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 full-scope maternity care (AP, IP, & PP).

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, via an online survey. The web address for accessing the survey is publicized both on the ACNM webpage and via all member-directed publications (Quick e-News, Quickening, etc…) beginning approximately one week prior to survey launch. The survey opens annually on February 15th and remains available until April 15th.

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 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 2012 data is **11:59pm Eastern DST on April 15, 2013**. The Benchmarking Project is not able to accept any late submissions due to stringent data analysis timelines.

Three supporting documents are included in this information packet and are intended to guide participants in collecting, aggregating, and reporting data for entry into the online survey. It is very important that participating midwives/practices review these documents prior to beginning data aggregation or survey response.

- **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 annually on April 15th. This allows time for extensive data cleaning and statistical analysis. A timeline for results reporting is as follows:

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

- **Individual midwife/practice reports**: generated by the ACNM national office; an email link is sent to the indicated contact person(s) for each participating practice; the report is viewable online; available late summer/early fall.

- **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 late fall to the ACNM Benchmarking website and in various organizational media releases

- **Full Benchmarking Report**: presented annually at the Fall Meeting of the Midwifery Business Network (MBN); 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 question #43 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.**

2. **Do not leave any item blank.**
   - If you DO NOT collect data for a particular survey item, **enter 9999** 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.

3. You will be entering a **raw number** for each item. DO NOT enter percentages! The Benchmarking Data Analyst will calculate the percentages for your practice. It is important that you enter an **accurate number** in each response box, so **read each item carefully.**

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

5. Only enter data related to **care provided between January 1, 2012 – December 31, 2012**.

6. **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.

7. 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:

   Question #1 – Total number of vaginal births

   Question #9 – Number of primary Cesarean sections

   Question #10 – Number of repeat Cesarean sections

   Question #40 – Number of CNM/CM full-time equivalents

   Question #51 – Practice name & mailing address

   Question #52 – Contact name, email address, & phone

   Reliable contact information is required for participation in the Benchmarking Program, as it is necessary for data cleaning, data verification, report generation, and notification of "best practices."

8. The online survey tool is *persistent*, which means you may begin entering data, stop at any point, and return later to complete your data entry, as long as the following conditions are met upon your return:
   - The survey deadline has not passed
   - You use the same computer
   - You access the survey using the same IP address (internet service provider)

   The survey recognizes you upon return by the IP address and electronic computer identifiers that you used to start your survey session. Returning to the survey using a different computer or different IP address risks loss of data and/or data duplication.

9. The **absolute deadline** for data submission is **11:59pm Eastern DST on April 15, 2013**. 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.

10. If you have any **questions regarding** the Benchmarking Program or data definitions, contact:
ACNM Benchmarking Liaison, **Tonia Moore-Davis, MSN, CNM** tonia.moore-davis@vanderbilt.edu

If you have **technical questions** about how to use the web-based survey, or need to report an error in your data entry, please contact:
ACNM Senior Staff Researcher, **Kerri Schuiling, PhD, CNM, FACNM** kschuiling@acnm.org

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

SPECIAL NOTE to midwives/practices that have participated in previous years:

The ACNM Benchmarking Program is excited to announce that beginning with the 2012 data cycle, a new online survey platform (Qualtrics) has been implemented for entry of practice benchmarking data. This new platform offers easier navigation and advantages that will expedite the data analysis phase of the project. You may notice a difference in the appearance of the survey platform, but the actual questions will look very familiar.

ACNM member log-in Information

ACNM Benchmarking is a free, membership benefit for all ACNM paid members. In order to access the ACNM survey an ACNM member log-in is required. 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.
The log-in for the Benchmarking survey is the same username and password used to access other members-only section of the ACNM webpage. By default, your username is your e-mail address on file with ACNM and the password is the first four letters of your last name and your member ID number. Please be certain you are using your ACNM member ID number and NOT your certificate number. Forgotten usernames and/or passwords can be retrieved by contacting ACNM Member Services at (240) 485-1800 or via email at memb@acnm.org

Definition of Terms for Data Collection

Clinical Measures:

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

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

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

Primary Cesarean Section: first c-section for a client

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

Birth Canal: condition of perineum, vagina or vulva after delivery

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

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)

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

Functional Measures:

Exclusive Breast Feeding: exclusive breastmilk feeding, not using formula or supplements

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

Cost Measures:

Started Prenatal Care: gestational age at which patient started her prenatal care with any provider (including any visits that may have occurred prior to transfer into your practice)

Prenatal Visits: number of provider encounters for the purpose of prenatal care which occurred during this pregnancy; the visits may have been conducted by a CNM/CM or designee; and may have occurred in an office, home, or birth center

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

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 $55,000/year and there are 4.5 FTEs, then the total salary expense would be $55,000 X 4.5= $247,500/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).

For more information: http://www.acro.org/washington/RVU.pdf
http://www.nhpf.org/library/the-basics/Basics_RVUs_02-12-09.pdf

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 15th and April 15th.

All data should reflect care provided during the 2012 calendar year (January 1, 2012 – December 31, 2012)

BIRTH OUTCOMES		
1	***This question is a core question and requires an answer for participation.*** 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.*	
2	How many of the total number of vaginal births were spontaneous vaginal births?	
3	How many of the total number of vaginal births resulted in a multiple birth?	
4	Is your practice doing VBACs?	Yes / No
5	Number of successful vaginal births after a previous Cesarean (VBAC).	
6	Number of failed VBACs	
7	Number of assisted vaginal births (vacuum extraction and/or forceps assisted).	
8	Did you collect outcome data about the Cesarean sections that occurred in your practice? *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.*	Yes / No
9	***This question is a core question that requires an answer for participation.*** Number of primary Cesarean sections (first Cesarean section for a woman). *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.*	
10	***This question is a core question that requires an answer for participation.*** 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.*	

PERINEAL OUTCOMES		
11	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).	
12	Number of episiotomies	
13	Number of women who experienced a 3rd or 4th degree laceration.	
INFORMATION RELATED TO INFANTS		
14	Number of infants from a singleton birth born at less than 37 weeks 0 days gestation.	
15	Number of infants from a singleton birth born weighing less than 2500 grams.	
16	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).	
17	Number of infants from a singleton birth assigned a 5 minute Apgar less than 7.	
BREASTFEEDING AND POSTPARTUM CARE		
18	Total number of women who initiated EXCLUSIVE breastfeeding of their infant during the first 24-48 hours after birth.	
19	Total number of women who attended their 6 week postpartum visit.	
20	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).	
PATIENT AGE		
21	How many women that gave birth within your practice were aged 19 or younger?	
COST MEASURES		
22	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.*	
23	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.*	

BIRTH SITE		
24	Number of home births (the woman planned to give birth at home).	
25	Number of births that occurred in a freestanding birth center.	
26	Of the number of births occurring in a freestanding birth center, how many births occurred in an AABC (formerly NACC) accredited birth center?	
27	Number of hospital births (any level hospital) including transfers from home or birth centers.	
RESOURCE UTILIZATION		
28	Number of inductions that occurred in your practice.	
29	Of the total number of inductions done by your practice, how many occurred prior to 41 weeks 0 days gestational age, for any reason?	
30	Number of epidurals used for pain relief during labor *(includes intrathecals BUT excludes epidurals for the sole purpose of anesthesia for c-sections or assisted vaginal births)*.	
LENGTH OF STAY (LOS): Hours from delivery to discharge.		
31	Number of women staying less than 12 hours after the infant's birth. **Do NOT include data from home births.**	
32	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.**	
33	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.**	
34	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?	
35	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.**	
36	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?	

PRACTICE MEASURES		
37	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 01, 2012 to December 31, 2012).	
38	Total number of births attended by the CNMs/CMs in the practice for the data period (January 01, 2012 to December 31, 2012) including transfers received in labor.	
39	***This question is a core question that requires an answer for participation.*** 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*	
40	Total dollar amount of all billings for 2012. 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.**	
41	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.**	
42	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.	
PRACTICE ID DATA		
43	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 / Please confirm with us first before publishing our name and location	
44	Have you or your practice participated in the Benchmarking Survey in the past? Yes / No / Not Sure	
45	Please identify the zip code in which your practice is located.	

46	Please identify the primary location of your practice. Use the following definitions to select your answer: o Urban - A city environment with a larger population (assumes the majority of the population that accesses your clinical site comes from within that city). o 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). o 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).	
47	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'. o Medicaid o Private insurance o Managed care program o Self payment o Other (please specify) *Examples: 50% Medicaid, 50% Private insurance* *or* *33% Medicaid, 33% Private Insurance, 33% Self-pay*	
48a	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. o Midwife-led model - Care provided as a caseload with midwives providing the care unless a client requires physician consultation or management. o 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.) o 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 o Other (please specify) _____ *Examples: CNM/CPM/LM combined practice* *CNM/NP combined practice*	

48b	***This question is a core question that requires an answer for participation.*** 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.	
49	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	
50	***This question is a core question. All fields must be completed for participation.*** Practice Identification Data Practice Name: _____ Street address: _____ City: _____ State: _____ Zip code: _____	

51	***This question is a core question. All fields must be completed for participation.*** Please provide the name, phone number, and email address of the contact person(s) for your practice. Contact Person #1 – First Name: _____ Contact Person #1 – Last Name: _____ Contact Person #1 – Phone number: _____ Contact Person #1 – Email address: _____ Contact Person #2 – First Name: _____ Contact Person #2 – Last Name: _____ Contact Person #2 – Phone number: _____ Contact Person #2 – Email address: _____

The ACNM Benchmarking Program is exploring future survey questions that would assess additional national quality indicators in perinatal care. We are trying to determine the number of midwifery practices that are currently collecting/tracking data on the metrics listed below.

52a	Does your practice/birth site collect/track data for the following quality metric: The number of nulliparous women with a term, singleton baby in vertex presentation (NTSV) admitted for labor and birth, during the year? If yes, please provide the number _____	Yes / No
52b	Does your practice/birth site collect/track data for the following quality metric: The number of nulliparous women with a term, singleton baby in vertex position (NTSV) who experience a spontaneous vaginal birth? If yes, please provide the number _____	Yes / No
52c	Does your practice/birth site collect/track data for the following quality metric: The number of nulliparous women with a term, singleton baby in a vertex position (NTSV) who experience a cesarean section birth? If yes, please provide the number _____	Yes / No

On behalf of the ACNM national office and the Division of Standards and Practice, we thank you for your time, contribution of these critical data, and support of this project. This joint project, supported by the ACNM National Office and the Division of Standards and Practice – Quality Management Section is an ACNM membership benefit.

We are always evaluating all aspects of the program. If you have suggestions, comments or feedback, please email us and share your thoughts and ideas. We hope to make this a workable project that provides accurate information to service directors, policy makers and others as we promote midwifery practice.