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

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2012 Annual Meeting Highlights

The Georgia OBGyn Society's 61st Annual Meeting at The Cloister on Sea Island, August 23-26, was a great success, featuring the highest ever attendance of physician members. The meeting was packed with classes and events of all kinds, not the least of which was the passing of the ceremonial gavel from former president, Dr. David Byck, to new president, Dr. Ruth Cline, at the Dinner Dance on Saturday evening.

More than 145 OBGyns attended, combining business, education and fun at the beach. Highlights included the Board of Directors meeting, the hands-on Sim Lab, lectures, receptions both Thursday and Friday nights, followed by the banquet on Saturday. Also featured were a residents' meeting, the Practice Managers' Steering Committee meeting, and a breakfast with a Cloister Chef for attendees' spouses and guests.

The Society gives a special thanks to Dr. Byck for his service as president this past year and extends a warm welcome to Dr. Cline as our new president for the 2012-2013 year.

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Incoming President, Dr. Ruth Cline, presents outgoing President, Dr. David Byck, with his presidential metal.

The Board of Directors discussed legislative policy and other issues impacting the Society.

Past presidents Drs. John Hill, John Moore, David Byck with new president, Dr. Ruth Cline, and Dr. Hal Lawrence, Exec. VP of ACOG.

GaDPH Commissioner Dr. Brenda Fitzgerald spoke about maternal and child health in Georgia.

Dr. Cyril Spann receives a flu shot from a Public Health nurse.

A record number of physicians attended this year's meeting.

in this issue

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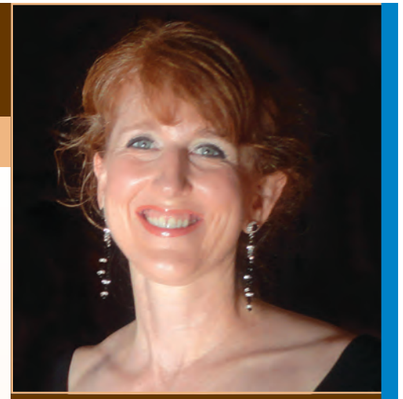
President's Column

The Society is Overflowing with Energy



P. Ruth Cline, MD
GOGS President
Athens, Georgia

Thanks to our Past President Dr. David Byck for his outstanding year of leadership culminating in a high quality Annual Scientific Program at the Cloister in August 2012. For those of you who were unable to join us at this unsurpassed facility, I can only hope to relay the energy that is overflowing from the Georgia OBGyn Society at this time.

We had a record number of physician attendees and had to turn away last minute vendors. The focus and purpose of the organization are escalating in intensity as physicians are unifying in tackling the challenge of providing quality and affordable care to the women in our state within the environment of health care reform.

On Saturday, November 3, the Society is joining our GA AAP colleagues to provide an opportunity to grasp a better understanding of how the new HB 954 "Fetal Pain Law" will affect our day-to-day practice. This law changes both the practice of obstetrics as well as the care of the extremely premature neonate. This event takes place at the Cobb Galleria from 8:30 a.m. to 2:30 p.m. and seating is limited, so register today if you have not already. Presentations applicable to physicians, hospital legal counsel, and administrators will clarify how our practice patterns around the state will need to be altered to avoid violation of this new criminal law that goes into effect January 1, 2013. Please see conference details in this newsletter or on the Society's Web site (georgiaobgyn.org).

The Society has other important events you should take note of as well. The winter CPT Coding Seminar will be Friday, December 7, 2012 at the Atlanta Marriott Buckhead Hotel. Topics include a 2013 CPT and ICD-9 coding update, HIPAA Privacy and Security Implementation, Phase II Meaningful Use Requirements and more. A CPT Coding Seminar flyer will be in the mail shortly.

Save these important dates in 2013: Legislative Day at the Capital is Thursday, February 7; our joint meeting with Georgia AAP, WinSym, Saturday, February 23 at the Atlanta Marriott Buckhead Hotel; the spring CPT Coding Seminar, Friday, May 3 at the Marriott Macon; and our annual Golf Tournament, Wednesday, May 15 at Bears Best, Suwanee. Last, but not least, it's not too early to plan to attend the Society's 2013 Annual Meeting, August 22-25 at Ritz Carlton, Lake Oconee. We are working diligently to plan a fabulous meeting and already have Dr. Zachary Stowe, medical director of Women's Mental Health Program, University of Arkansas for Medical Sciences; Dr. Linda Bradley, vice chair of the Cleveland Clinic in Cleveland, OH, and many other great faculty presenters.

As always, the Society will continue to prepare for the unknowns that tend to accompany the state legislative session each year. Please do not hesitate to contact the Society or myself with your concerns or questions. Remember this Society's greatest strength is its members and ensuring that your practice remains strong and viable.

Why Follow Georgia OBGyn Society in Social Media?

- Legislative Updates during the Georgia General Assembly
- News items and articles of importance to our membership
- Event notices or reminders

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http://twitter.com/GaOBGynSociety/

Editor's Column

View from Outside the Rat Race

Margaret D. Schaufler, MD
Editor
LaGrange, Georgia

Only when you step out of the rat race, can you begin to appreciate what it was you left behind. My partner (who is also my husband) and I recently devolved our OBGyn practice in LaGrange, GA into an office Gyn and primary care for women practice. People think we've retired, probably because we feel like it and act like it! We only work 40 hours a week and although we are available by phone to our patients, we seldom get calls after hours.

After 18 months, we still are giddy as we walk out of the office knowing that our time is our own. I can cook a meal start to finish, eat the meal, start and finish a movie. Sleep will not be interrupted, nor will all other private times. This, after 28 years of week day call, plus weekends and holidays shared with two to four other invaluable colleagues.

In today's climate of having to document to the teeth and beg, claw and scrape to get paid for anything, it's abominable to consider that being "on call" for our patients is not a billable service. Somehow as healthcare evolved over the last century, being "on call" came to be an obligatory, non-compensated contribution. And now, rather than feeling privileged to accept those inconveniences, we feel resentful towards a system that penalizes us if we do not. To be on active staff of most hospitals, we must provide continuous coverage for our patients, 24/7, 365 days a year.

I have great respect for doctors of the past and present with our heroic dedication and sacrifice. But times have changed and this system doesn't fit our culture any more. Heroism is not all it's cracked up to be. Now that I'm out of the rat race, I see that this is no way to live. The constant anticipation of a call, staying within reach, never starting a project wholeheartedly, waiting to dash to the hospital for who knows what for who knows how long, borders on insanity.

The internists have their hospitalists; other professionals have shiftwork. The sooner OBGyns join them, the better for all involved – patients, doctors, hospitals and doctors' families. Until then, insurance companies should follow the lead of some hospitals and pay doctors for their time on call. For example, $1 a day per patient, year round, to be at her beck and call. Let's face it, this is not Doctors Without Borders. Regardless of how much we love helping people, this is a business and we are responsible as well as liable.

Let's encourage leaders in our specialty to push for change in an on-call system that is taking a toll on practicing OBGyns and is likely a deterrent to attracting future doctors to our specialty.

Maternal Mortality in Georgia

Paul Browne, Maternal-Fetal Medicine, Georgia Health Sciences University

The first warning came from California. The state detected a small but significant upward trend in maternal deaths from hemorrhage[1]. After heeding that warning from California, an analysis of data from Georgia shows our state is also experiencing an upward trend in maternal mortality.

I've practiced maternal-fetal medicine in Georgia since the late 1980s. Because of my job as a consultant, I see a disproportionate share of bad maternal outcomes and maternal deaths. Statistics from World Health Organization (WHO)[2] and Centers for Disease Control[3] list maternal hemorrhage and maternal hypertensive disorders as the most frequent causes of maternal death. In addition, domestic violence, trauma, influenza and complications related to obesity are now becoming more prevalent as causes of maternal death in Georgia and in the United States.

I recently analyzed data from the Georgia Department of Public Health's (DPH) Web site, http://health.state.ga.us/healthdata/index.asp. This site is a great source of public information about pregnancy outcomes in Georgia. My analysis shows two important trends:

1. Women over 35 are disproportionately represented in maternal deaths
2. Decreases in state funding for prenatal care are contributing to maternal deaths

The percentage of pregnancies born to women over 35 years of age has risen from 5% in the 1980s to 15% in the past decade. There are many social factors contributing to this trend. Women are postponing both marriage and childbirth. Contraceptive use in Georgia is lower than in most other states. Access to abortion is more limited in Georgia now than at any time since Roe versus Wade[4,5]. Nearly half of pregnancies conceived in Georgia are unplanned, resulting in many older women presenting for prenatal care.

Although advanced maternal age (AMA) patients are 15% of the population, they represent more than half of the maternal deaths in Georgia over the past five years. This is a disturbing trend that merits study.

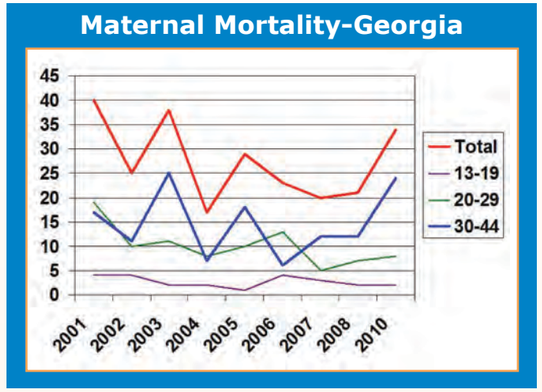
Chronic maternal diseases such as pre-gestational hypertension, pre-gestational diabetes and obesity are more common in patients over 35 years of age. These risk factors likely contribute to the increased maternal death rate in these patients. Although the number of deliveries in Georgia has decreased since 2008, the total number of maternal deaths and the rate of maternal mortality have both increased.

Decreases in public health funding for OB and decreases in reimbursement in OB care are also contributing to the increase in maternal mortality in Georgia. Lack of access to third party payment has resulted in an increase in late presentation for care or no prenatal care at all. The shrinking number of hospitals permitting delivery services has forced many rural Georgians to travel great distances for prenatal care and delivery. This geographic barrier should not be underestimated as it discourages both scheduled prenatal visits and emergency care.

Georgia DPH has been severely downsized since the start of the recession in 2008. DPH funds the Regional Perinatal System, which attempts to provide geographic access to maternal-fetal medicine and neonatology in all areas of Georgia. DPH Commissioner Dr. Brenda Fitzgerald, an obstetrician-gynecologist, has been forced to prioritize programs and cut public health nurse positions to meet legislative mandates. Georgia has fewer healthcare professionals to handle serious public health crises, such as an outbreak of drug-resistant tuberculosis or a new mutant strain of influenza. It is vital that physicians in our state support increases in funding to DPH. We must strengthen our ability to deal with both low-profile health issues (gonorrhea, tuberculosis, HIV) and high-profile health crises (drug-resistant bacteria, Asian bird flu).

Decreases in payment for OB services have contributed to the loss of OB providers and to the loss of hospitals with delivery services in Georgia. In the 30 years since I started residency, reimbursement for total prenatal care and delivery has actually gone down, while medical services for other specialties have seen inflation-adjusted increases. The lack of inflation-adjusted increases for prenatal care and delivery has resulted in a significant decrease in net payment to OB providers over the past three decades. *Inc Magazine*, a business publication, once listed private OBGyn practice as the "worst small business" in America[6]. The article cited inability to raise prices to customers to offset increases in labor costs, insurance costs, rent and other overhead items.

Payments for physician services from Medicaid now average only 10% of the payments made by CMOs to healthcare providers. No wonder hospital systems throughout the United States are buying OB practices and employing those obstetricians. While Georgia Medicaid pays $1000 to $1200 for 10 months of physician care, hospitals collect $4000 to $6000 for 3-4 days of inpatient care. Hospital systems may lose money on their employed obstetrician, but make up for the loss in hospital income from the delivery and NICU services.



No OB care provider should be forced to operate at a loss. Even with more efficient care models like "Centering Care," it is time for Georgia and the federal government to acknowledge the underpayment of Medicaid OB services and re-evaluate provider payments.

The remedy to every public health crisis starts with increasing awareness. I want to make you aware that maternal deaths are increasing in Georgia. I want to make you aware that women over 35 are at particular risk for death related to pregnancy. I want to ask you to support Georgia's Department of Public Health so it can monitor public health in Georgia and respond to crises such as the increase in maternal death. Lastly, I want to thank the hundreds of physicians in Georgia who continue to practice obstetrics in the face of shrinking reimbursement for physician services.

Dr. Browne is director of Maternal-Fetal Medicine at Georgia Health Sciences University, Georgia's public medical school.

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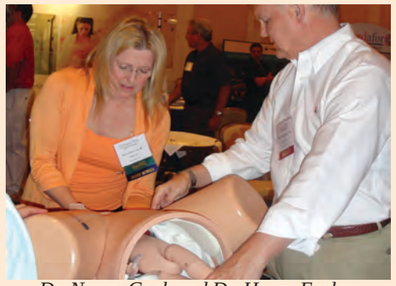
5. 2012 Official Code of Georgia Annotated (O.C.G.A) 16-12-141
6. Inc. Magazine, December 2003, Noel Weyrich

2012 Annual Meeting Highlights

Educational and Professional Opportunities

Dr. Terry Pope tries a hands-on demonstration in the Sim Lab



Dr. Nancy Cook and Dr. Henry Easley at the Shoulder Dystocia training station.

Residents and Junior Fellows meet.

Drs. Tommy Hatchett and Joel Higgins at the focus group on OBGyns vaccinating patients.

PAPARAZZI TIME

Drs. Cathy Bonk, Hugh Smith, Ruth Cline and Roland Matthews talk with Jerry Dubberly, Chief Medicaid Division, DCH (2nd from right).

Dr. William Butler participates in discussion time during one of the lectures.

Dr. Jeffrey Korotkin asks a question during one of the education sessions.

Spouses and Guests' Breakfast with Cloister Chef David Carrier.

Practice Managers' Steering Committee met to plan their 2013 meeting.

The presidency passed from Dr. Byck to Dr. Cline at the Saturday night banquet.

PAPARAZZI TIME

News from Around the State

October National Breast Cancer Awareness Month

The National Breast Cancer Awareness Month (NBCAM) is a collaboration of national public service organizations, professional medical associations, and government agencies working together to promote breast cancer awareness, share information on the disease, and provide greater access to services.

As the OBGyn Society, we know every day is important for breast exams and promoting women's health. We're excited that this month raises awareness for the importance of regular breast exams and for the fight to end breast cancer. For more information on NBCAM or for resources about breast cancer, visit any of these websites: http://www.nbcam.org/, www.acog.org; http://www.cancer.org/Cancer/BreastCancer/, http://www.komen.org/, http://www.nationalbreastcancer.org/

Whooping Cough Cases Higher this Year in Atlanta Area

Whooping cough, also known as pertussis, has recently increased in the eight-county metropolitan Atlanta area of Clayton, Cobb, DeKalb, Douglas, Fulton, Gwinnett, Newton, and Rockdale counties. As of July 28, 2012, 95 cases of whooping cough had been reported, compared to 51 cases during the same time period last year.

"Though we have not seen a substantial increase in the number of whooping cough cases statewide, the increase in whooping cough cases in highly-populated metro-Atlanta is of concern," said state epidemiologist Cherie Drenzek, DVM.

The increase is similar to national trends, as the US appears to be headed for its worst year for whooping cough in more than five decades. Nearly 18,000 cases have been reported nationally so far—more than twice the number seen last year.

Seven Georgia Hospitals Awarded NICHQ/Best Fed Beginnings

National Initiative for Children's Healthcare Quality (NICHQ) selected seven Georgia hospitals to participate in Best Fed Beginnings, a national initiative to increase the number of US hospitals implementing a model for maternity services that better supports a new mother's choice to breastfeed. The hospitals chosen in Georgia are: Atlanta Medical Center, Atlanta; DeKalb Medical, Decatur; Doctors Hospital, Augusta; Emory University Hospital Midtown, Atlanta; Grady Health System, Atlanta; Piedmont Henry Hospital, Stockbridge; and WellStar Cobb Hospital, Austell.

Ninety hospitals nation-wide were selected from 235 applicants. These hospitals will collaborate for 22 months to transform their maternity care services in pursuit of "Baby-Friendly" designation. This designation verifies a hospital has implemented the "Ten Steps to Successful Breastfeeding," as established in the WHO/UNICEF Baby-Friendly Hospital Initiative. Breastfeeding rates are higher and disparities in these rates are virtually eliminated in hospitals that achieve this status. To learn more about the Ten Steps to Successful Breastfeeding, visit www.babyfriendlyusa.org/eng/10steps.html.

Dr. Kathryn Calhoun Joins ACRM

Kathryn C. Calhoun, MD, joined the Atlanta Center for Reproductive Medicine in July, 2012. She completed her fellowship training in Reproductive Endocrinology and Infertility at the University of North Carolina, Chapel Hill. Her undergraduate degree in psychology is from the University of Virginia, and her medical degree is from the University of North Carolina. Dr. Calhoun completed her residency in Obstetrics and Gynecology at the Hospital of the University of Pennsylvania in Philadelphia. Dr. Calhoun's clinical interests include in vitro fertilization, polycystic ovarian syndrome, ovarian aging and reproductive surgery. Her research and teaching has focused on elevated body weight and reproduction.

Do you have news you would like to share about your doctors or your practice? Send the information to OBGyn News at akowal@georgiaobgyn.org. We will highlight physicians joining a practice, special recognitions or achievements, educational or not-for-profit events of interest to physicians, etc. We reserve the right to determine which news items will appear each month due to appropriate content or space considerations.

In Memory of Hugh Randall, Jr., MD

Dr. Hugh W. Randall, Jr. 63, passed away July 1, 2012 in Crossville, TN. Dr. Randall served as president of the Society in 1993-94 and received the Society's Distinguished Service Award in 2006.

A former resident of Georgia, Dr. Randall moved to Crossville to work in private practice at Cumberland Medical Center. Dr. Randall earned his medical degree from Emory University School of Medicine in Atlanta. He completed an internship and residency in gynecology and obstetrics at Emory University and affiliated hospitals in Atlanta.

Dr. Randall received numerous other awards and honors throughout his OBGyn career, including Chair Emeritus at Emory University and Outstanding Faculty Award from the American College of Obstetricians and Gynecologists (ACOG). Dr. Randall was a fellow of the American Congress of Obstetricians and Gynecologists and a diplomat of the American Board of Obstetrics and Gynecology. He was also a member of the American Institute of Ultrasound in Medicine, the Society of Laparoendoscopic Surgeons and the Georgia Obstetrical and Gynecological Society. He was an affiliate member of the Society of Maternal-Fetal Medicine.

Kay Entrekin: Reaching the Summit

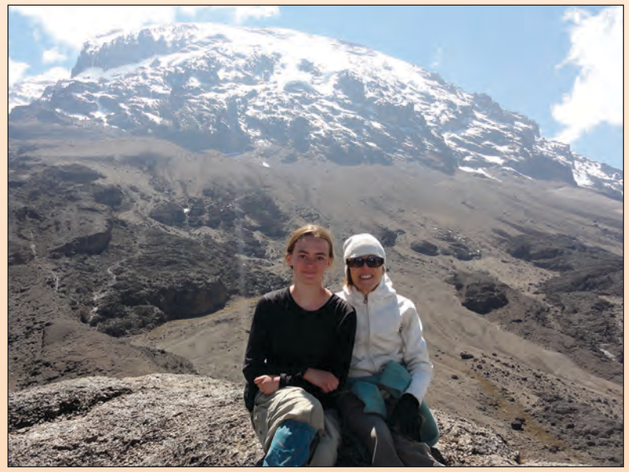
Catherine M. Bonk, MD, Managing Partner, Atlanta GYN & OB. P.C.

I have always known that my partner, Kay Entrekin, MD, was fast (at everything). After working side-by-side our first year together in 1999, I was humbled to learn she had won the Atlanta Thanksgiving Marathon in 1986. The humbling continued year after year every July 5th when I scoured the pages of the AJC and saw her name in the top 500 finishes of the Peachtree Road Race.

Dr. Kay Entrekin's award for placing first in the Women's 50-54 bracket of the 2012 Peachtree Road Race in July.

This year I figured things were no different, so I failed to look at the newspaper on July 5th. When I asked her how the race went, she said, "I finally beat my old nemesis." However, she did not tell me the bigger fact. She WON the Peachtree Road Race (the largest 10K in the world) for women over the age of 50. She completed the race in 41 minutes and 42 seconds, a personal best for the Peachtree. She is so unassuming that she left that detail out of our conversation.

Then, to top it all off, two weeks later, she accompanied her husband and two daughters on a mission trip to Africa and climbed Mount Kilimanjaro. The mission trip with Young Life was to help repair a school in a small village of the African Masaai tribe. Following this endeavor, the group began their challenging trek to the summit of Mount Kilimanjaro. Kay worried for months about the possibility that altitude sickness might prohibit her or any other family members from summiting the climb. Her worries were set aside as all four made it to the top of the 19,340 foot mountain.



Dr. Entrekin with her daughter, Rebecca, during the climb to the summit of Mount Kilimanjaro.

The Kilimanjaro trip was her gift to her husband for his 50th birthday. Her victory in the Peachtree Race was her 50th birthday gift to herself.

An avid runner all her life, Kay knew her best shot of winning the over 50 age category would come in her first race after she turned 50 in June of this year.

Her stamina helps her in many aspects of her life.

As everyone in our field knows, the average age for a woman to stop practicing obstetrics is her early 40s. The good news for our practice is that Kay will continue to deliver babies and to practice obstetrics and gynecology for many years to come.

To Kay, this is all a piece of cake. She has the stamina of 15 women and the heart of 50 women. I am proud to be her partner and inspired every day by her accomplishments.

30 Day Advance Tubal Sterilization Consent Time Requirement: Is it Necessary?

Catherine Bonk, MD, Decatur, GA

GOGS has been lucky to have a very cooperative, information-sharing relationship with the Georgia Department of Community Health under the tenure of David Cook, the chairman appointed by Governor Nathan Deal in 2010. One of the questions frequently posed by our membership surrounds the 30 day advance time requirement for tubal sterilization consent.

In effort to streamline the process for tubal sterilization for Medicaid patients in Georgia, the question was asked of the Department of Community Health by officers of the Society, "Is the 30 day rule necessary in the information age?"

The unfortunate answer is yes, the 30 day rule for Medicaid sterilization consents is still necessary. The reason it is necessary is not a state rule. The 30 day requirement is specified in the code of federal regulations. These regulations have not changed for over 20 years and, in fact, had to be looked up by the Department of Community Health staffers to answer our question. None of the current staff was around when the consents were developed and no one could remember where the rules originated.

For anyone interested in the federal code, the regulations are in 42 CFR Ch. IV Subpart F-Sterilizations 441.250, 441.253 and 441.257 and are listed in part below. Anyone interested in updating these rules in an era where electronic consents are commonplace and information on the permanence of a procedure is only a click away is encouraged to work through ACOG with the help of other states and districts.

The Code of Federal Regulations. 42 CFR Ch. IV Subpart F-Sterilizations:

441.253 Sterilization of a mentally competent individual aged 21 or older.

FFP is available in expenditures for the sterilization of an individual only if—

(a) The individual is at least 21 years old at the time consent is obtained;

(b) The individual is not a mentally incompetent individual;

(c) The individual has voluntarily given informed consent in accordance with all the requirements prescribed in 441.257 and 441.258; and

(d) At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, *except* in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, *the informed consent must have been given at least 30 days before the expected date of delivery.*

441.257 Informed consent.

(a) Informing the individual. For purposes of this subpart, an individual has given informed consent only if—

(1) The person who obtained consent for the sterilization procedure offered to answer any questions the individual to be sterilized may have concerning the procedure, *provided a copy of the consent form* and provided orally all of the following information or advice to the individual to be sterilized:

(i) Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled.

(ii) A description of available alternative methods of family planning and birth control.

(iii) Advice that the sterilization procedure is considered to be irreversible.

(iv) A thorough explanation of the specific sterilization procedure to be performed.

(v) A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used.

(vi) A full description of the benefits or advantages that may be expected as a result of the sterilization.

vii) Advice that the sterilization will not be performed for at least 30 days, except under the circumstances specified in § 441.253(c).

(2) Suitable arrangements were made to insure that the information specified in paragraph (a)(1) of this section was effectively communicated to any individual who is blind, deaf, or otherwise handicapped;

(3) An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent;

(4) The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained;

(5) The consent form requirements of 441.258 were met; and

(6) *Any additional requirement of State or local law for obtaining consent, except a requirement for spousal consent*, was followed.

(b) When informed consent may not be obtained. Informed consent may not be obtained while the individual to be sterilized is—

(1) In labor or childbirth;

(2) Seeking to obtain or obtaining an abortion; or

(3) Under the influence of alcohol or other substances that affect the individual's state of awareness.

AAP Releases Policy Statement on Levels of Neonatal Care

The American Academy of Pediatrics Committee on Fetus and Newborn has issued a policy statement that revises the Levels of Neonatal Care to include four levels of care with no subdivisions. The Academy notes that the overall purpose of these new levels is to ensure the provision of risk-appropriate care so that infants are born at the right place to improve perinatal outcomes.

The new AAP neonatal levels of care are as follows:

- **Level I**: Basic care;
- **Level II**: Specialty care for newborns at 32 weeks gestation or more and weighing 1,500 grams or more with problems expected to resolve rapidly or who are convalescing from a higher level of intensive care;
- **Level III**: Subspecialty care for high-risk newborns needing continuous life support and comprehensive care for critical illnesses. This includes infants weighing less than 1,500 grams or who were less than 32 weeks gestation at birth; and
- **Level IV**: Includes capabilities of a level III neonatal intensive care unit (NICU) as well as the ability to provide on-site pediatric medical and surgical subspecialists to care for infants with complex congenital or acquired conditions, coordinate transport systems, and provide outreach education within their catchment area.

As stated in a letter from the AAP Chapter Committee on Fetus & Newborn, the revised policy statement notes other factors that influence care decisions such as "facility experience, geographic location, and case-mix," "culturally appropriate, family- and patient-centered care," and back-transport issues. Overall, this statement supports efforts to improve perinatal regionalized systems and sets the foundation for pediatricians, nurses, obstetricians and other health providers to "improve state definitions of neonatal care; functional and utilization criteria; quality improvement, compliance and funding; and data for outcome and performance measures at regional and/or state levels."

The entire statement from the September issue of *Pediatrics* can be view at http://pediatrics.aappublications.org/content/130/3/587.

An Update from Georgia Maternal Mortality Review Committee

Debbie Sibley, Maternal Mortality Review Coordinator

Georgia Maternal Mortality Review (GA MMR) Committee has taken giant steps toward re-establishing a process of pregnancy-related mortality review for our state. The recent accomplishments are in two areas: establishing committee membership and orientation for GA MMR members.

Committee Membership: The committee now consist of 43 members representing a wide range of disciplines, including certified nurse midwives, cardiologists, epidemiologists, high-risk labor and delivery clinical nurse, district health directors, family medicine, medical examiner, domestic violence case reviewer, Georgia Department of Public Health, fire chiefs, EMS directors, Healthy Mothers Healthy Babies, Healthy Start, insurance administrator, nursing administrator, OBGyn pathologist, OBGyn physicians, neonatologist, perinatal outreach coordinator, perinatologists (MFMs) and a psychiatrist. The members are both multidisciplinary and geographically representative.

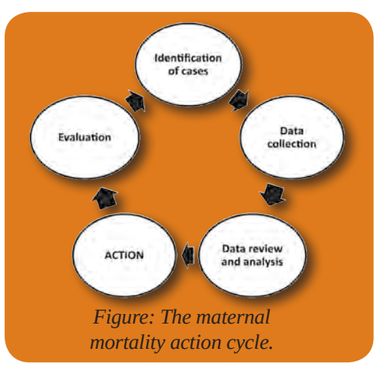


Figure: The maternal mortality action cycle.

Orientation for GA MMR Membership: During the full committee's first meeting in September, Dr. Michael Lindsay, GA MMR chair, welcomed the members and reviewed events relating to re-establishing a maternal mortality review process in Georgia. Drs. Cynthia Berg, William Callaghan and David Goodman (all from CDC) led the day of orientation. Topics covered were confidentiality, liability and the maternal mortality action cycle.

Next Steps for GA MMR: The first review cases have been identified by matching death records of women of reproductive age and to related birth certificates. The next step will be to abstract case data and present them to the GA MMR Committee at its next meeting. After committee findings are compiled for approximately 1-2 years, reports will be shared with public health, professional organizations, like GOGS, and any other appropriate agencies or entities. These reports will recommend improvements to reduce maternal deaths in Georgia, based on the patterns or trends noted from case reviews.

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