Georgia Obstetrical and Gynecological Society, Inc.

OBGyn News

PROMOTING EXCELLENCE IN WOMEN'S HEALTHCARE in GEORGIA

Georgia Section The American Congress of Obstetricians and Gynecologists

MAY 2012 • VOLUME 6, NUMBER 3

Obstetric Provider Shortage in Georgia

Adrienne DeMarais Zertuche, MD, MPH
GMIHRG Leader

Georgia has 10.9 obstetrician/gynecologists per 100,000 residents, a number which falls significantly short of the national average of 14.1. Population growth and provider exodus continue to exacerbate this shortage, and the problem disproportionately affects rural areas.

The obstetric situation is especially grave. Georgia received March of Dimes "F" and "D" ratings for preterm delivery in 2010 and 2011, and it has the tenth highest infant mortality in the United States (8.1 per 1,000 live births). Of the 82 Georgia primary care service areas[1] (PCSAs) outside metropolitan Atlanta, 52% have an overburdening or complete absence of obstetric providers. That is, 36% of the PCSAs outside of Atlanta have no delivering obstetricians, and 16% have a shortage. If Georgia fails to recruit additional providers over the next 10 years, the number of PCSAs with a deficit will double. By 2020, 75% of the PCSAs outside Atlanta will lack sufficient obstetric services.

Provider age and sex play an important role in this grim picture, as they contribute to earlier retirement from obstetric services. On average, male OBGyns stop practicing obstetrics at age 52 and females at age 44. In 44% of the PCSAs outside Atlanta with delivering providers, more than half of the obstetricians are female, and in 67% the average obstetrician age is ≥45 years.

Georgia obstetricians indicate that more and more OBGyns are eliminating the obstetric portion of their practice due to:

a) overwhelming schedules, worsened by the retirement of other local obstetricians;
b) high malpractice risk, exacerbated by the lack of tort reform; and
c) invariably low Medicaid reimbursement rates, which pay for approximately 60 percent of the state's deliveries (and up to 80 percent in rural areas).

These findings are the results of recent work by the Georgia Maternal and Infant Health Research Group (GMIHRG), which consists of thirteen graduate students from the Emory University Schools of Medicine, Nursing, and Public Health.[2] GMIHRG was established in May 2010 to investigate the current status of obstetric care in Georgia and to explore the reasons for and the consequences of the provider shortage and maldistribution.

Our members conducted a piloted phone survey of the obstetric nurse managers at all 63 Georgia birthing facilities in the 82 PCSAs outside metropolitan Atlanta (response rate

Continued on page 6

The GMIHR Group was honored at the February GOGS Board Meeting for their excellent research and reporting of the OB physician shortage in Georgia. Left to right: Brittany Argotsinger, Kayla Lavilla, Roger Rochat, Adrienne DeMarais Zertuche, Pat Cota, Bridget Spelke, Andy Dott (behind) Nikita Boston, and Abby Yandell.

in this issue

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

President's Article

WALKING THE THIN LINE

David Byck, MD
President, GOGS
Savannah, Georgia

HB 954—Mandating Substandard Care for Patients

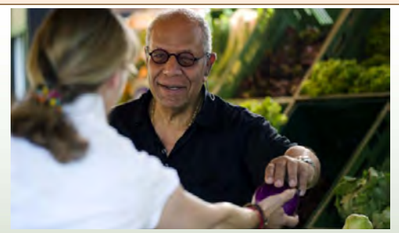
As many of you know, this has been a very difficult year at the Capitol. We have worked diligently to protect our patients and membership on many bills that came through "the legislative process." The most highly publicized of these bills was HB 954 which was titled "The Fetal Pain Bill" but was really about mid-trimester pregnancy terminations. So how do we lead a diverse Society on this issue? This was indeed a question that your leadership struggled with early in 2012.

I fully recognize that our membership falls on both sides of the abortion issue, and your leadership took neither a pro life nor a pro abortion stance. As we looked at the real substance of the bill, we found it necessary to get back to the basics: protection of our members and our patients. Our concern with HB 954 was based on the fact that many of us will be left providing substandard care for our regular OB patients to meet this new law and that the legislation spilled over into our ability to provide everyday obstetrical care in a quality manner. Furthermore, if we do not adhere to the altered standard, we will be liable to go to jail!!!

Here in Savannah, our tertiary medical center cares for many women who have the unfortunate situation of having preterm ruptured membranes at 21 weeks. Should these patients be delivered by classical C-section if they labor? Can we terminate the pregnancy if the patient gets septic? Does the patient with trisomy 18 have to carry that fetus to term? If we try to save a 20 week pregnancy but are unsuccessful, do we report this as a termination? These were just a few of the dilemmas we foresaw based on this piece of very poorly written legislation. These are also issues that are very difficult to explain to a legislator or lay person who does not deal with these issues day in and day out as we do.

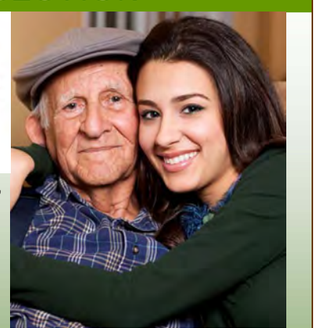
With some very hard work from our legislative team, as well as our professionals, we were able to find some compromises and a last minute amendment for the bill. We still face some significant challenges in providing care for the patients that fall into the "gray zone," of 20 to 24 weeks, but are pleased some improvement was made to the bill before it passed.

I hope this brief update will help some of you understand our thought process. How this will translate into clinical practice remains to be seen. This will certainly be a topic of discussion this summer at our Annual Meeting. One of our speakers at the meeting is Representative Ben Watson (R-Savannah) who is currently the only physician in the House. We have a very good agenda planned and look forward to having you all join us!



NEW DIABETES PREVENTION & AWARENESS SECTION

Live Healthy Georgia



Live Well in Georgia: Protecting the Eyes, Hearts, Kidneys and Feet of Georgians with Diabetes, Pre-Diabetes (Borderline Diabetes), and Gestational Diabetes

Live Well....
Find American Association of Diabetes Educators (AADE) Accredited Diabetes Self-Management Education (DSME) Programs & Certified Diabetes Educators

Resources:
- Diabetes and Pregnant: Gestational Diabetes
- Diabetes Prevention Programs
- Financial Resources for Diabetes Care
- Healthcare, Businesses, Universities,
- Faith-Based & Other Organizations
- Diabetes during Natural Disasters and Travel
- Diabetes Resources for Schools (Grades K-12)
- *What's New in Georgia*

Live Well & *Learn more* about new resources:
www.livehealthygeorgia.org

Learn More....
Find American Diabetes Association (ADA) Recognized Diabetes Education Programs

2012 Legislative Session Wrap-Up

The Georgia General Assembly concluded its 2012 Legislative Session on March 29th.

Arthur "Skin" Edge
GeorgiaLink Public Affairs Group

This is the earliest the General Assembly has adjourned in 8 years, and it was, as usual, a very busy and significant session for your lobbying team and the members of the Georgia OBGyn Society.

On the positive side, for the first time in a number of years we were not engaged in a battle to prevent cuts being made to Medicaid reimbursement rates. We have spent a great deal of time on this issue for several sessions and we have been able to educate key members of the Legislature, as well as Governor Deal and his staff, about the detrimental impact further cuts in Medicaid reimbursement would have on patients and physicians. We were very pleased when Governor Deal proposed a budget with no Medicaid cuts. The General Assembly followed the Governor's lead in this regard, and I am hopeful we can now turn our focus and the focus of the Legislature towards increasing Medicaid reimbursement rates in the years to come. This is an issue we will continue to work on and your input and assistance is greatly appreciated.

The most significant piece of legislation that we dealt with during this year's session was HB 954, the "Fetal Pain Bill" This was a very controversial piece of legislation. No matter what side of the pro-life/pro-choice spectrum you find yourself on, there is no question that this bill will have a significant impact on the way OBGyn's conduct their practices in Georgia.

The bill prohibits abortions after the unborn child has attained the gestational age of 20 weeks and provides criminal penalties on abortions performed in violation of the provisions of this Act. After extensive lobbying we were able to amend the bill so that abortions could be performed if the pregnancy has been diagnosed as "medically futile" or, if in reasonable medical judgment, the abortion is necessary to avoid the death of the pregnant woman or avert serious risk or substantial and irreversible physical impairment of a major bodily function of the pregnant woman.

The measure also contains reporting requirements about physicians who perform or attempt to perform abortions. We were also successful in amending the bill so that the names and the identities of the physicians filing reports would remain confidential. As of the date of this article, the bill had not yet been signed by Governor Deal. Should Governor Deal sign the bill, we will be meeting with the appropriate officials to determine how certain aspects of the bill will be implemented and interpreted. We welcome any questions, comments or input with respect to this most important issue.

With the adjournment of the Legislature, we now turn our attention to election season. This year we will see all 56 members of the State Senate and all 180 members of the House of Representatives up for re-election. As of now, approximately 19 members of the General Assembly have announced their intention to either retire or seek other elective office, so there will be plenty of new faces at the Capitol when they reconvene next January. The Society is making contributions from our PAC to those candidates that have been supportive of our issues and issues affecting women's health in Georgia. I would urge members to make a contribution to our PAC to support these efforts.

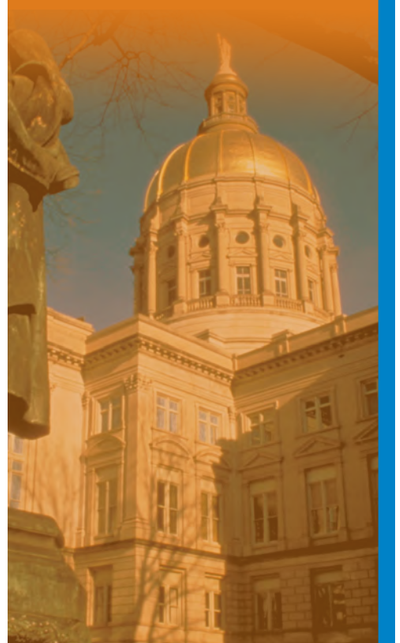
Thank you again for your support of the Society. If you have any questions, or if I can be of any assistance to you with respect to any matters at the State Capitol, please do not hesitate to contact me. Our firm appreciates the opportunity to represent your interests before the General Assembly.

Factoid: Tobacco Cessation:

Each year in Georgia, more than 10,000 adult deaths are attributable to smoking, approximately 15% of all deaths annually.

In 2010, 17.6% of adults in Georgia (more than 1 million Georgians) were current smokers. This rate was the 25th greatest among all states.

In 2009, 16.9% of Georgia high school students were current smokers compared to 17.9% nationally.



Doctor2Doctor

Peer Support Program

Al Sermons, MD, F.A.C.O.G.
Dunwoody, Georgia

Medical liability litigation is a common part of practicing medicine, and most physicians will be sued at some point in their careers. This is a sad but true fact that must be accepted and addressed by doctors in current practice, and by professionals who aspire to enter into the field of medicine. A recent survey by the American Medical Association (AMA), reported that 60% of all physicians over the age of fifty-five have been sued at least once, with that percentage of suits increasing to 90% for surgeons in the same age group. Physicians in solo and single specialty practice settings (e.g., OBGyn physicians) had the highest rates of claim frequency, and both obstetricians/gynecologists and general surgeons experienced the highest number of lawsuits. These two specialties were more than five times as likely to be sued when compared with pediatric and psychiatric specialties.

While data from the AMA survey revealed large differences in claim frequency across medical specialty, there are very few differences in the way that physicians, as a whole, experience the litigation process. Specialty notwithstanding, physicians in the midst of malpractice litigation are likely to experience the same sequence of emotions and emotional distress from the time they are served with the complaint until far after the case is settled, dismissed, or otherwise resolved. Studies show that all doctors involved in lawsuits may experience feelings of intense anger, frustration, anxiety and depression. These negative emotions can be intensified by: 1) the legal requirement made of the physician to tell no one, and 2) the personal/professional need to maintain control and protect one's family and employees by not allowing a show of these emotions. During what could well be the most stressful period of a physician's professional life, the doctor can often feel frustrated, vulnerable and isolated.

As a group of professionals, physicians characteristically exude integrity, competence, and strong self-concepts. We are compassionate, but hard-working and accustomed to being in control. We tend to set high expectations for ourselves, and demand the best efforts from others around us. However, one encounter with the legal system can take the practicing physician completely out of his or her professional element and render the individual helpless, powerless, frustrated from loss of control, and, again, alone. The gut-wrenching onslaught of legal proceedings against a practicing physician is ironically not the time for that individual to be without the support and assistance of others whom she or he can trust and confide in.

I am pleased to report that today there is help! The emotional impact of a lawsuit on one physician can be lessened by involvement with another physician who has been there and experienced that. One industry insurance company, Mag Mutual, has created the Doctor2Doctor Peer Support Program. This new professional mentoring program has been launched in response to the need for physician support during the litigation process. Thanks to the Doctor2Doctor Peer Support Program, policyholders facing a lawsuit will now have access to support from their professional peers.

The program works by pairing a physician in litigation with a colleague who has completed the trial process and has first-hand understanding of the litigation experience. The Peer Support physician is available to provide emotional support and an empathetic ear.

Dr. Willis Lanier, a GOGS Board member, had this to say about the program: "The Doctor2Doctor program will give physicians an emotional outlet during litigation, where previously the legal process did not invite conversation with anyone other than the physician's legal counsel."

MAG Mutual has compiled a list of physicians who have experienced the litigation process and are ready to help other doctors through the emotional upheaval of a trial without feeling completely isolated. Peer counselors are asked to read and sign a MAG Mutual Professional Peer Support Agreement that outlines services to be offered, confidentiality, and terms of the agreement. A small stipend is provided to each Peer Supporter.

The defendant physician will be paired with a "litigation experienced" doctor of another specialty to limit discussion of case details that should be shared only with legal counsel. The Peer Supporter will be available to provide emotional support, validation of personal experiences, stress buffering and stress management support, empathetic listening, which will help eliminate feelings of isolation and negative stress related to being sued.

As one of the physicians involved, I am excited about the new program and agree that it can be mutually beneficial for all parties. I expect that the program will provide a powerful growth experience for both the doctor on trial and the physician who has completed the legal process, and who now serves as a Doctor2Doctor Peer Supporter.

For questions or more information about the program, please contact Rebecca Aqua, J.D., Senior Litigation Specialist, MAG Mutual Insurance Company at (404) 842-5661.

Sources:

American College of Obstetricians and Gynecologists. Coping with the stress of medical professional liability litigation. ACOG Committee Opinion No. 406; May 2008

American College of Obstetricians and Gynecologists. Coping with the stress of medical professional liability litigation. ACOG Committee Opinion No. 497; August 2011

American Medical Association. Medical Liability Claim Frequency: A 2007-2008 snapshot of physicians. (Kane, C.K.: American Medical Association, 2010).

Charles SC. Coping with a medical malpractice suit. West J Med. 2001 Jan; 174 (1): 55-8

Ruminations on the New Law: HB 954

Ruth Cline, MD
Editor
Athens, Georgia

The legislative session came to a welcomed conclusion in 2012. Obstetricians and gynecologists were once again confronted by unanticipated legislation, HB 954: the Fetal Pain Bill. Unfortunately, this bill will become the law in Georgia on January 1, 2013. While I could write a book or Hollywood miniseries on the history of this legislation behind the scenes and in the public eye, what is most concerning is how this legislation will affect the patients and citizens in the state of Georgia after the law goes into effect.

As I wrote in my last newsletter editorial, there are some serious flaws in the legislation that have nothing to do with abortion. Firstly, the legislation uses medical terminology in a way that is defined by the bill's author (not necessarily consistent with true medical definition). Representative McKillip defined gestational age as being the fetal age from the time of conception. He assumes that the day of conception is certain for all pregnancies. He also states that 99% of fetal anomalies are detected by a 16 week ultrasound. This contradicts ACOG's statement that 70% of fetal anomalies are detected at the 20 week ultrasound, and expert testimony given by a perinatologist, a neonatologist and a practicing obstetrician were not heeded.

This law appears to require obstetricians in Georgia to provide interventional medical care that will ensure the best chance of survival for any fetus that is 22 weeks or older using medical gestational age. The law doesn't allow for any patient input or the ability of the physician to provide the best medical care given the specific situation. Therefore, all pregnancies 22 weeks and older will require fetal monitoring and surveillance to optimize the delivery of a live newborn. Thus, for any non-vertex presentations or non-reassuring fetal heart rate tracings, a C-section could be necessary. This is a very difficult C-section for the delivery of a fetus that will not survive if the patient has preterm labor or PPROM. To reiterate the seriousness of this law, the obstetrician may be at risk for a one to 10 year jail sentence if not compliant with this law.

This law completely disregards the woman as the patient. The law appears to require doctors to put Georgia women's health and reproductive future in jeopardy for the unborn non-viable fetus. We need our Neonatologist colleagues to be more vocal about the intensive, prolonged, and expensive interventional care for the newborn that the law mandates after the hysterotomy has been completed.

I would be remiss in not recognizing the heroes of this legislative session who bravely voted against their Republican party-lines in the past session. These elected officials are men and women who respect the complexity of the clinical medical decisions for the extremely premature fetus. They also respect the privacy of the women and men who are confronting the tragedies that occur on the labor and delivery unit. Please give them your financial and moral support—and most importantly your vote— this July and November.

We need to encourage our colleagues and the women of Georgia to voice their objections and VOTE!!

Sharing Information on Text4baby

Seema Csukas, MD, PhD
Interim Program Director
Maternal and Child Health and WIC Program

As the Interim Program Director of the Georgia Department of Public Health (DPH), Maternal and Child Health (MCH) Program, I invite you to partner with us by promoting Text-4baby in your practice. Text4baby is an educational program of the National Healthy Mothers, Healthy Babies Coalition (HMHB) that provides pregnant women and new moms with free text messages regarding pregnancy and infant care.

Women may sign up by texting BABY (or BEBE for Spanish) to 511411. Once enrolled, text messages are sent on a weekly basis to mothers' cell phones that are timed to their due date or baby's date of birth and focus on a variety of topics critical to maternal and child health. Topics include: immunization, nutrition, seasonal flu, mental health, birth defects prevention, oral health and safe sleep. DPH has invested in customized Text4baby messages that inform women about prenatal and infant care services and other resources specific to Georgia.

MCH is the lead partner coordinating this initiative for Georgia. Please assist us by sharing information about text4baby with your patients. National HMHB offers free pre-printed posters, tear pads, and other promotional items that may be accessed at www.text4baby.org.

For more information, please contact Kristal Ammons at klammons@dhr.state.ga.us or 404-657-3147.

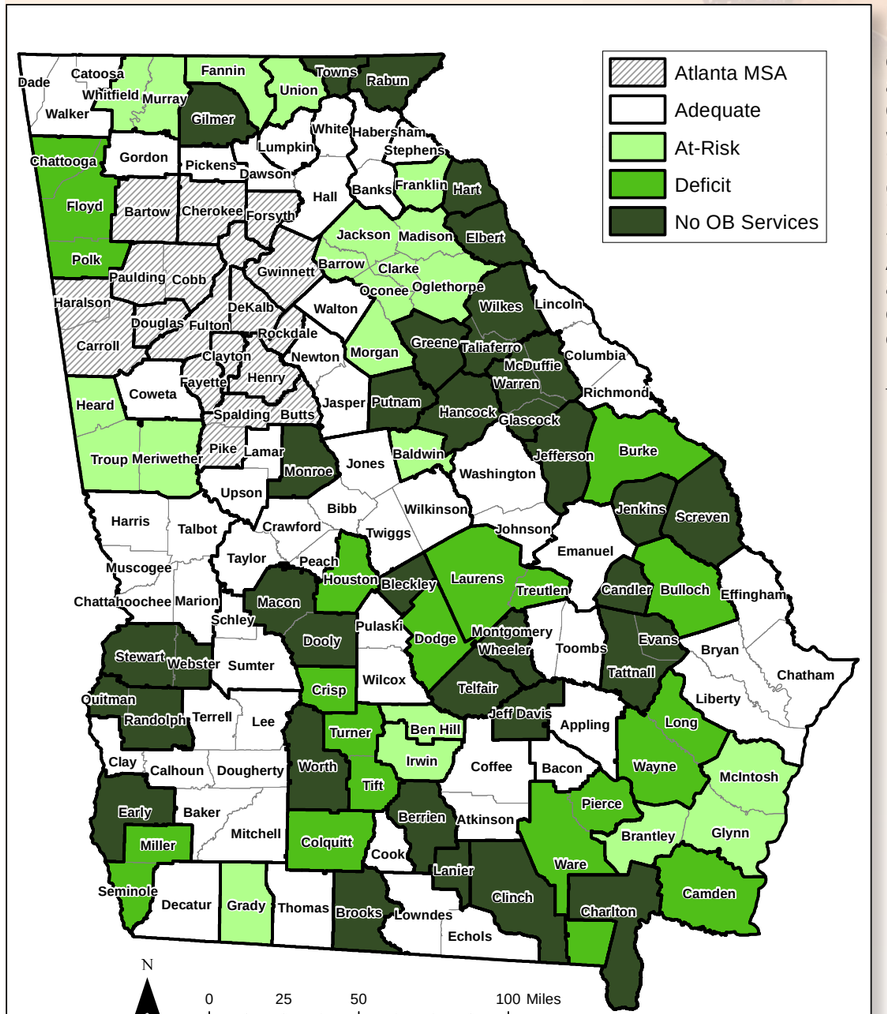
Obstetric Provider Shortage in Georgia

Continued from page 1

>90%); at each facility, we inquired about the obstetric provider workforce[3] and each provider's age, sex, and sustainability. We also interviewed four physicians that recently stopped providing obstetric services to Georgia women.

In order to make the GMIHRG findings easily accessible for healthcare providers, patient advocates, and Georgia legislators, the results were mapped and individualized "report cards" by counties and PCSAs were created. To review and print information related to your local area, please visit the Georgia OBGyn Society website (http://gaobgyn.com/resources/category/ob-shortage-study). We hope you can use our materials to educate yourself and others about the obstetric care issues facing your region and the state as a whole.

Now that GMIHRG has delineated and publicized Georgia's OB shortage areas, we plan to investigate potential solutions to this problem. Our next project will examine the characteristics and attitudes of the state's OBGyn residents and midwifery students. We hope to identify traits that may predict delivery of obstetric services in rural Georgia upon completion of training. Please contact Adrienne DeMarais Zertuche at adrienne.d.zertuche@emory.edu if you have any questions, or if you want to get involved.



SOURCES: Georgia Board of Physician Workforce [2010]. U.S. Census Bureau [2010].
Georgia Maternal and Infant Health Research Group; phone survey [2011].

*Each Legislator PCSA Card included this map of Georgia with color coding to show the status of Obstetric coverage in each county. The darkest green color shows the counties which currently have **NO** obstetric services. Pregnant women in these areas must travel to other counties to receive obstetric care or they go without care. The second darkest green shows areas where there are some OB services, but not enough to meet the demand.*

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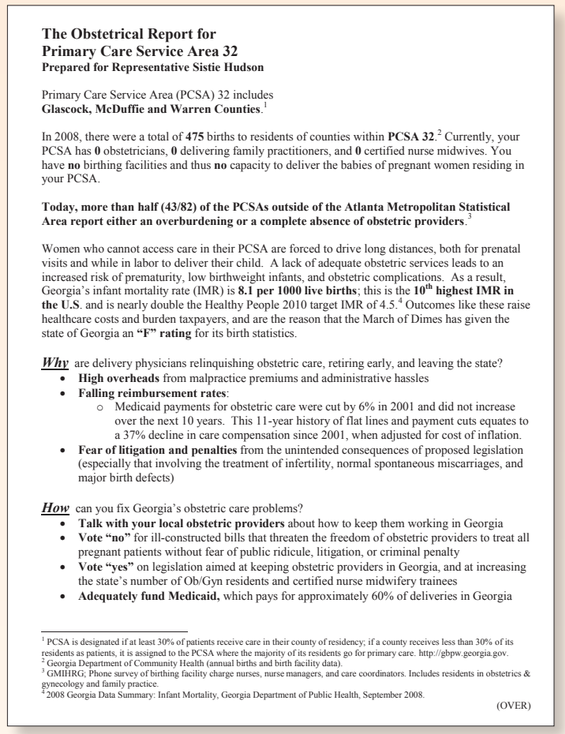
1 Primary care service area (PCSA) is designated if ≥30% of patients receive care in their county of residence. If a county receives <30% of its residents as patients, it is assigned to the PCS A where the majority of its residents go for primary care.

2 Brittany Argotsinger, MPH*; Danika Barry, MPH*; Nikita Boston, CHES, MPH*; Ansley Howe (MSN/MPH Candidate)*; Sylvie Hua, MPH*; Kayla Lavilla, MPH*; Hilary Moshman, MPH; Bridget Spelke (MD/MPH Candidate)*; Dena Vander Tuig, MD, MPH; Audra Williams (MD/MPH Candidate); Abby Yandell (MD/MPH Candidate)*; Brittany Young (MD/MPH Candidate); Adrienne DeMarais Zertuche, MD, MPH.*
** Denotes direct involvement in project.*

3 Based on ideal annual delivery rates (155 deliveries per obstetrician, 100 per certified nurse midwife, and 70 per family practitioner), we converted all providers into "obstetrician equivalents." Using these equivalents and facility birth data, we calculated the average annual deliveries per provider (AADP) within each PCSA, labeling the workforce as "adequate" if AADP<144, "at risk" if 144<AADP<166, and "deficient" if AADP>166.



The Obstetrical Report for
Primary Care Service Area 32
Prepared for Representative Sistie Hudson

Primary Care Service Area (PCSA) 32 includes
Glascock, McDuffie and Warren Counties.[1]

In 2008, there were a total of **475** births to residents of counties within **PCSA 32**.[2] Currently, your PCSA has **0** obstetricians, **0** delivering family practitioners, and **0** certified nurse midwives. You have **no** birthing facilities and thus **no** capacity to deliver the babies of pregnant women residing in your PCSA.

Today, more than half (43/82) of the PCSAs outside of the Atlanta Metropolitan Statistical Area report either an overburdening or a complete absence of obstetric providers.[3]

Women who cannot access care in their PCSA are forced to drive long distances, both for prenatal visits and while in labor to deliver their child. A lack of adequate obstetric services leads to an increased risk of prematurity, low birthweight infants, and obstetric complications. As a result, Georgia's infant mortality rate (IMR) is **8.1 per 1000 live births**; this is the **10th highest IMR in the U.S**. and is nearly double the Healthy People 2010 target IMR of 4.5.[4] Outcomes like these raise healthcare costs and burden taxpayers, and are the reason that the March of Dimes has given the state of Georgia an **"F" rating** for its birth statistics.

Why are delivery physicians relinquishing obstetric care, retiring early, and leaving the state?
- **High overheads** from malpractice premiums and administrative hassles
- **Falling reimbursement rates**:
  - Medicaid payments for obstetric care were cut by 6% in 2001 and did not increase over the next 10 years. This 11-year history of flat lines and payment cuts equates to a 37% decline in care compensation since 2001, when adjusted for cost of inflation.
- **Fear of litigation and penalties** from the unintended consequences of proposed legislation (especially that involving the treatment of infertility, normal spontaneous miscarriages, and major birth defects)

How can you fix Georgia's obstetric care problems?
- **Talk with your local obstetric providers** about how to keep them working in Georgia
- **Vote "no"** for ill-constructed bills that threaten the freedom of obstetric providers to treat all pregnant patients without fear of public ridicule, litigation, or criminal penalty
- **Vote "yes"** on legislation aimed at keeping obstetric providers in Georgia, and at increasing the state's number of Ob/Gyn residents and certified nurse midwifery trainees
- **Adequately fund Medicaid,** which pays for approximately 60% of deliveries in Georgia

[1] PCSA is designated if at least 30% of patients receive care in their county of residency; if a county receives less than 30% of its residents as patients, it is assigned to the PCSA where the majority of its residents go for primary care. http://gbpw.georgia.gov.
[2] Georgia Department of Community Health (annual births and birth facility data).
[3] GMIHRG; Phone survey of birthing facility charge nurses, nurse managers, and care coordinators. Includes residents in obstetrics & gynecology and family practice.
[4] 2008 Georgia Data Summary: Infant Mortality, Georgia Department of Public Health, September 2008.

(OVER)

One Sample of the Legislator PCSA Cards

The GMIHRG created legislator-specific "PCSA cards" for distribution to all 178 Georgia Representatives and 56 Georgia Senators. The front of each card incorporates a map of Georgia's OB provider shortages, as well as revealing quotations from obstetricians across the state. The back displays data specific to the PCSA(s) in the legislator's district, including number of births and deliveries; number, age, and sex of delivering providers; and current and predicted provider burden (average annual deliveries per provider). ***Please download your card(s) from the Georgia OBGyn Society website*** *(http://gaobgyn.com/resources/category/ob-shortage-study)* ***and ask your Representative and Senator to protect our profession and our patients.***

What obstetricians in Georgia are saying...

"In rural Georgia, 70-80% of patients are Medicaid, and with today's reimbursement rates, no matter how smart you run your business, it's hard to get by."
Americus, GA

"We are the only obstetrical practice in town. With 1 OB and a midwife, we did 550 deliveries last year. Sometimes we see 60 women in a day. 75 to 80 percent of our patients are Medicaid. It's difficult to recruit physicians of any kind to this area."
Moultrie, GA

"[From] Preston, it's 30 miles to Americus and 40 to Columbus. If [patients] have cars, they don't have much gas, and there's no public transportation. They don't come for prenatal care, they are less likely to have problems picked up, and Georgia is more likely to have [poor health] indicators."
Americus, GA

"Physicians are small business people. They need to be able to stay financially solvent and pay a living wage to their employees. ...Tort reform would really help. If doctors could practice medicine without worrying about being sued all the time, I believe we would practice better medicine."
LaGrange, GA

Take action to ensure that women in your county have access to obstetric health care.

The Harriet Tubman Women's Clinic Needs Volunteer Physicians

The Harriet Tubman Women's Clinic, an Emory University student-run, free clinic located at the Open Door Community on Ponce De Leon Ave, needs additional volunteer OBGyn and Family Medicine physicians to help see patients and train medical student volunteers.

The Harriet Tubman Clinic, which was founded in 2009 by two ambitious Emory medical students, has enjoyed great success providing free gynecology services to homeless, under-insured and uninsured women. The clinic was recently awarded the AOA Medical Student Leadership and Service Project Award from Emory. This grant is especially beneficial as it allows the free women's clinic to expand from opening bi-monthly to weekly on Tuesday evenings, as well as provide more services and resources to the patients.

To facilitate this expansion, the HTWC is asking more physicians and team members to become involved in this wonderful endeavor. The majority of the physician volunteers are currently recruited from the Emory Clinic OB/GYN department. But as the clinic expands both its services and clinic dates, it hopes to recruit additional volunteer OBGyn and Family Medicine physicians from around the city.

Physician volunteers graciously donate three hours of their time on Tuesday evenings to see patients and train medical student volunteers on basic gynecological practices. The clinic currently offers pap smears, STI testing, breast exams, and onsite treatment options. The clinic also allows medical students to gain experience and hopefully peak their interest in obstetrics and gynecology.

While the clinic is doing a wonderful part to help the underserved women of Atlanta, it is impossible to do this without the help of volunteer physicians. The clinic staff would be honored if you would join their efforts and volunteer at the clinic. For additional information, please contact Leah Machen, 2012 Physician Recruitment Coordinator, at lmachen@emory.edu or email harriettubmanfreewomensclinic@gmail.com.

WOMEN KEEP MEDICAID COVERAGE AFTER DELIVERY

Women who are uninsured or underinsured covered for Contraceptives and routine GYN Care

Finally a plan that covers women's health services.
Contraceptives, Paps, STD treatment and screening, and more.
Planning for Healthy Babies Plan has women covered!!

Benefits to Providers:

- Allows OBs to keep Medicaid women in the practice between pregnancies
- Allows OBs to bill for routine gyn and family planning services
- Improves continuity of care with your reproductive age patients
- Maintains your patient base between pregnancies
- Many CMO patients will automatically roll over to P4HB after delivery

Billing:

- Check with CMOs and Medicaid for additional billing information
- Services should be billed with a family planning modifier

Where do women get more information about Planning for Healthy Babies?

- Refer women to www.planning4healthybabies.org, where they can apply online or download an application
- Applications can be picked up at local health department or DFCS offices
- Refer patients to www.dch.georgia.gov/p4hb or 1-877-P4HB-101 for more information

EMRs and The Physical Exam

Steve Adams,
CPC, CPC-H, CPC-1, PCS, FCS,
InGauge Healthcare Solutions

With an increasing number of providers continuing the transition to electronic medical records (EMR), it is important to review one component of evaluation and management (E/M) coding that is often overlooked when creating your EMR templates.

The federal government, in conjunction with the American Medical Association (AMA) has developed two sets of physical exam guidelines that providers must adhere to when documenting and selecting any set of E/M codes.

Whether you select to document with the "1995" exam guidelines, or "1997 - bullet" exam guidelines is up to you. However, most providers are unaware of the difference in these two guidelines and if you don't specify which set you want to use with your EMR, you are setting yourself up for disaster if ever audited.

Let's take a look at the two sets of guidelines so you will be able to make a decision on which one you want to use to help ensure documentation compliance.

1995 Guidelines

This is a set of body areas and organ systems that when used in conjunction with each other allows you to document and select any number of E/M codes. The only compliance issue that we see with the 1995 exam happens when a provider selects E/M services that require a "comprehensive 8-organ system exam."

The AMA and CMS specify that a comprehensive exam be made up of only organ systems and not a combination of organ systems and body areas. These 12 organ systems are the only recognized organ systems from CMS and the AMA: Constitutional, Eyes, ENMT, Lymphatic, Cardiovascular, Respiratory, Gastrointestinal, Genitourinary, Musculoskeletal, Neurological, Psychiatric, and Skin. If you document a comprehensive exam and any of your headings are different from these key organ systems, you'd need to contact your EMR provider and change the headings.

Once you get the headings correct, you can document whatever findings you want to regarding the system(s) being examined. In fact, CMS writes that a notation of "normal" is acceptable.

1997 Guidelines

These guidelines were then developed as an option for providers not wanting to document exams of organ systems, but to be able to document findings from a combination of systems and areas. However, the federal government is very specific about the areas and systems you examine and what you are able to document regarding your findings within those systems and areas.

In other words, it's not sufficient to perform an exam of the Neurological/Psychiatric system, under the 1997 guidelines and document whatever you want regarding your findings. Specifically, for a neurological/psychiatric exam under the guidelines for a single system musculoskeletal exam, the government will only give you "credit" if you document findings, similar to the statements below, pertaining to any of the following five elements:

NEURO/PSYCH:

- In upper and lower extremities, coordination smooth and accurate.
- Deep tendon reflexes 2+ bilaterally;
- Superficial touch and pain sensation intact bilaterally.
- Alert and Oriented X 3;
- No mood disorders noted, calm affect

Different E/M codes require a different number of "elements" be documented for each E/M code.

If you believe you are set up to document the 1997 guidelines, but you weren't informed of the only findings you could document for proper "credit," you're documentation might not be as compliant as you think.

The point is, unless you are familiar with the specific set of examination guidelines you are using (1995 vs. 1997), the use of an EMR for documentation compliance could be a fruitless endeavor.

What to do?

1. Contact your EMR vendor to ensure they are familiar with the difference in the 1995 and 1997 guidelines as they pertain to the physical examination.
2. Ask them to let you know which system you are currently using for your template.
3. Do some research. The following is a direct link to the CMS web site that outlines the difference in the 1995 and 1997 guidelines: www.cms.gov/mlnedwebguide/25_emdoc.asp
4. Consider having an outside review of some of your new and established patient notes to ensure you have had your templates set up appropriately. Normally after a review of 5 new and 5 established physical examinations, an auditor can offer you suggestions on your documentation compliance.

Please don't overlook this very important component of your EMR documentation compliance.

Perinatal Hepatitis B Prevention in Georgia – A Collaborative Effort

The Centers for Disease Control and Prevention (CDC) estimates that 800 infants are born to hepatitis B-infected women in Georgia each year,[1] placing them at risk of developing perinatal hepatitis B virus (HBV) infection. Only half of these infants are reported to the Georgia Department of Public Health (DPH). The Advisory Committee on Immunization Practices (ACIP) recommends that all newborns receive hepatitis B (HepB) vaccine soon after birth and before hospital discharge, regardless of maternal HBV status.[2] As a healthcare provider, you have the ability to help prevent HBV transmission from mother to child.

Prenatal care providers play a key role in identifying hepatitis B-infected pregnant women. All pregnant women should be tested routinely for hepatitis B surface antigen (HBsAg) in each pregnancy, even if they have been previously vaccinated or tested. In an effort to reduce transcription errors, the CDC recommends that a copy of the original laboratory report with HBsAg test results be transferred to the delivery hospital prior to delivery.[2] Infants born to HBsAg-positive women and those with unknown HBsAg status must receive immunoprophylaxis with HepB vaccine and hepatitis B immune globulin (HBIG) within 12 hours of birth to help prevent perinatal transmission.

In 2011, DPH collaborated with Children's Healthcare of Atlanta (CHOA) to survey 89 birthing centers in Georgia. The project focus was to determine current policies and practices regarding HepB birth dose administration and documentation of maternal hepatitis B surface antigen (HBsAg) status. Of the 72 centers that responded to the survey, 90% have policies or standing orders in place to administer HepB vaccine to all newborns before hospital discharge. Only 89% of responding centers reported having policies and/or standing orders in place to administer both HepB vaccine and HBIG to the infant within 12 hours of birth, when the mother is HBsAg positive; 83% have a policy in place addressing procedures for infants born to mothers with unknown HBsAg status.

As part of the collaborative project, a research team conducted site visits at eight birthing centers, to review medical records of 25 consecutive live births and corresponding maternal charts. The goal was to review practices surrounding HBsAg testing and HepB birth dose administration. Unfortunately, inconsistencies were identified between CDC birth dose recommendations and actual administration of the vaccine, despite existing policies. Failure to follow national recommendations that are endorsed by the American Academy of Pediatrics (AAP)[3] places infants at higher risk for developing chronic HBV infection.

Another component of the DPH and CHOA project was a series of five focus groups that were held in Metro Atlanta to determine existing attitudes, knowledge and behavior among pregnant women and new mothers surrounding childhood vaccinations, the HepB birth dose, and other prenatal issues. Focus group discussions revealed that half of the participants expressed limited-to-no familiarity with hepatitis B. Group participants were asked to identify potential sources of credible information. Three sources scored highly: The American Academy of Pediatrics, Centers for Disease Control and Prevention, and Children's Healthcare of Atlanta. Medical providers also ranked high as a trusted source of information, assuming the role of coach, advisor and medical expert. Some participants reported that they are still more likely to follow advice received from medical providers than social media or relatives. These women reported following the vaccine schedule as outlined by their physicians and other experts.

Perinatal hepatitis B infection remains an important health concern in Georgia. Healthcare providers play a crucial role in preventing HBV transmission. Results from the collaborative project revealed that there are many challenges to overcome, including improvement in policy adherence and increase of HepB birth dose administration rates. Together, we can make a difference in the fight against perinatal hepatitis B.

Recommendations for obstetrical care providers:

- Test all pregnant patients for HBsAg during every pregnancy
- Report HBsAg-positive results to the Georgia Department of Public Health
- Forward a copy of the patient's HBsAg lab report to the birthing hospital prior to delivery
- Refer infected patients for medical management and possible treatment of chronic HBV[2]
- Vaccinate susceptible high-risk women with HepB vaccine

For more information, contact the Perinatal Hepatitis B Prevention Program (404-651-5196). Additional resources can be found on the Georgia DPH website: http://health.state.ga.us/programs/perinatalhepatitisb.

1 Centers for Disease Control and Prevention (CDC). Unpublished data
2 CDC. A comprehensive immunization strategy to eliminate transmission of hepatitis B virus infection in the United States: recommendations of the Advisory Committee on Immunization Practices (ACIP); Part 1: Immunization of Infants, Children, and Adolescents. MMWR 2005;54(No. RR-16).
3 American Academy of Pediatrics. Hepatitis B. In Pickering LK, Baker CJ, Kimberlin DW, Long SS, eds. Red Book: 2009 Report of the Committee on Infectious Diseases. 28th ed. Elk Grove, IL: American Academy of Pediatrics; 2009; 347-350.

Georgia Obstetrical and Gynecological Society, Inc.
Administrative Office
4485 Tench Road
Suite 2410
Suwanee, Georgia 30024
Telephone: 770 904-0719
Fax: 770 904-5251