Pursuant to 201 KAR 20:660, LCPM annual report forms submitted for LCPM Advisory Council review shall be regarded as correspondence with private individuals, not notice of the final action of a public agency, and shall not be disclosed to the public. The Kentucky Board of Nursing shall make public aggregate incident and annual report data that does not identify individual licensees or information that would violate the confidentiality of information or knowledge concerning any patient, except as authorized or required by law such as pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub.L. No. 104-191, 110 Stat.1936. Nonetheless, avoid any direct reference to patient identifying information.

KBN, KBN staff and KBN contractors will retain LCPM annual reports and incident reports in accordance with standards that are at least as stringent as the security and breach investigation procedures and practices established by the Commonwealth Office of Technology: COT-067 - Security Standard Procedures Manual; CIO-061 - Social Media Policy; CIO-072 - Identity and Access Management Policy; CIO-073 - Anti-Virus Policy; CIO-074 - Enterprise Network Security Architecture Policy; CIO-076 - Firewall and Virtual Private Network Administration Policy; CIO-078 - Wireless LAN Policy; CIO-084 - Email Review Request; CIO-085 - Authorized Agency Contacts; CIO-087 - Internet Usage Review Request Policy; CIO-090 - Information Security Incident Response Policy; CIO-091 - Enterprise Information Security Program; and CIO-092 - Media Protection Policy. See, https://technology.ky.gov/ciso/Pages/InformationSecurityPolicies,StandardsandProcedures.aspx

Licensed Certified Professional Midwives Annual Report

Pursuant to KRS 314.404(10) and 201 KAR 20:660, an LCPM shall report the following information to the Board of Nursing on or before September 1 of each year for the period of July 1 through June 30 preceding. The LCPM Advisory Council shall review all reports.

Midwife name: _____ License #: _____

Calendar Year Reporting: _____

The total number of clients under your care for any reason during the reporting period (this number should include clients who were under your care at any point during the reporting period to include clients who have had their care transferred to another provider, clients who had an intrauterine fetal demise or who completed six weeks of post-partum care, etc.) ___

The total number of clients whose pregnancy resulted in a miscarriage prior to 20 weeks gestation _____

The total number of clients whose pregnancy resulted in a miscarriage after 20 weeks gestation _____

The total number of clients whose pregnancy ended without a live birth due to other outcomes. Please specify the other outcomes _____

The total number of clients whose pregnancy resulted in a live birth _____

For the following questions, please answer for all clients served, even if the client transferred care before delivery (the sum of the next three questions should equal the total number of live births) _____

How many infants were delivered vaginally? _____

How many infants were delivered through cesarean section? _____

How many had an unknown delivery method? _____

The total number of clients who did not complete care with the certified professional midwife due to attrition for non-medical reasons: _____

The number of cases of newborn deaths, defined as deaths occurring within 28 days after delivery: _____

The number of cases of maternal deaths, defined as the death of a woman while pregnant or within 42 days of the end of pregnancy: _____

Please provide the following information for each category:

Referral: Referral is defined as the process by which a licensed certified professional midwife arranges for an accepting physician or other appropriate licensed healthcare provider to assume primary management responsibility for the condition requiring referral, which shall not preclude the licensed certified professional midwife from continuing in the provision of care as mutually agreed upon with the accepting provider, as regulated by the board.

The number of referrals for:

Of a client in the antepartum period _____

Of a client in the intrapartum period _____

Of a client in the immediate postpartum period _____

For the total number of referrals indicated above, enter the number of occurrences for each indication:

_____ Abnormal vaginal bleeding during pregnancy other than first trimester bleeding

_____ Abnormality in a screening test indicative of possible genital tract malignancy or premalignant condition during the pregnancy

_____ Acute or chronic bacterial or fungal infection

_____ Anatomic fetal abnormalities: Known potentially serious anatomic fetal abnormalities

_____ Cardiovascular disease, including hypertension

_____ Diabetes: Any type of diabetes not controlled by diet

_____ Endocrinologic abnormalities

_____ Gestational age greater than forty-two (42) weeks

_____ Hematologic abnormalities other than physiologic anemia of pregnancy

_____ History of cervical incompetence

_____ History of impaired glucose tolerance, history of diabetes satisfactorily controlled by diet and lifestyle changes alone, abnormal blood sugar or glucose tolerance test, or history of gestational diabetes

_____ History of invasive malignancy

_____ History of preterm birth

_____ History of prior intrauterine fetal demise or neonatal death

_____ History of severe shoulder dystocia as documented by objective findings

_____ HIV infection

_____ Intrauterine growth restriction, oligohydramnios or polyhadramnios in the current pregnancy

_____ Liver or kidney disease

_____ Multifetal gestation

_____ Non-cephalic presentation after thirty-six (36) weeks gestation

_____ Placenta previa: Complete placenta previa

_____ Placenta previa: Partial placenta previa persisting after thirty-two weeks

_____ Pre-eclampsia or eclampsia

_____ Prior cesarean section or other surgery resulting in a uterine scar

_____ Psychiatric illness: History of severe and persistent mental illness

_____ Psychiatric illness: Severe psychiatric illness that may result in bodily harm to self or others

_____ Pulmonary disease: Current asthma or other significant pulmonary disease

_____ Seizure disorder or other significant neurologic disease

_____ Substance use disorder, in remission

_____ Substance use disorder with current or recent use

_____ Any other condition or symptom which may threaten the life of the client or fetus or which could adversely affect the client or fetus, as assessed by an LCPM exercising reasonable skill and knowledge (to include space to provide additional information)

Transfer/Transport: "Transfer" and "Transport" are defined as the act of transporting a client to a licensed healthcare facility providing a higher level of care.

The number of transfers/transports for:

Of a client in the antepartum period _____

Of a client in the intrapartum period _____

Of a client in the immediate postpartum period _____

The reason for each transfer/transport

_____

_____

_____

The outcome of each transfer/transport

_____

_____

_____

How many clients with live born infants initiated breastfeeding (exclusive breastfeeding defined as feeding your baby only breast milk)? _____

How many clients with live born infants were exclusively breastfeeding at the six-week post-partum checkup? _____

Provide a brief description of any complications resulting in the maternal morbidity or mortality of a mother through 42 days following the end of a pregnancy or a newborn that occurs within the first 28 days. Morbidity is defined as a condition requiring the unplanned involvement of another health care practitioner. (if additional space is needed please submit the information on a separate sheet of paper):

_____

_____

_____

_____

For deliveries that occurred at a location other than the planned location how many occurred at the following:

_____ In transit

_____ In a hospital

_____ Other, if other location is identified please identify the other location for each instance generally without identifying a physical address

_____

_____

_____

Attestation Statement:

I certify that I am the person named in this annual report and that all statements contained herein and on all attachments, if any, are true and correct in every respect. I further understand that all information on this annual report is subject to audit for verification and that the falsification of any information contained herein will be cause for disciplinary action.

Signature: _____ Date: _____