Secrets of a Best Practice

by Cassie Moore, ACNM Writer and Editor

Athens Regional Medical Center Midwifery Practice in Georgia, which employs seven midwives and delivers between 600-700 babies per year, was recognized as a "Best Practice" in the large practice category by the ACNM Benchmarking Project for their low 2009 figures for 3rd and 4th degree laceration rates. The practice's director, Susan Fisher, CNM, recently spoke with ACNM about how they achieved their 0.2% rate, how they gather their benchmarking data, and what she wants to improve in the future.

Did you know that you would achieve "Best Practice" numbers for this metric? What makes your 3rd and 4th degree laceration rate so low?

We had no idea that we would be in the lead on that category, but we were pleasantly surprised. I think the first step in reducing perineal tears is to try to reduce to the extent possible the risk factors that are known to contribute to tearing. We've always had low rates of episiotomy, epidural, and vacuum-assisted birth.

As far as management of the second stage, we try to avoid lithotomy position—in fact we encourage the mother to choose the position to birth in that she feels most comfortable [with], and we support non-directed pushing.

On the perineum technique, it actually varies considerably from midwife to midwife in the practice, so I'm not convinced that the way you handle the baby on the perineum is really the most important factor. We do have a group of very experienced midwives—the average tenure of the midwives at our practice is greater than 10 years—so over time you develop techniques that seem to work best for you as far as avoiding tears.

What is your process for recording benchmarking data?

We're very fortunate in that all of our data is on electronic medical records. We utilize Philips OB TraceVue and the computer itself can aggregate and analyze the numbers. That makes it relatively easy to look at the statistics in each category—we just run a report for each metric. We can do that monthly, we can do it annually, over time we can trend the rates in certain things.

We have the entire prenatal, intrapartum, and postpartum record all in one electronic medical record. So we've taken all of the metrics from the Benchmarking Project and plugged those into OB TraceVue's programs so that you can query any one of those fields for our practice and come up with the outcome.

We often hear midwives are frustrated about Electronic Health Records (EHR). How long has your practice been using that EHR program? Was it a rocky beginning?

The midwifery practice has been using it for about eight years. It's not easy in the initial phases. You need a lot of support. But once the program is customized to fit your needs, it's wonderful. We've got a fairly easy situation here now; when it's time to do benchmarking, we can get everything we need within two days.

How has the Benchmarking Project affected your practice's goals?

The process has increased our awareness of our own outcomes and where we stand in comparison to other practices within our cohort…We would like to reduce the number of inductions in our practice. We don't do elective inductions prior to 41 weeks, but we found looking at the benchmarking data that our induction rate is a little bit higher than some of the practices, so that's something that we're going to work on.

One challenge to that, though, is that when you're looking at the benchmarking, it's hard to tell if you're comparing apples to apples. Even though we're looking at other large hospital-based practices, because of the intrinsic differences in collaborative relationships with physicians in different midwifery practices, you may have a completely different population than someone else in another large hospital practice. For instance, in our practice, we have patients who are preterm, gestational diabetic, hypertensive—the midwives deliver those patients. In other practices, those patients are referred for medical care, and they're delivered by their physician. The induction rate is going to be higher when you have a high-risk group. When you have women with medical problems, sometimes induction is required.

Why do you think the Benchmarking Project is important?

I think it's crucial to improving midwifery outcomes, which obviously are good already! But in our practice, until we started doing the benchmarking, we were comparing our outcomes to obstetric outcomes and [ours] were always better, so it didn't really give us the information that we needed to improve. Q

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Are you benchmarking yet?

See **www.midwife.org/benchmarking** to learn how to benchmark, see the best practices roster, and get prepared for the benchmarking survey coming in early 2012.

PLUS: See the special flash presentation, ***The ABCs of Benchmarking***