



Progress Made Improving Georgia's Infant Mortality Rate

Mitch Rodriguez, MD, FAAP, Macon, GA

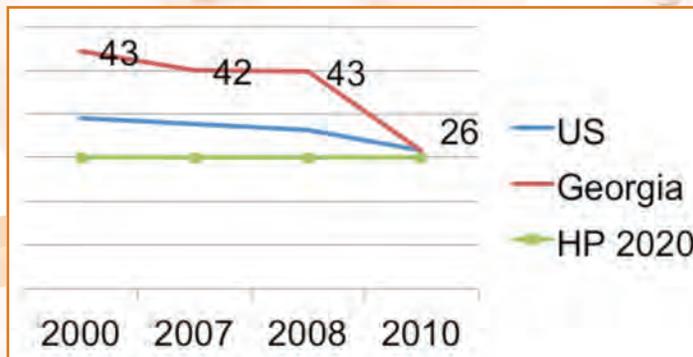
September was Infant Mortality Awareness Month, which provided an opportunity to highlight progress Georgia has made in reducing infant mortality. It also provided opportunity to examine what remains to be done to continue improving survival of our most vulnerable population and educate all Georgians on the importance of reducing the infant mortality rate (IMR). Dr. Brenda Fitzgerald, commissioner of the Georgia Department of Public Health (DPH), recently established an infant mortality task force to create a public health perinatal community plan and identify strategies to reduce infant mortality in the state.

Infant mortality is a surrogate measure of the well being and health of a population. For 2008, the United States ranked 31st among industrialized countries on infant mortality.¹ On average, the U.S. infant mortality rate was almost two times the average of industrialized European countries. Various explanations and theories have been presented to rationalize this difference in infant mortality rate, with only one statistic clearly correlating with the relatively high U.S. infant mortality rate: Our high prematurity rate. The United States' prematurity rate remains twice that of industrialized European countries. Prematurity and/or low birth weight remains one of the leading causes of infant mortality in the U.S. In Georgia, prematurity/low birth weight is the number one cause of infant mortality accounting for nearly 20% of infant deaths per year.

As you "peel back the onion," the picture is even less appealing, revealing a concerning racial disparity. For any given year, African-American infant mortality rate in Georgia is twice that of the white population. Once again the prematurity

rate is a telling statistic underscoring this disparity.

Healthy People 2020 (HP 2020) set as a goal an IMR for the United States of 6 per 1000 live births by 2020.² Among various strategies that will be pursued to reach this goal, the primary focus



should center on reducing prematurity. The March of Dimes (MOD) and Association of State and Territory Health Officers (ASTHOS) challenged all health officers to reduce prematurity by 8% by 2014. Dr. Fitzgerald accepted this challenge, and as of 2012 we have reduced the prematurity rate in the state by 8%. Our goals now should focus on sustainability and continued improvement.

Infant mortality can be impacted in anyone for all of the following stages:

- Preconception
- Pregnancy
- Delivery
- Neonatal period
- Post-neonatal period

The Online Analytical Statistical Information System (OASIS) website is Georgia's repository of public health data providing the state and its citizens with a wealth of information and data for analysis. This website is free and open for all to review and use.³ In working toward improving outcomes, quality initiatives serve a role in improving care and establishing benchmarks to improve the system as a whole. As such, the Georgia Perinatal Quality Collaborative (GaPQC) was established and is co-chaired by

Dr. Cathy Bonk (OBGyn) and Dr. David Levine (neonatologist). GaPQC has identified its first project and will start roll out this January 2014.

For years, Georgia ranked among the highest states in the nation for IMR, typically ranking about 43rd. For 2010, Georgia significantly improved its IMR ranking, dropping to 26th in the nation and reducing its rate from 8 to 6.3 deaths per 1000 births. The task force continues to review data to identify those practices that have helped reduce the IMR with the goal of sustainability.

Georgia is a member of the Collaborative Improvement and Innovative Network (COIIN), a collaborative supported by Health Resources and

Continued on page 2

in this issue

Progress Made Improving Georgia's Infant Mortality Rate	1
GOGS President's Column	2
Editor's Column	3
Legislative Column	4
ACOG Redefines Term Pregnancy	5
Teen Birth Rate Declines, But Repeat Teen Births Remain a Problem	6
Contracting Versus Employing Certified Nurse Midwives	8
Improve Postpartum Hemorrhage Outcomes	9
News from Around the State ...	10
Coding Corner An Introduction to the ICD-10-CM Book ..	11

Administrative Office

4485 Tench Road, Suite 2410
Suwanee, Georgia 30024
Telephone: 770 904-0719
Fax: 770 904-5251
www.georgiaobgyn.org

President's Column

Too Many Obstacles for New OBs Practicing in Georgia

Meet Dr. Lawrence Wilson. He is a newly-minted OBGyn. He was raised in Georgia and wants to practice here. To make him even more attractive, he is finishing a fellowship in critical care to make sure he is prepared for the emergencies of a rural Georgia practice.

Georgia has 40 counties without an OB. In the last 18 years 25 L&D units in Georgia have closed, 14 in rural Georgia counties. Dr. Wilson wants to practice in rural Georgia and he is part of a loan repayment program that requires him to work in certain rural counties; however, he can't find a job. What is wrong with this picture?

The rules governing the loan repayment program requiring Dr. Wilson to work in low-population counties is based on legislation drawn up in the 1990s. Many of these underserved counties have populations that now exceed the legislative-mandated population level even though they remain rural and underserved. The legislation is so dated it is now a hindrance to placing OBs in many parts of rural Georgia.

In addition, the few places that meet the population criteria cannot support an OBGyn physician. We know an OB has to practice close to a hospital with obstetrical services. An OB has to have call coverage and/or partners; the nature of the business is 24/7/365. With low Medicaid reimbursement, the practice must have both a large enough patient base and an appropriate patient

mix to keep the business doors open. These days, it is not unusual for a new physician graduate to owe a quarter million dollars in education debt. Our politicians must redirect their focus to pass legislation that addresses these issues and improves the obstetrician/gynecologist's ability to provide quality care to the women of Georgia.

Recent studies of OBGyn residents in Georgia indicate that 75% have no interest in working in rural Georgia when they graduate. Yet most of our state is rural. Currently, 50% of our rural service areas, meaning the nearest OB hospital and the surrounding counties it serves, have an OB shortage. Without a major initiative, by 2020, 75% of the OB service areas outside metro Atlanta will lack sufficient prenatal services.

What can Georgia do?

- Update laws regarding where OBs with loan repayment obligations can practice.
- Create more OBGyn residency slots in Georgia and more training funds—now! It takes years to train an OB.
- Expand Medicaid so that the 25% of uninsured women in Georgia have a payment source for care, either through Medicaid or the Exchange. This gives us the entire population of Georgia women who need OBGyn care as our practice base and may help rural practices survive.



Roland Matthews, MD
GOGS President
Atlanta, Georgia

- Ensure adequate reimbursement by Medicaid. Sixty percent of our OB patients are covered by Medicaid, a system that has seen no increase in reimbursement for 13 years.
- Focus on legislation that solves these problems rather than causes diversion while our state ranks 49th in maternal mortality and fourth highest in repeat teen pregnancy in the U.S.

The bottom line is, all qualified OBs who want to practice in rural, underserved Georgia should be welcomed with open arms by our laws and our systems. There are too few of them already. Our women's healthcare statistics will not improve until women's access to care improves.

Dr. Wilson, we are working hard to find a way to keep you in Georgia. We need you!

Progress Made Improving Georgia's Infant Mortality Rate

Continued from page 1

Services Administration (HRSA) that allows states to share efforts and collaborate to reduce infant mortality. The five strategies identified by the COIIN groups are:

- Eliminate elective deliveries prior to 39 weeks
- Reduce SIDS/SUID
- Reduce tobacco use during pregnancy
- Expand regionalization
- Expand access to interconceptional care

Georgia is represented in each one of these groups. We have a number of great programs and initiatives ongoing at the state and local levels to reduce

infant mortality. One goal is to expand the information provided by the OASIS website to provide birth weight and gestational age specific survival data, in addition to developing a perinatal dashboard. This perinatal dashboard would allow counties, health districts or perinatal regions an immediate look at how they compare to the Georgia average for 10 selected perinatal health data points.

Identifying and supporting strategies that positively impact IMR is a large task. The state's progress has been good to date. Hopefully, it not only will be sustainable, but it will continue to improve. We need to move toward making the reduction of infant mortality

a priority for everyone. Awareness is key. We can accomplish this by educating, informing and engaging all Georgians.

Mitch Rodriguez, MD, FAAP, is Chair of the Georgia Infant Mortality Task Force.

References

- 1 Organization for Economic Cooperation and Development, OECD Health Data, 2010, <http://www.oecd.org/dataoecd/4/36/46796773.pdf>. Updated 08/12/2012.
- 2 Healthy People2020. <http://healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26#85899>. MICH-1.3 Reduce the rate of all infant deaths (within 1 year). Accessed 11/5/2013.
- 3 Georgia Department of Public Health, Office of Health Indicators for Planning (OHIP). <http://oasis.state.ga.us/oasis/>.

Editor's Column

On Learning

My patient, Betty I. died last week. Her passing is significant not just because she had this inexplicable affection for me, but because she was there when I learned some elementary lessons in medicine.

I was 17 and had been hired on as a nurses' aide for the summer at the hospital where I was born just across the Alabama state line. She was in her mid-40s and a seasoned aide. Lesson number one was that white hose are only for RNs. I showed up the first day in my snap front nurses' aide dress with white hose on. In my defense, they were the style at the time and I thought they made my legs look more shapely. Betty was a witness as the director of nursing callously escorted me down the elevator to the front door with instructions to return wearing plain hose.

Lesson number two was what a scrotum is. Betty was there when an elderly patient of mine kept exposing himself in the bed and it turned out he had a problem with his scrotum. This was brought out during a shift meeting in the tiny conference room on the third floor. We were a team caring for these patients and I didn't happen to know that word. When I inquired as to its meaning, the question was met with disgust. The head nurse was way too busy and knowledgeable to help with that information. When I saw Betty as a patient years later, she recounted these stories and we had a good laugh about them.

Although these occurrences were uncomfortable for me then, they served as an introduction to the

way medical people sometimes teach each other. With so much to learn, it's common to feel inadequate in our knowledge. We cover up or compensate for that feeling by making someone else look or feel inadequate. Lower level residents and students are easy prey. Most of us have been on the receiving end of this scenario more than once and the memories are as vivid as if they happened yesterday.

The *way* doctors learn and the *culture* they learn in is just as important as *what* they learn. When we teach students, we are also teaching them how to teach. The best teachers know how to encourage honesty and vulnerability in students. In order to learn, one must first be able to honestly admit she doesn't know. If the consequences of admitting ignorance are too painful or shameful, learning will be stymied and cover-up behavior will happen.

Much has been written recently about physicians with "disruptive" behavior, poor communication skills and inability to take responsibility for errors. The Joint Commission, ACOG and other specialty societies have issued statements about this. Medical school



Margaret D. Schaufler, MD
Editor
LaGrange, Georgia

admissions committees have begun to screen for students with good "people" skills. In 2015, the MCAT will focus more on social and behavioral sciences as part of a "holistic admissions" process.¹ This sounds great for the future, but there's no time like the present for the teachers among us to foster a learning environment of honesty and compassion for patients, students and each other.

Reference

¹ Association of American Medical Colleges. New Visions, New Approaches, New Insights: Annual Report 2012. Eric Weissman, ed. AAMC: 2013:17. <https://members.aamc.org/eweb/upload/New%20Visions,%20New%20Approaches,%20New%20Insights.pdf>. Accessed November 27, 2013.

Thousands of Practices Saving Millions of Dollars!

PAA is helping practices of all sizes and specialties nationwide

**Join
Today!**



PhysiciansAlliance.com

**Savings on a full range of goods and services covering essentially every area of practice operations with over 80 vendor partners -
Injectables to Office Supplies; Vaccines to EMR;
Medical Supplies to Insurances and MUCH more!**

**FREE Membership!
No Contract!**



866-348-9780

2014 Legislative Session Preview

The 2014 Georgia General Assembly session will convene on January 13, and with an election year upon us, it promises to be an active and important one. All 236 members of the legislature will be up for election as will Governor Deal, Lieutenant Governor Cagle and all of Georgia's statewide Constitutional officers. The date for the primary has been moved from July to May, with early voting commencing in April. The pressure will be on the lawmakers to take care of business as soon as possible and get back to their districts for campaigning.

Once again, the Georgia OBGyn Society will be heavily involved in a wide variety of issues at the Capitol. As usual, we will work to insure no cuts are made to the state's Medicaid reimbursement formula. The outlook for state revenues and the budget is brighter than it has been for years. We are hopeful this stabilizes Medicaid reimbursement and we can begin obtaining increases in the reimbursement rate for our physicians, something long overdue.

An issue garnering a lot of attention is Senate Bill 141, the so-called Patient Protection Act. This measure, which was introduced last year and which is currently being considered by the Senate Health and Human Services Committee, seeks to overhaul the current medical malpractice system in Georgia. While the

current system is not perfect, studies show the proposed system under SB 141 would result in more claims being filed against doctors, with more money being paid to alleged "victims of malpractice" and, not surprisingly, increases in insurance premiums for physicians.

Since the passage of tort reform in 2005, the number of malpractice claims has decreased, the amount of money paid out has decreased, there is more competition between malpractice insurance carriers in Georgia and malpractice premiums are down. The system is working and the Georgia OBGyn Society will continue to oppose efforts such as SB 141 that would harm doctors in this state and, in essence, create a new entitlement program for anyone claiming an injury as a result of a medical procedure.

We will support Senate Bill 273, which was introduced by Senator Dean Burke, who is the only OBGyn in the Senate. SB 273 will be heard by the Senate Health and Human Services Committee and deals with a serious issue in this state – maternal mortality review (MMR). This legislation protects the MMR committee reviewers and process, ensures confidentiality, and provides for an annual report of findings to help Georgia improve maternal mortality statistics.

We also will push legislation to amend Georgia's current law regarding crediting



Arthur "Skin" Edge
GeorgiaLink
Public Affairs Group

doctor's student loans in exchange for their locating to rural, underserved areas of our state where current OBGyn shortage is critical. We need to re-examine how this program works and change some of the requirements so physicians are allowed to locate near existing obstetrical units, since 25 have closed in the past 15 years, and still receive credits toward their loans.

It promises to be a busy and exciting session and I appreciate the support from members of the Society on these issues as well as on other issues that may arise. Please contact your senators and representatives prior to the session to urge their backing on these matters and I feel confident we can have a positive and productive year.

2014 Legislative Day at the Capitol



Thursday, February 13, 2014

Visit the Georgia State Capitol with your physician colleagues

- Review legislative priorities
- Visit legislators at the Capitol
- Breakfast with guest speakers
- Lunch with legislators

To register, visit our website for a registration form at georgiaobgyn.org or call our office at 770-904-0719.

ACOG Redefines Term Pregnancy

Dan Eller, MD, Atlanta, GA

The American College of Obstetricians and Gynecologists (ACOG) released a Committee Opinion in November 2013 (Number 579) entitled Definition of Term Pregnancy.¹ Traditionally, the definition of a term pregnancy has been 37 0/7 weeks to 41 6/7 completed weeks from the last menstrual period (LMP). This definition was based on the assumption that neonatal outcomes were uniform and optimal in this gestational age range. Recent research has shown variable outcomes of infants delivered within this time frame, particularly respiratory morbidity. Uniform definitions are helpful to facilitate data reporting, assess and improve quality of healthcare, and promote effective clinical research. As a result, a work group composed of representatives from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD), ACOG, the Society for Maternal-Fetal Medicine (SMFM), and other interested parties was convened to address this issue.²

The work group recommended further classification regarding deliveries within the traditional five-week window previously defined as term. Those delivering from 37 0/7 through 38 6/7 weeks would be classified as **Early Term**, those between 39 0/7 to 40 6/7 as **Full Term**, those between 41 0/7 and 41 6/7

as **Late Term**, and finally, those at 42 weeks and beyond as **Post Term**.

Of course, these definitions are predicated on a reliable and uniform determination of gestational age. The work group provided a suggested method for determination of gestational age based on standard clinical criteria. Evidence based consensus recommendations on determining gestational age will likely be forthcoming from ACOG, SMFM and others.

Previously, ACOG published a Committee Opinion entitled Medically Indicated Late-Preterm and Early-Term Deliveries (Number 560, April 2013)³ which utilized the definition of *late preterm* (34 0/7-36 6/7 weeks of gestation) and *early term* (37 0/7-38 6/7). The Committee on Obstetric Practice submitted a list of proposed medical indications for delivery earlier than 39 weeks and suggested gestational age ranges for delivery, taking into account the overall clinical circumstances. This list

included placental/uterine issues (such as placenta previa/accreta/increta/percreta, prior classical CD, prior myomectomy), fetal issues (IUGR with and without concurrent conditions, multiple gestation, oligohydramnios), maternal issues (chronic hypertension, diabetes), and obstetric issues (PROM).

New ACOG Definitions of Term Pregnancy

Early Term 37 0/7 to 38 6/7	Full Term 39 0/7 to 40 6/7	Late Term 41 0/7 to 41 6/7	Post Term 42 0/7 and later
---------------------------------------	--------------------------------------	--------------------------------------	--------------------------------------

Previous ACOG Definition of Term Pregnancy

37.0 weeks through 42 6/7 weeks

Finally, the Committee on Obstetrics, in the Committee Opinion entitled Nonmedically Indicated Early-Term Deliveries (Number 561, April 2013)⁴ listed neonatal morbidities associated with *early term* deliveries such as respiratory distress syndrome, transient tachypnea of the newborn, ventilator use, pneumonia, respiratory failure, NICU admission, hypoglycemia, neonatal mortality and 5 minute Apgar score less than 7.

These new definitions are likely to be clinically useful in guiding the management of our gravid patients, in tracking the quality of care and in producing valuable clinical research in obstetrics and pediatrics. They are relevant to our daily practice and will likely lead to improved health in the population we are privileged to serve.

Dr. Dan Eller joined Maternal-Fetal Specialists in 1995. He is board certified in OBGyn and maternal-fetal medicine and has done extensive research in obstetrics.

References

- American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. Definition of Term Pregnancy, Committee Opinion No. 579. *Obstet Gynecol.* 2013; 122:1139–40.
- Spong CY. Defining "term" pregnancy: recommendations from the Defining "Term" Pregnancy Workgroup. *JAMA.* 2013; 309:2445–6.
- American College of Obstetricians and Gynecologists and Society for Maternal-Fetal Medicine. Medically Indicated Late-Preterm and Early-Term Deliveries, Committee Opinion No. 560. *Obstet Gynecol.* 2013; 121:908–10.
- American College of Obstetricians and Gynecologists. Nonmedically Indicated Early-Term Deliveries, Committee Opinion No. 561. *Obstet Gynecol.* 2013; 121:911–5.



Teen Birth Rate Declines, But Repeat Teen Births Remain a Problem

Melissa Kottke, MD, MPH, MBA, Atlanta GA



We could all use some good news...and here it is: **The teen birth rate is declining!**

The preliminary report on birth statistics from 2012 from the National Vital Statistics Report was recently released and indicated the birth rate for young

economic attainment of the mother, but now with the additional stresses of parenthood, a teen mother who has a repeat birth is much less likely to continue her education and secure employment. Repeat births amongst teens are also commonly rapid-repeat

user (in this case, a busy teenaged mother) to achieve this high efficacy, the typical and perfect use efficacies are essentially the same and continuation rates for LARC are higher than for other reversible contraception.⁴

This is especially important because teens have more difficulties with contraceptive compliance. In the Contraceptive CHOICE project (which provided free contraceptives to nearly 10,000 women in St. Louis), 70% of adolescents under 21 chose a LARC method (this compares to about 5% nationally). The risk for unintended pregnancy in women who chose non-LARC methods (contraceptive pill, patch, vaginal ring) was 20 fold higher than for those who selected LARC methods. This was amplified for young people; the risk of pregnancy for those under 21 who chose non-LARC methods was nearly double that seen in older women. See Figure 2 from Winner and colleagues.⁵

OBGyns are uniquely situated to help prevent repeat teen birth. While nearly 90% of teen mothers

report using some type of birth control, only one-fifth are using the most effective types of birth control. Recently, ACOG released Committee Opinion 539 that reaffirmed that LARC methods *should be offered as first line contraception for teens.*⁶ This document cites the safety and efficacy of LARC for adolescents and reviews the most up-to-date literature on this use including counseling strategies and overcoming myth. According to the CDC's Medical Eligibility Criteria for Contraceptive Use, neither age nor nulliparity are contraindications for any reversible contraceptive, including IUD and implant use.⁷ Finally, the recently-released CDC Selected Practice Recommendations highlight practices that reduce barriers to LARC placement, including same day placement and immediate postpartum placement.⁸

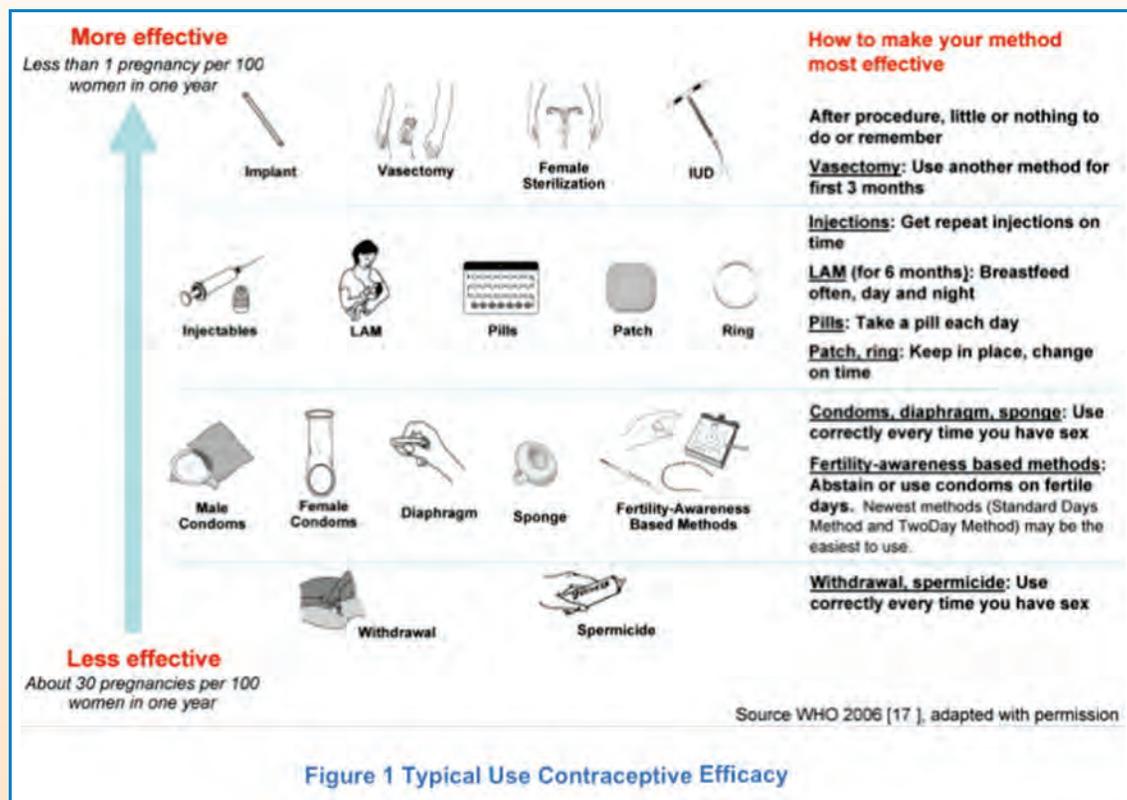


Figure 1 Typical Use Contraceptive Efficacy

women 15-19 years old was 29.4 per 1,000 teenagers.¹ But, here's the bad news: In 2012, there were 305,420 births to adolescent mothers in the U.S. Though this represents the lowest teen birth rate since 1946, it continues to represent very high numbers of new teen mothers and remains far above that seen in other developed countries. In 2011, 12,910 teens ages 15-19 gave birth in Georgia. Of these, roughly one-fifth (2,493) of these births were to teens who were already mothers. Unfortunately, **Georgia is fourth in the nation in repeat teen births!**

Repeat teen birth is especially troubling. While it is true that any birth to a teen mother is associated with an increased likelihood of unfavorable outcomes for both mother and baby, having a second amplifies them. Teen pregnancy decreases educational and

pregnancies.² This increases the likelihood of preterm birth and low-birth-weight infants and has negative associations with breastfeeding and prenatal care.

Use of highly effective contraception, especially long acting reversible contraceptives (LARC) decreases teen pregnancy. More than 75% of the decline in teen pregnancy can be attributed to improved use of contraceptives by teens.³ With that, not all contraceptive methods are equally effective at pregnancy prevention. LARC methods, including the Copper IUD, Levonorgestrel IUS and contraceptive implant, have the lowest failure rates of any reversible methods of contraception (Figure 1) and are considered "top tier" for pregnancy prevention. Furthermore, because they do not require action on behalf of the

Teen Birth Rate Declines, But Repeat Teen Births Remain a Problem

As OBGyns, we are uniquely situated to identify teen mothers, and we are an essential link to preventing repeat teen births.

Dr. Melissa Kottke is Assistant Professor at Emory University School of Medicine, Department of Gynecology and Obstetrics, Director of the Jane Fonda Center for Adolescent Reproductive Health and Medical Director of the Teen Services Clinic at Grady Health System.

References

- 1 Hamilton BE, Martin JA, Ventura SJ. Births: Preliminary Data for 2012. *National Vital Statistics Reports*. Hyattsville, MD: National Center for Health Statistics; 2013:62(3).
- 2 Stevens-Simon CK. A village would be nice but...it takes long-acting contraceptive to prevent repeat adolescent pregnancies. *Am J Prev Med*. 2001;21(1):60-65.
- 3 Santelli JD. Explaining recent declines in adolescent pregnancy in the United States; The contribution of abstinence and improved contraceptive use. *Am J Public Health*. 2007; 150-156.
- 4 Trussell J. Contraceptive failure in the United States. *Contraception*. 2011;83(5), 397-404.
- 5 Winner BP. Effectiveness of long-acting reversible contraception. *N Engl J Med*. 2012;366(21): 1998-2007.
- 6 ACOG. Committee opinion no. 539: adolescents and long-acting reversible contraception: Implants and intrauterine devices. *Obstet Gynecol*. 2012;120(4):983-8.
- 7 CDC. U.S. medical eligibility criteria for contraceptive use, 2010 adapted from the World Health Organization medical eligibility criteria for contraceptive use. *MMWR*. 2010;May 28 (4).
- 8 CDC. U. S. selected practice recommendations for contraceptive use. *MMWR*. 2013;62(No. RR-5):1-60.

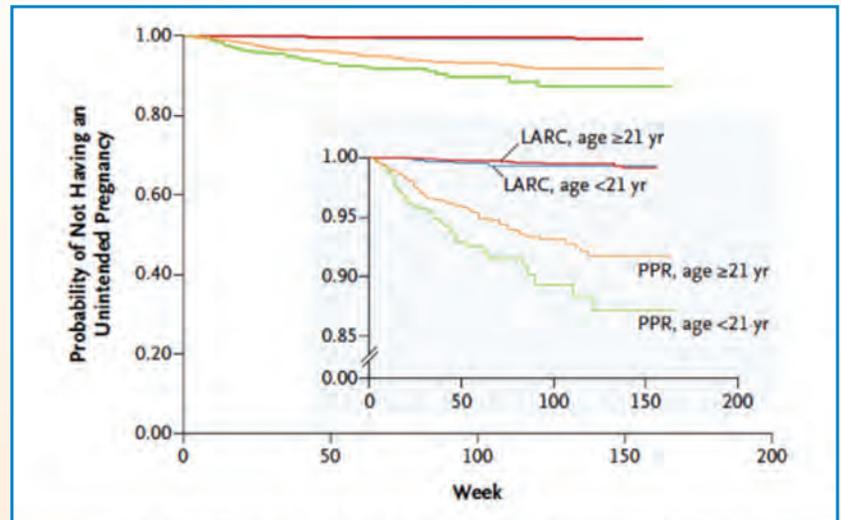


Figure 2. Probability of Not Having an Unintended Pregnancy, According to Contraceptive Method and Age.

Survival curves show the probability of not having an unintended pregnancy, stratified according to age group. LARC methods were the most effective, and failure rates did not vary according to age ($P=0.49$). PPR methods were less effective, and failure rates in participants younger than 21 years old were twice as great as in women 21 years of age or older ($P=0.02$).



GYN RESOURCES, INC.

Office Based Surgical Services

987 Chattahoochee Ave., Ste. A, Atlanta, GA 30318

404-605-7087

www.gynresourcesinc.com

Providing surgical equipment, supplies and personnel to physicians desiring to perform minimally-invasive procedures in an office based setting using MAC anesthesia.

AT NO COST TO YOU!

Innovative medical/surgical services
The comfort of an office setting
Smaller out-of-pocket cost to patient
Minimally-invasive procedures
Uncompromised safety, convenience and care
Enhanced practice efficiency for physicians

Diagnostic Hysteroscopy/Biopsy
Hysteroscopic Sterilization
Endometrial Ablation
LEEP procedures
Various other minor gynecologic procedures requiring anesthesia

Contracting Versus Employing Certified Nurse Midwives

Stephanie Beasley, CNM

Certified nurse-midwives (CNM) have traditionally been employed by obstetricians, medical groups or hospitals as regular staff. With the coming changes in medicine, many physicians are looking for ways to reduce costs or improve their work load while still providing excellent care to patients. One way to achieve these goals is to consider the advantages or disadvantages of contracting with qualified CNM groups.

Certified nurse midwives are advanced practice registered nurses with Master's degrees. Advanced practice nurses include certified nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists, as defined by the Georgia Board of Nursing. CNMs receive extensive training in normal obstetrics and gynecology and are board certified by the American Midwifery Certification Board. The American College of Nurse-Midwives works closely with ACOG.

Many CNMs have advanced training and are skilled in repair of third and fourth degree lacerations, circumcision, colposcopy, IUD insertion, endometrial biopsy, ultrasound, surgical first assisting, and vacuum delivery, among other skills. CNMs can manage high-risk obstetric patients and those with more complicated gynecologic problems in collaboration with a physician. CNMs function under protocols that are agreed upon by the physician or hospital and are specific to their individual practice.

Most CNMs deliver babies in hospitals and have many patients with medicated births and epidurals, as well as patients choosing unmedicated births.

CNMs are trained in normal obstetrics and can safely and professionally manage those patients independently, while screening for high risk patients. In the office setting, CNMs can do annual exams and treat routine problems, such as UTIs,

vaginitis, menopausal symptoms, and contraceptive issues. Many CNMs have advanced training in managing more difficult problems, such as abnormal bleeding, breast problems, and other conditions seen frequently in an OBGyn practice. CNMs cannot take the place of a physician because there must always be physician backup for c-sections and consultation or collaborative management of high-risk patients.



CNMs function differently in different groups. In some groups the CNMs deliver all the low-risk patients while the physicians deliver the high risk patients. In other groups all the patients are delivered by the CNMs while the physician provides consultation for high-risk patients, delivering only those that are outside the scope of midwifery care. In still other groups, the patients are given a choice for MD or CNM delivery.

Advantages to having CNMs work with physicians or hospitals:

- Increased revenue by allowing the physician to spend more time in surgery and in the office
- Increased revenue by attracting patients who are looking for nurse-midwifery care
- Improved quality of life for the physician by protecting the physician's sleep at night
- Improved quality of life due to more free time while the CNM is covering the hospital
- Readily available first assist for C-sections, either scheduled or unanticipated.
- Readily available provider for those patients who deliver immediately on admission
- Excellent childbirth, breastfeeding, newborn, and CPR classes taught by people "in the trenches"

If a physician's practice cannot support hiring a CNM directly, or if the practice needs additional help beyond the CNMs currently on staff, contracting with a CNM group may provide the needed support.

Differences in Contract CNM Group vs. Employee CNMs:

	Contract Per diem or per patient	Employee Salary or Salary + Bonus
Cost		
Liability Insurance	Paid by CNM Group	Paid by Employer
Benefits	Paid by CNM Group	Paid by Employer
Taxes	Paid by CNM Group	Paid by Employer
Required Work	"As needed" basis	Requires regular work and pay
HR Issues	Group manages HR issues	Employer manages HR issues

Contracting with CNM groups can work well in hospitals as well. CNM groups already assist physicians in delivering babies at many hospitals around Georgia. CNMs can serve as first assist on C-sections with physicians for whom they do no other work. At some hospitals, CNM contractors can even provide same-day service to physicians on an as need basis. In other words, if a physician walks into a busy day at the hospital, he or she can utilize CNM group services immediately.

The majority of practices that contract with an outside CNM group have a full stable of CNMs on staff. Contract CNMs either do PRN work for those groups or are a regular part of the established nurse-midwife service, depending on how a

Continued on page 9

Improve Postpartum Hemorrhage Outcomes

AWHONN's Multi-Year Initiative

The Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN) recently launched a multi-year initiative to improve the management of postpartum hemorrhage (PPH). Obstetric hemorrhage is the leading cause of maternal deaths in the United States and it is estimated that 54-93 percent of these deaths are preventable.

Supported by a grant from Merck for Mothers, the AWHONN Postpartum Hemorrhage Project will start as a demonstration among hospitals in the District of Columbia, Georgia and New Jersey. Georgia was selected, in part, because of our painfully high maternal mortality rates. The maternal mortality ratio for Georgia is 20.5 maternal deaths per 100,000 live births, which ranks 50th among all states in the U.S.

The first step in improving your postpartum hemorrhage outcomes is to participate in AWHONN's baseline survey about PPH practices at your institution. By completing this survey, your hospital will be part of the select group providing information that will help shape innovative quality improvement practices for postpartum hemorrhage. All data will

be kept confidential and AWHONN will only discuss the results of the survey as a whole. All hospitals that complete the baseline survey will receive a free copy

multi-state learning collaborative. Hospitals selected to participate will work with a group of national experts composed of nurses, physicians, and AWHONN staff

The Facts on Maternal Morbidity & Mortality

Every 10 minutes a woman in the United States almost dies of pregnancy-related complications and 2-3 women die every day in the U.S. from these complications, making the U.S. the 46th country in the world for maternal mortality. Through this important three-year project and the collective influence of the individuals and organizations in the AWHONN community, we can work together to eliminate preventable deaths and injuries of pregnant women in the U.S.

Learn more at WWW.PHPROJECT.ORG

of AWHONN's Obstetric Hemorrhage monograph.

The next phase of the project will be a no-cost, learning collaborative which will begin in the summer of 2014 and end in the winter of 2015. To participate in the learning collaborative, hospitals must have completed a baseline survey. Hospitals interested in shaping clinical practice and reducing errors related to postpartum hemorrhage can apply to participate in a multi-hospital,

to identify areas of improvement and work to change clinical practice at their facility.

If you would like more information, contact hemorrhage@awhonn.org or consider participating in one of the informational webinars on January 9 or 16, 2014.

To register for a webinar or to obtain a copy of the baseline survey and information on how to join the learning collaborative, visit www.pphproject.org.

Contracting Versus Employing Certified Nurse Midwives

Continued from page 8

particular group decides to function. However, CNM contractors also work with groups that do not have nurse-midwives, filling in for physicians in the office when they are out of town or busy and by covering the hospital while they are in the office or elsewhere.

Contract CNMs' revenue potentially comes from three sources:

- 1) The physicians or hospitals (whoever the CNM is contracted with) pay for office days or hospital shifts.
- 2) Insurance companies pay claims for which the CNM contract company files for first assisting on C-sections.
- 3) Patients pay for childbirth, infant CPR, breastfeeding, and newborn classes they choose to take.

CNMs can be contracted individually by a patient who goes to a physician group that does not have CNMs, but desires a CNM delivery, as long as the following specific criteria are in place:

- These patients must fit strict screening guidelines and be approved by their physician.
- The CNM must have delivery privileges at the hospital where their physician practices.
- The physician must agree to be the CNM's medical backup

for operative delivery. The physician is paid the entire global fee while the patient pays out of pocket for the CNM's services.

The model of using CNM groups can be applied to rural areas, as well as urban areas. CNMs can run clinics that are overseen by a physician, thus increasing access to care for those patients who currently cannot get to a place that provides care. The clinic could be in a building or in a mobile unit, bringing the care to the patients. One physician would be able to supervise several clinics that are run by CNMs and nurse practitioners, with the CNMs doing the majority of the deliveries in the nearest hospital. This would improve the morbidity and mortality rate in Georgia, which everyone would like to see happen.

This model can work well into the future, as physicians are required to do more and more volume to keep revenue up. CNMs can help to prevent burnout, prolonging a physician's productive years.

Stephanie Beasley, CNM, is president and founder of Advanced First Assistants, LLC, dba Advanced Laborists and First Assistants (ALFA).

News from Around the State

Celebrating 62 Years of OBGyn Practice



After 62 years, Dr. John Inman, Jr. had his last day of officially practicing medicine on September 30, 2013 at his practice, OB-GYN Associates at the Veranda.

Dr. Inman began his OBGyn practice in 1952 in his hometown of Albany, GA.

Dr. Inman, who graduated from Emory University School of Medicine, Atlanta in 1945, completed an internship and surgical residency at St. Joseph Hospital, Lexington, Kentucky and a residency in obstetrics and gynecology at Crawford Long Hospital in Atlanta. He has been recognized as a Diplomat of the American Board of Obstetrics and is a past chairman, Georgia Section of the American College of Obstetrics and Gynecology, past president of the Georgia OBGyn Society and past vice president of the South Atlantic Association of OB/GYN. He is a founding member of the National Council of Emory University's School of Medicine. The Emory University School of Medicine presented Dr. Inman with the Arnall Patz Lifetime Achievement Award in 2008.

Georgia Improves its Preterm Birth Rate

For the first time, Georgia earned a passing grade on the March of Dimes' 2013 preterm birth report card. In 2012, Georgia lowered its preterm birth rate to 12.7 percent from 13.2 percent, according to the report.

Georgia's "C" is the highest grade given to the state in the six years March of Dimes has been issuing its preterm birth report cards. The nation as a whole also scored a "C". Babies born before 37 weeks of completed pregnancy are considered preterm.

The state's significant improvement comes after Georgia's public health

officials and the March of Dimes worked in recent years to ensure doctors made newborn health a priority when deciding whether to deliver before a pregnancy reaches full term.

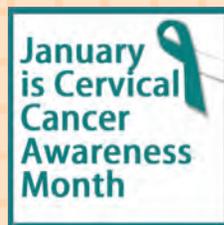
HPV Educational Webinar: "You are the Key to HPV Cancer Prevention"

Join the webinar "You are the Key to HPV Cancer Prevention" Understanding the Burden of HPV Disease and the Importance of the HPV Vaccine Recommendation on December 18th, 12:00 - 1:00 pm.

This program will be presented by Jill Roark, MPH, Health Communication Specialist, Carter Consulting Inc. for the Health Communication Science Office, National Center for Immunization and Respiratory Diseases, Centers for Disease Control and Prevention.

Objectives of this program are: To express the importance of HPV vaccination for cancer prevention and the rationale for vaccinating at ages 11 or 12; to demonstrate concrete knowledge of all indications for HPV vaccine for girls and boys; to provide useful and compelling information about HPV vaccine to aid parents in making the decision to vaccinate; and to provide tips and time savers for talking with parents about HPV vaccine. To register, visit: <https://www4.gotomeeting.com/register/324073815>.

January is Cervical Health Awareness Month



Raise awareness for the women you know that cervical cancer is highly preventable because screening tests for cervical cancer and vaccines to prevent human

papillomavirus (HPV) are available. Unfortunately, half of cervical cancers occur among women who are rarely or never screened for cancer, and another 10%–20% of cancers occur among women who were screened but did not receive adequate follow-up care. When cervical cancer is found early, it is highly treatable and associated with long survival and good quality of life. For additional information about Cervical Cancer or Cervical Health Awareness

Month, visit the <http://www.cdc.gov/cancer/cervical/> or <http://www.nccc-online.org/index.php/january>.

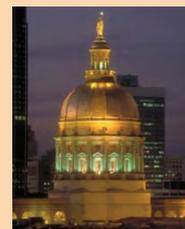
2014 GRHA Annual Conference



The Georgia Rural Health Association's Annual Conference will be January 13-15, 2014 at the Desoto Hilton, 15 East Liberty Street, Savannah. The theme is "Creating the Tool Box." For registration information, visit grhainfo.org. For hotel accommodations, call the Hilton Savannah DeSoto at 1-912-232-9000.

GOGS Legislative Day at the Capitol

Thursday, February 13, 2014 is Legislative day at the Capitol. Physicians from all specialties will meet their state legislators and top government officials and learn how the state government and legislature impacts their practices and their specialties in Georgia. Join us under the Gold Dome! Visit www.Georgiaobgyn.org for a registration form or call the GOGS office at 770-904-0719 to register.



2014 ACOG Annual Clinical Meeting



The 2014 ACOG ACM is April 26-30 in Chicago, Illinois. Registration is open and the Annual Clinical Meeting will offer cutting edge topics, Lunch and Learn seminars, hands-on courses, postgraduate courses and clinical seminars. For additional meeting information visit the ACOG ACM webpage <http://www.acog.org/acm>.

GOGS CPT Coding Seminar May 9th

The next GOGS CPT Coding Seminar will be May 9th at the Macon Marriott in Macon, GA. Seminar highlights include: ICD-10 CM for OB Services & OBGyn Coding Updates for 2014, ICD-10 CM for Genitourinary and Other Primary

Continued on page 11

CODING CORNER

An Introduction to the ICD-10-CM Book

Steve Adams and Bonnie Dubbs

As we begin to draw closer to the October 2014 date, we will publish more articles to introduce you to the make up of the ICD-10-CM book and some of the ways you can find the 3-7 character codes representing more than 69,000 diagnostic services within the ICD-10-CM manual you will use everyday.

The National Center for Health Statistics (NCHS) is the Federal agency responsible for the International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) in the United States and has developed a **clinical modification** of the classification for morbidity purposes. In essence, they take the World Health Organization's (WHO) ICD-10 and convert it into what we will begin using in the United States in October of 2014 – ICD-10-CM.

This month I thought we might look at some of the terms we will need to know in order to locate diagnosis codes within the ICD-10-CM book.

Basically, there are three terms we need to learn in order to find a code: **Chapters, Blocks and Rubrics**.

Chapters – There are 21 chapters in the ICD-10-CM book. Each chapter starts with an alpha character representing various diseases, injuries, symptoms, or causes of the same.

Blocks – Each chapter is broken up into blocks that are just a range of codes within a chapter.

Rubrics – Once you find the block containing your range, the rubric will identify the specific code you are looking for in order to file your claim.

Chapter 14 in ICD-10-CM begins with the Alpha Characters "N" and covers "diseases of the genitourinary system." So let's say you want to find a diagnosis code for a patient with: Acute

cystitis without hematuria. You know this is a condition that would be found in the genitourinary system so you'd go to chapter 14. Once there you'd see this: This chapter contains the following blocks:

N00-N08	Glomerular diseases
N10-N16	Renal tubulo-interstitial diseases
N17-N19	Acute kidney failure and chronic kidney disease
N20-N23	Urolithiasis
N25-N29	Other disorders of kidney and ureter
N30-N39	Other diseases of the urinary system
N40-N53	Diseases of male genital organs
N60-N65	Disorders of breast
N70-N77	Inflammatory diseases of female pelvic organs
N80-N98	Noninflammatory disorders of female genital tract
N99	Intraoperative and postprocedural complications and disorders of genitourinary system, not elsewhere classified

Just to review: The chapter you'd look into for acute cystitis without hematuria is Chapter 14 – Genitourinary System. The block for Acute Cystitis without hematuria (from the list above) is:

N30-N39 Other diseases of the urinary system

When we go to that block of codes we will see the individual rubrics that cover all the diseases in that block. For acute cystitis without hematuria we will see the rubric - N30:

N30 Acute cystitis
Excludes 1: irradiation cystitis (N30.4-)
trigonitis (N30.3-)

N30.00 Acute cystitis without hematuria
N30.01 Acute cystitis with hematuria

Interstitial cystitis (chronic)

N30.10 Interstitial cystitis (chronic) w/o hematuria
N30.11 Interstitial cystitis (chronic) with hematuria

Other chronic cystitis

N30.20 Other chronic cystitis without hematuria
N30.21 Other chronic cystitis with hematuria

So, for this patient with acute cystitis without hematuria we would use ICD-10-CM: N30.00

The key to understanding ICD-10-CM is to know your **Chapters, Blocks and Rubrics**. As we get closer to that ICD-10-CM date of October 2014 we'll submit more articles introducing you to more chapters and tools that you can use to become an expert at ICD-10-CM.

Don't forget, if you missed this year's GOGS annual coding meeting in Atlanta, the next coding seminar will be May 9th at the Marriott in Macon and we will have two hours devoted to OBGyn specific ICD-10-CM coding issues that we don't want you to miss!

News from Around the State

Continued from page 10

Care Services, Risk Management and Patient Safety for the Medical Office, and Understanding and Implementing the Affordable Care Act. Additional information will be available soon on the Society website. Please contact our office at 770-904-0719 for registration or additional information.

2014 GOGS Golf Tournament— Save the Date

The GOGS annual Golf Tournament will be Wednesday, May 14, 2014 at Bears Best, Suwanee, GA. Save the date and make your plans to attend.

2014 GOGS Annual Meeting



Make your hotel reservations now for the 2014 GOGS Annual Meeting, August 21-24, 2014 at The Cloister, Sea Island, GA. Standard room block rates start at \$325 per night. Call 1-800-732-4752 for reservations.



Georgia Obstetrical and
Gynecological Society, Inc.

Administrative Office

4485 Tench Road
Suite 2410

Suwanee, Georgia 30024

Telephone: 770 904-0719

Fax: 770 904-5251

Presorted
Standard
U.S. POSTAGE
PAID
Permit #39
Atlanta, GA

Defending our Georgia owners for more than 30 years



Call **1-800-282-4882** or visit **MagMutual.com**

Founded by Georgia physicians, we know how to protect you

- The best Georgia attorneys
- Georgia peer physician claims review
- Industry leading Patient Safety
- Doctor2Doctor® peer support
- Consistent dividends*
- Owners Circle® rewards program

Medical malpractice insurance for Georgia physicians

*Dividend payments are declared at the discretion of the MAG Mutual Insurance Company Board of Directors. Since inception, MAG Mutual Insurance Company has distributed more than \$120 million in dividends to our policyholders.
Insurance products and services are issued and underwritten by MAG Mutual Insurance Company and its affiliates.