of the above is to be selected when the prenatal record has been reviewed for all the items in this section but the record shows no evidence of the above risk factors. Do not select this item if the prenatal record has not been reviewed.
* Unknown is to be selected when the medical record is either not available for review or the details in the record are not sufficient to properly ascertain status for these risk factors.

**Infections during pregnancy** have been rearranged and grouped into a single item with checkboxes. The item is defined as “Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.”

**The obstetric procedures** section has been reduced to a single procedure: **External Cephalic Version**, successful/failed. If an ECV was performed, the provider must report whether the procedure was successful (fetus was converted to a vertex position) or failed. If the mother did not receive an External cephalic version, the provider should check “none of the above”.

LABOR AND DELIVERY

**Principal source of payment for delivery** is the majority payer for the mother’s delivery. The payer for the delivery may or may not be the same as the payer for the prenatal care. Do not assume they are the same. Principal source of payment for delivery provides information about the mother’s access to insurance coverage and is an integral component for perinatal outcomes research, cost analyses, and programmatic change.

**Characteristics of labor and delivery** have been updated to a set of 6 items that provide information about the course of labor and delivery. Check all characteristics that apply to this mother. The definitions have been provided on the new Worksheet to assist with reporting.

**Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F)** is an “either/or” definition. This item should be checked is a clinical diagnosis of chorioamnionitis during labor was made by the delivery attendant –OR- if the mother had a maternal temperature at or above 38°C (100.4°F).

**Method of delivery** has been revised to collect the fetal presentation at birth and then the final route and method of delivery.

* If the method of delivery was Cesarean, the sub-item *If cesarean, was a trial of labor attempted?* is required.

**Maternal morbidity** lists five serious complications associated with labor and delivery that may have been experienced by the mother. These morbidities should be reported if they occur during the post-partum period even when they were not present at the time of delivery.

NEWBORN

**Plurality of birth** is defined as the number of infants delivered live or dead at any time in the pregnancy regardless of gestational age, or if the fetuses were delivered at different dates in the pregnancy. If the plurality is multiple, the medical provider is instructed to report:

* Total LIVE births in this pregnancy (delivered alive at any point in this pregnancy; include this birth), and
* Birth order of this infant amongst all infants delivered (alive or dead) in this pregnancy.

**APGAR score** is now collected at 5 minutes for every infant. If a 5 minute APGAR score is less than 6, then a 10 minute APGAR score is required. Note that the new Worksheet no longer collects the 1min APGAR score.

**Obstetric estimate of gestation at delivery** is the birth attendant’s final estimate of gestation based on the best obstetric estimate of gestation in completed weeks. Beginning in October of 2014, the obstetrician’s best estimate of gestational age per *ACOG’s Guidelines for Re-dating Based on Ultrasonography* should be used as the primary measure for establishing gestational age.

**Abnormal conditions of the newborn** is a check list of seven conditions (disorders or significant morbidity) experienced by the newborn either prenatally or during the first few days of life. Many of the conditions in the new Worksheet have been revised or are new to the birth certificate. Each condition has a definition provided on the new Worksheet.

* The option “None of the above” is to be checked when the labor and delivery records and newborn’s medical records have been reviewed for all the items in this section but the records show no evidence of the above conditions. Do not check “None of the above” item if the medical records have not been reviewed.

**Congenital anomalies of the newborn** are malformations of the newborn diagnosed prenatally or after delivery and through the first few days of life. Since congenital anomalies may manifest sometime after delivery, the newborn’s medical records should be reviewed upon discharge to confirm whether a congenital anomaly was diagnosed prior to discharge. Each anomaly has a definition provided on the new Worksheet.

* For Down Syndrome and Suspected Chromosomal Disorder, the new Worksheet includes the sub-items “Karyotype confirmed” and “Karyotype pending”. The medical provider must report if the karyotype has been confirmed or if the results are pending. We encourage the hospital staffs to review the newborn’s medical record for the results of any pending genetic tests prior to submitting the birth record to ensure that the most accurate information is reported on the birth certificate.
* The option “None of the above” is to be checked when the labor and delivery records and newborn’s medical records have been reviewed for all the items in this section but the records show no evidence of the above conditions. Do not check “None of the above” item if the medical records have not been reviewed.

**Is infant being breastfed at discharge** has been added to the new Worksheet to ascertain whether the infant was receiving breastmilk or colostrum during the period between birth and discharge from the hospital.