ACNM Benchmarking Program Information Packet

PLEASE NOTE: The intent of this survey is to capture perinatal quality data across a variety of settings where CNMs/CMs are providing intrapartum care.

PURPOSE

The purpose of the ACNM Benchmarking Program is two-fold: 1) to provide members with a platform for monitoring, maintaining, and improving the quality of midwifery care; 2) to provide a national snapshot of midwifery quality metrics, related to perinatal outcomes in all settings where CNMs/CMs are involved in full-scope maternity care.

These purposes are achieved by providing a forum for members to compare their practice outcomes and productivity measures against other midwifery practices, facilitating quality management techniques in clinical practice, and by increasing member awareness of "best practices" in midwifery care. **Midwives are encouraged to participate even if they do not collect data for every indicator included in the Benchmarking survey**.

HOW TO BE INVOLVED

Data is submitted once a year online. The survey opens February 1st and remains available until March 15th. Members who have participated in the past will receive an email with the link and log in information.

The data requested is in the form of aggregate practice-level data (i.e. raw numbers in total for the practice) and should represent care provided during the prior calendar year (January 1st – December 31st). Collection and reporting of individual patient-level data is NOT the goal of this project.

The specific data points requested remains similar from year to year, but occasionally there are changes implemented to ensure that definitions and quality metrics are consistent with other national perinatal quality indicators. When Benchmarking survey questions are edited or altered, ACNM membership is notified as early in the data collection cycle as possible.

The absolute deadline for submission of 2017 data is **11:59pm Pacific DST on March 15, 2018**. The Benchmarking Project is not able to accept any late submissions due to stringent data analysis timelines.

This user guide is intended to assist participants in collecting and reporting data for entry into the online survey. It is very important for participating midwives/practices to review the information below prior to beginning data aggregation and submission. There are three sections:

- **Benchmarking Instructions** – guidelines for participation in ACNM Benchmarking
- **Data Definitions** – detailed definitions for specific data metrics; ensures consistency and uniformity across participant data
- **List of Survey Items –** intended to guide midwives/practices in data collection and aggregation. The questions listed on this form are exact duplicates of those that will be encountered during online data entry.

BENCHMARKING RESULTS

The online survey closes on **March 15th.** This allows time for extensive data review and statistical analysis. A timeline for results reporting is as follows:

- **Individual practice reports**: Practices can view their outcomes online immediately after they submit their data. A report showing comparisons to other participating like-sized practices is available when the online survey closes.

- **Preliminary Summary**: a brief summary highlighting survey participation rates and various summary measures; presented publicly during the ACNM Annual Meeting

- **Best Practice Roster & National Benchmark Recognition**: various recognition rosters indicating participants with excellent outcomes; practice data that meets/exceeds common national benchmarks in perinatal quality; published in the summer to the ACNM Benchmarking website and in various organizational media releases

- **Full Benchmarking Report**: presented annually at the ACNM Midwifery Works conference; provides summary data for all data points and highlights findings and best practices for selected categories of outcomes

CONFIDENTIALTY

ACNM strives to maintain the confidentiality of the midwives/practices who participate in the Benchmarking Program. Confidentiality is important to ensuring midwives/practices are comfortable sharing their practice information without concern for the information being shared without their consent.

The Benchmarking Program maintains a system for protecting the identity of the survey participants. Participant names and practice locations are separated from the survey data. Participants are identified using a unique, randomly assigned code. The only instance where the survey data might be re-linked with the participant identity is if contact with the participant is needed for the purposes of clarifying data or if the midwife/practice agrees to be recognized for achieving "best practice".

Survey asks participants to indicate whether they agree to have their name/location listed in publications related to benchmarking. Midwives/practices will only be referred to by their unique identification code, unless they have agreed to have their identity shared.

ACNM DATA PROTECTION STATEMENT

Clinical data and membership information collected in this survey may be used in research describing practice characteristics, membership characteristics, and workforce characteristics of ACNM members. This information may be used to inform policy makers, legislatures, consumers, and others. The information may be published on the ACNM website, in Quickening, or professional journals. Data will be de-identified and analyzed in the aggregate to assure confidentiality and maintain anonymity of those responding. Responding to the survey is voluntary and implies consent for ACNM to use the data provided.

Benchmarking Instructions

The following instructions are important to review **BEFORE** entering any information into the survey.

1. Please **read all directions carefully.**
   - If you DO NOT collect data for a particular survey item, **leave it blank** in the response box. Do NOT enter a zero!!
   - **Only enter zero** if you DO collect the requested data and the actual result is zero.

2. You will be entering a **raw number** for each item. DO NOT enter percentages! The percentages will be calculated for your practice and listed in your report. It is important that you enter an **accurate number** in each response box, so **read each item carefully.**

3. Check your responses to be sure they are **logical**.
   - *For example*, the number of episiotomies should not exceed the total number of vaginal births.

4. Only enter data related to **care provided between January 1, 2017 – December 31, 2017**.

5. **Review the data definitions** for all items before entering any survey responses. The accuracy of survey results is based on the assumption that each participant is defining and counting the same things and in the same way. The definitions are included as part of this information packet.

6. Some items require a response in order to participate in Benchmarking. If you do not enter data for these items you will not be able to advance to the next survey item and your submission will be omitted from the Benchmarking database. **Six survey items are mandatory** for all participants:

   - Total number of vaginal births
   - Number of primary Cesarean sections
   - Number of repeat Cesarean sections
   - Number of CNM/CM full-time equivalents (FTEs)
   - Practice name and mailing address
   - Contact name, phone number, and email address
     - Reliable contact information is necessary for data verification, report generation, and notification of Best Practices.

7. The online survey tool allows you to, begin entering data, stop at any point, and return later to complete your data entry.
8. The **absolute deadline** for data submission is **11:59pm Pacific DST on March 15, 2018**. The Benchmarking Program is unable to accept any late submissions. Please start the data collection and survey response process as early as possible, in case you need assistance or have questions.

9. If you have any **questions regarding** the Benchmarking Program or data definitions, contact: ACNM Benchmarking Liaison**, Karen Perdion** kperdion@ucsd.edu (858) 249-5996

If you have **technical questions** about how to use the web-based survey, or need to report an error in your data entry, please use the **HELP** button on the benchmarking survey website. This will allow you to send a message to our web experts.

***Our Benchmarking Program team strives to respond to your email within 48 hours during the survey period. ***

ACNM member log-in Information

ACNM Benchmarking is a free membership benefit for all ACNM paid members. While not every CNM/CM in the practice is required to be a member to submit data to the Benchmarking Program, at least one CNM/CM must hold a paid membership in order to access the survey.

If your practice participated in the past, a link to the new benchmarking site will be sent to the email(s) of the contact(s) who received reports.

Definition of Terms for Data Collection

Labor/Birth

Vaginal births: all vaginal births including forceps and vacuum assisted births and VBACs.

SVD: all spontaneous vaginal births including those that are classified as VBAC's; does NOT include vaginal births requiring assistance from vacuum or forceps

Primary Cesarean Section: first c-section for a client

Repeat Cesarean: A c-section after a previous c-section, with or without attempting labor

VBAC: any vaginal birth (spontaneous or assisted) after a previous c-section

Assisted or Operative Vaginal Delivery: vaginal birth as a result of assistance by vacuum extraction and/or forceps application

Home Birth: planned delivery at home

Birth Center Birth: planned delivery in a freestanding birth center

Hospital Birth: any level hospital

Induction of Labor: The initiation of labor using synthetic oxytocin, prostaglandins, mechanical means, and/or another method when spontaneous labor has not begun. This item is measuring the number of times labor is initiated by a means other than spontaneous labor but excludes augmentation of labor which is performed after spontaneous labor has begun but is not progressing.

Epidural: use of an epidural, including intrathecal for labor pain relief but excluding epidural initiated exclusively for Cesarean sections and/or assisted vaginal delivery

Birth Canal: condition of perineum, vagina or vulva after delivery. Outcomes for these measures include all births of women admitted into the participating service. If the client is transferred to another provider for vacuum/forceps, etc., the perineal outcome is attributed to the service. This also means any episiotomy performed is included in the data.

Intact: Intact birth canal or any laceration not requiring repair.

3rd or 4th Degree Laceration: lacerations of higher order that require repair of the capsule, sphincter and/or rectal mucosa.

Postpartum hemorrhage: For vaginal birth this is typically defined as blood loss of > 500ml or c-section blood loss > 1000ml. However, use the definition that your practice uses. Some practices use the ACOG ReVITALize definition: *Cumulative blood loss of >=1000ml or blood loss accompanied by sign/symptoms of hypovolemia within 24 hours following the birth process (includes intrapartum loss).*

Postpartum endometritis: usually defined as a fever during the first 10 days postpartum that cannot be attributed to another etiology

NTSV: Nulliparous, term, singleton, and vertex.

Newborn

Gestational Age at Birth: Age of baby at birth, expressed in completed gestational weeks (< 37 weeks 0 days is considered preterm)

Birth Weight: weight of baby at birth, expressed in grams (<2500 grams is considered low birth weight). Low birth weight includes both term and preterm babies.

NICU Admission: any admission to a level 2 or level 3 nursery, for any length of time during the infant's initial hospital stay

5-min Apgar: baby's Apgar score assigned at 5 minutes after birth

Delayed cord clamping: delaying the clamping of the cord for > 3 minutes for term infants, and > 45 seconds for preterm infants.

Breastfeeding and Postpartum Care

Exclusive Breast Feeding: exclusive breast milk feeding, not using formula or supplements during the first 48 hours after birth

Length of Stay (infant or mother): time in hours from birth to discharge

Readmission (infant or mother): unplanned readmission to hospital within 6 weeks of birth

Practice Measures

CNM/CM FTEs in practice: the calculated number of CNM/CM FTEs (full time equivalents) assigned to practice including the midwife director's clinical and administrative time

Billings: total professional fees billed for the CNMs/CMs in the practice during the data period. If you have a contract with a clinic to provide services but you don't bill for those services, then the revenue from that contract would be included in here.

Births: total number of births attended by the CNMs/CMs in the practice for the data period including transfers received during labor

Outpatient Visits: total number of OB and GYN outpatient visits conducted by all CNMs/CMs during for the data period

Salary: total salaries (excluding benefits) for all the CNMs/CMs in the practice during the data period. Should also include any compensation from bonuses received based on productivity compensation models.

***For example, the average CNM/CM salary in a practice is $80,000/year and there are 4.5 FTEs, then the total salary expense would be $80,000 X 4.5= $360,000/year. ***

Total Work RVUs: using the HFA National Physician Fee Schedule values, provide the total work component of RVUs for all CNMs/CMs for all aspects of work performed (inpatient and outpatient).

Benchmarking Items for Data Collection

This list of items is provided as a guideline. It is NOT the final format for the survey you will complete online through the ACNM website, but it provides you with the list of items to gather and have available for data entry into the survey between February 1st and March 15th.

All data should reflect care provided during the 2017 calendar year (January 1, 2017 – December 31, 2017)

Required Questions – These must be answered in order to participate in benchmarking

Please provide the name, phone number, and email address of the contact person(s) for your practice.

Contact Person #1:

First and Last Name: _____
Email Address: _____
Phone Number: _____

Contact Person #2:

First and Last Name: _____
Email Address: _____
Phone Number: _____

Practice Name: _____

Street address: _____

City:___State:__Zip code: _____

If your practice is identified as one of the "best practices" for a specific item, do we have your permission to publish the name and location of your practice?

Yes / No

Total number of **vaginal births** that occurred in your practice including VBACs, forceps, vacuum assistance and/or transfers to physician care for vaginal birth. *If the birth resulted in more than 1 infant (e.g. twins) it is still counted as one (1) birth.*
Number of primary Cesarean sections *You must report the number of C-Sections, but do not have to report C-Section birth outcome data if you transfer care of these clients to a physician during the intrapartum period.*
Number of repeat Cesarean sections (Cesarean after a previous Cesarean with or without attempting a trial of labor). *You must report the number of C-Sections, but do not have to report C-Section birth outcome data if you transfer care of these clients to a physician during the intrapartum period.*
Did you collect outcome data about the Cesarean sections that occurred in your practice? Yes / No *You must report the number of C-Sections, but do not have to report C-Section birth outcome data if you transfer care of these clients to a physician during the intrapartum period.* ***NOTE: If you mark YES, all of the rates calculated for you will include cesarean sections. (e.g. if you track breastfeeding data it includes the cesarean sections if you mark yes).***
Number of CNM/CM FTEs (full-time equivalents) in the practice (number of CNM/CM FTEs assigned to the practice including the midwife director's clinical and administrative time). *(typically) 1.0 FTE = 2080 work hours per year*
LABOR AND BIRTH
How many of the total number of vaginal births were spontaneous vaginal births?
Number of operative vaginal births (vacuum extraction and/or forceps assisted).
How many of the total number of vaginal births resulted in a multiple birth?
Does your practice attend planned VBACs? Yes/No
IF you attend planned VBACs, number of successful vaginal births after a previous Cesarean (VBAC). (if you had unintended VBACs, leave this blank)
IF you attend planned VBACs, number of failed vaginal births after a previous Cesarean (VBAC). (if you had unintended VBACs, leave this blank)

Number of planned home births
Number of births that occurred in a freestanding birth center.
Of the number of births occurring in a freestanding birth center, how many births occurred in an AABC accredited birth center?
Number of hospital births (any level hospital) including transfers from home or birth centers.
Number of water births
Number of inductions that occurred in your practice.
Of the total number of inductions, how many occurred for the indication of postdates at any gestational age?
Of the total number of inductions done by your practice, how many occurred prior to 41 weeks 0 days gestational age, for any reason?
Number of epidurals used for pain relief during labor *(Includes intrathecals <u>BUT</u> excludes epidurals for the sole purpose of anesthesia for c-sections or assisted vaginal births)*.
Number of women with an intact birth canal (perineum, vagina, and labia are intact or have only small laceration(s) not requiring repair after birth). Include births attended by any provider (CNM/CM or MD) and both spontaneous and assisted vaginal births.
Number of episiotomies performed. Include births attended by any provider (CNM/CM or MD) and both spontaneous and assisted vaginal births.
Number of women who experienced a 3rd or 4th degree laceration. Include births attended by any provider (CNM/CM or MD) and spontaneous or assisted vaginal births.
The number of women who sustained a postpartum hemorrhage (this includes intrapartum transfers for labor complications or operative delivery) For vaginal birth this includes EBL > 500ml or c/s EBL > 1000ml
The number of women diagnosed with postpartum endometritis? (this includes intrapartum transfers for labor complications or operative delivery)
The number of nulliparous women with a term, singleton baby in vertex presentation (NTSV) admitted for labor and birth, during the year?

The number of nulliparous women with a term, singleton baby in a vertex position (NTSV) who experience a cesarean section birth?
NEWBORN
Number of infants from a singleton birth born at less than 37 weeks 0 days gestation.
Number of infants from a singleton birth born weighing less than 2500 grams, both term and preterm.
Number of infants from a singleton birth admitted to a NICU (any admission to a level 2 or level 3 nursery for any length of time during initial hospitalization).
Number of infants from a singleton birth assigned a 5 minute Apgar less than 7.
If your practice routinely delays cord clamping on term (>3 minutes) and preterm births (>45 seconds) # term births with delayed cord clamping____ # preterm births with delayed cord clamping____
BREASTFEEDING AND POSTPARTUM CARE
Number of women staying less than 12 hours after the infant's birth. **Do NOT include data from home births.**
Number of women who had a vaginal birth and stayed more than 48 hours after the infant's birth. **Do NOT include data from home births.**
Number of women who had a Cesarean birth and stayed more than 72 hours after the infant's birth. **Do NOT include data from home births.**
Of the total number of women who gave birth in your practice, how many had an unplanned re-admission to a hospital within 6 weeks after delivery for any obstetrical reason?
Of the total number of births, how many infants had a required length of stay that was longer than his or her mother's? **Do NOT include data from home births.**
Of the total number of women who gave birth in your practice, how many had infants who had an unplanned admission to a hospital within 6 weeks of birth?
Total number of women who exclusively breastfed for the first 48 hours
Total number of women who attended their 6 week postpartum visit.

Of the number of women who attended their 6 week postpartum visit, give the total number of women CONTINUING to breastfeed (any breastmilk provided to infant at 6 weeks postpartum; may be supplementing or providing formula in addition to breastmilk).

PRACTICE MEASURES

How many women that gave birth within your practice were aged 19 or younger?

Total number of women who received prenatal care in your practice to the point of birth.

This number should NOT include women who transferred out of your practice prior to the onset of labor or birth.

Of the total number of women who received prenatal care with your practice, how many began prenatal care at or before 12 weeks gestational age?

Be sure to consider any visits that may have occurred prior to transfer into your practice.

Total number of outpatient visits per year (total OB and GYN outpatient visits) conducted by the CNMs/CMs in the practice for the data period **(January 1, 2017 – December 31, 2017)**

Total number of births attended by the CNMs/CMs in the practice for the data period **(January 1, 2017 – December 31, 2017)** including transfers received in labor.

Total dollar amount of all billings for 2017. Billings are total professional fees billed for the CNMs/CMs in the practice for the review period. If you have a contract with a clinic to provide services but you do not bill for those services, then the revenue from that contract would be included here instead of the billing amount. **Do NOT use the dollar ($) sign or commas (,) in your answer.**

Gross salary/year (total salaries including bonuses, [but excluding benefits]) for all the CNMs/CMs in the practice for the review period. For example, the average CNM/CM salary is $55,000/year and you have 4.5 FTEs, then the total salary expenses would be $55,000 x 4.5 = $247,500/year). **Do NOT use the dollar ($) sign or commas (,) in your answer.**

Total work RVUs per year (using the CMS National Physician Fee Schedule values, only total the work RVUs for all the CNMs/CMs for all the work). **Do NOT use the dollar ($) sign or commas (,) in your answer.**

RVUs are Relative Value Units: These are numerical values that have been assigned to most CPT codes by CMS. The RVUs are listed in the CMS National Physician Fee Schedule. A total RVU includes 3 components: 1) work, 2) practice expense and 3) malpractice costs. This question requests that you enter only the **WORK RVUs** for ALL CNMs/CMs for all of the work that they performed.

Please identify the primary location of your practice. Use the following definitions to select your answer:

- Urban - A city environment with a larger population (assumes the majority of the population that accesses your clinical site comes from within that city).
- Metropolitan - A suburban location where there is not a primary city center for living, but which encompasses several smaller communities (assumes the majority of the population that accesses your clinical site comes from a variety of areas outside of the city center).
- Rural - A smaller community or country-like setting with sparse population and remote living spaces (assumes that your client population travels a distance to reach the clinical sites).

Please identify the PRIMARY payment method for the MAJORITY of your clients (select ONLY one). If your practice receives an EQUAL proportion of payments from two or more payor sources, please provide a description under 'other'.

- Medicaid
- Private insurance
- Managed care program
- Self payment
- Other (please specify)

Examples: 50% Medicaid, 50% Private insurance

or

33% Medicaid, 33% Private Insurance, 33% Self-pay

Please identify the category that BEST describes the clinical care model of your midwifery practice (Select only one). If none of the responses describe your practice, please select 'other' and provide a description.

- Midwife-led model - Care provided as a caseload with midwives providing the care unless a client requires physician consultation or management.
- Combined practice model – Care provided in combination with physicians so that women may receive care from midwives or physicians regardless of risk status. (Applies to CNMs in resident education/training.)
- Shared practice model – Care provided in a model with both physicians and midwives, but where there is an exclusive midwifery caseload distinguishable from the physician caseload
- Hospitalist/Laborist
- Other (please specify) _____

Examples: CNM/CPM/LM combined practice

CNM/NP combined practice

Please identify the category that BEST describes your clients' "risk" profile. Your response will be used by the Benchmarking Program to help group participants based on similarities in medical/obstetrical risk profiles for the purposes of cohort comparisons. (Select only one).

- Low Medical/Obstetrical Risk – Practices that self-describe as low risk usually have risk screening criteria for clients on admission to antenatal care. Typically, these practices do not accept women with pre-existing medical conditions requiring medication (e.g. diabetes, hypertension, HIV, cardiac disease). These practices also screen pre-existing obstetric risk factors (e.g. previous classical cesarean section, uterine scar without subsequent successful vaginal delivery). These practices typically refer clients with medical/obstetric risk factors to a different level of care during the antenatal course (e.g. breech, twins, gestational hypertension).

- Moderate Medical/Obstetrical Risk – Practices that self-describe as moderate risk typically have some risk screening criteria on admission to antenatal care. This risk screening may trigger some women to be immediately referred to a different system or level of care, but in these practices the midwives maintain care management of women with some pre-existent medical or obstetrical conditions (e.g. diet controlled diabetes, pre-hypertension, hypo or hyperthyroidism, history of pediatric cardiac surgery, psychiatric mediation, history of cesarean section). Practices that self- describe as moderate risk are likely to maintain management of women who develop some obstetrical risk factors during their antenatal care (e.g. mild pre-eclampsia, gestational diabetes controlled by diet or oral medication, infectious hepatitis, syphilis).

- Complex Medical/Obstetrical Risk – Practices that self-describe as complex risk typically care for women within an interprofessional system of care, consulting with specialists for disease specific concerns (e.g. perinatologists, endocrinologists, infectious disease specialists, psychiatrists, cardiologists). These practices maintain primary midwifery management of the pregnancy or may provide complete interprofessional obstetric management. Complex medical risk practices continue to care for clients throughout the antenatal and intrapartal periods as client risk profiles increase (e.g. insulin dependent diabetes, trial of labor with undocumented uterine incision, multiple previous cesarean sections, preterm labor and birth, pre-eclampsia, HELLP, breech position.

Do you provide Centering pregnancy or Group prenatal care Y/N

If yes, do you participate in Centering Counts or another data registry Y/N

What is the PRIMARY site in which maternity care is provided by your practice?

- Tertiary care hospital
- Community-based hospital
- Home birth
- Freestanding Birth center