



## Zika Virus Epidemic Now an International Crisis

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**D**ue to an explosive rate of infection since its 2015 outbreak in Brazil, the Zika virus epidemic is now being considered an international emergency. On February 1st, 2016, the Zika Virus outbreak was declared a "Public Health Emergency of International Concern" by the World Health Organization. This designation is quite rare, and has previously only been given to outbreaks like the H1N1 in 2009 and Ebola in 2014.

The Zika virus was first identified in the Zika Forest of Uganda in 1947. Prior to 2007, only 14 documented cases of illness caused by the Zika virus were identified. Since the 2015 Zika virus outbreak, there have been record-breaking numbers of Zika infections cited across the Americas and the Caribbean, with a few in the U.S. and **several travel-related Zika cases in the state of Georgia.** Prior to 2015, Zika virus infection had only occurred in Africa, Southeast Asia and the Pacific Islands. According to Centers for Disease Control and Prevention (CDC) predictions, the current Zika outbreak will only continue to spread, with an average of 1 in 5 of those infected becoming ill.

The Zika virus is carried by the Aedes species of mosquito and is primarily transmitted through the bite of an infected mosquito. Common symptoms of Zika virus disease include fever, rash, joint pain and conjunctivitis. The symptoms typically begin within seven days of being bitten by an infected mosquito and are usually mild. The diagnosis can be made by blood tests. There is no specific treatment for Zika other than supportive care such as getting plenty of

rest, increasing fluid intake, and taking acetaminophen to reduce fever and pain.

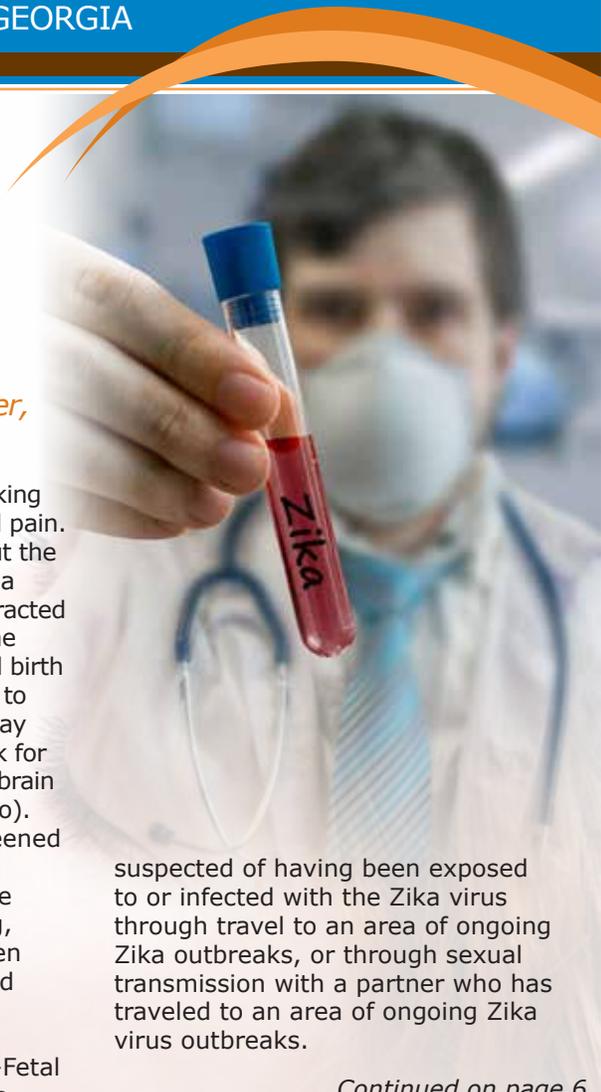
One of the biggest concerns about the Zika virus is its potential effects on a developing fetus if the virus is contracted during pregnancy. Knowledge of the relationship between Zika virus and birth outcomes is evolving, but evidence to date suggests that Zika infection may be associated with an increased risk for congenital microcephaly and other brain and eye abnormalities (Oliveira Melo).

Pregnant women should be screened for recent travel and if identified as having been to a country where Zika virus transmission is ongoing, management should be undertaken as outlined in algorithms published by CDC, the American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal-Fetal Medicine (SMFM), and the Georgia Department of Public Health (GDPH).

All providers caring for reproductive age and pregnant women are strongly encouraged to check the CDC and specialty websites such as ACOG, the SMFM and the GDPH regularly for the latest information on the Zika virus and the management of pregnant women who are at risk for having contracted this

virus. Likewise, the American Academy of Pediatrics has published guidelines for caring for infants with possible congenital Zika virus infections. These websites are updated periodically as new information about the virus and patient management becomes available.

A maternal blood sample may be indicated if a pregnant woman is



suspected of having been exposed to or infected with the Zika virus through travel to an area of ongoing Zika outbreaks, or through sexual transmission with a partner who has traveled to an area of ongoing Zika virus outbreaks.

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Pictured below:  
**Aedes Mosquito**, responsible for  
Zika Virus infection

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# President's Column

Change is inevitable; We Must Be Change Agents.

As OBGyns, we are stellar at embracing change clinically. These clinical changes include new procedures, new surgical techniques, new treatments, and even old treatments that have fallen out of practice only to become new again as part of our professional repertoire.

In stark contrast, statistical practice patterns of OBGyn professionals indicate that our adaptation to change outside the clinical realm is not so stellar. In a field where upwards of 95% of the graduates are women, opportunities for job sharing, part-time work or creative scheduling continue to remain very limited.

The overarching problem for many OBGyns is that life, and the ever-present struggle to achieve an ideal work/life balance often involves heavy multi-tasking with little time for personal or professional development. This is a real concern and often a deterrent for OBGyn hopefuls. For myself, I admit there were many years that I ran to work and then to home,

and if any task or meeting was not 100% required, I did not engage.

To complicate matters, malpractice premiums in Georgia, like many states, are only available for full-time positions, making employers reluctant to even consider offering part-time positions. This forces many OBGyns into full-time work, inhibiting their schedule flexibility.

Last, but not least, there is the call. The fact that the nature of our specialty requires availability at all hours of the day leaves many docs with the assumption the only means to obtaining a fulfilling work/life balance is to quit obstetrics entirely.

The age at which women quit obstetrics in the U.S. is 42 and for men, it is 52. These statistics leave a small window of obstetric work per graduating resident. Certainly, there is plenty of gynecological work to go around, yet many residents choose OBGyn sub-specialties that remove them from the delivering workforce.

OBGyn residencies are still very popular, with at least 20 applicants per



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open slot in the U.S. However, if we cannot make the work environment for docs to maintain obstetrics practice (1/2 of their training), our specialty will fail our communities.

As a profession, we have the opportunity to change and possibly reverse the negative trends that have



emerged, and we must do so. This begins with facing the reality that our future workforce desires a work/life balance above all else. Sadly, if that doesn't exist, we'll continue to see a decline in the numbers of both men and women practicing obstetrics. That being said, we must find ways to structure our jobs to fit the desires of incoming OBGyn professionals.

Some options, like the use of laborists and midwives, have already been integrated, which decreases the in-hospital time requirement for an individual OBGyn. Other proposals to consider include a "return-to-practice" training program for docs who have left the obstetrics field but later decide to re-enter, which will supply them the means to retool so they can begin to practice obstetrics again. Perhaps the largest incentive for emerging OBGyns is introducing a malpractice premium alternative for part-time doctors.

Being an OBGyn can be a highly rewarding and fulfilling specialty. As OBGyns, we interface with women, and take part in some of their most significant life moments. Moreover, we help to bring our future citizens into the world.

Many of our patients take great pride in their health, and work hard to maintain healthy lifestyles for themselves and their future offspring. No other specialty can lay claim to such motivated patients. For reasons like these, we must make it a top priority to extend the career longevity of our OBGyn practitioners.

Georgia OBGyn Society members can help protect the integrity and longevity of the OBGyn craft by creating innovative solutions to maintaining an ideal work/life balance. I also advise that seasoned OBGyns take the initiative to mentor new docs who are transitioning from residency and are the future of our specialty. This year and last, we have worked hard to be able to include more Georgia's OBGyn residents in our annual meeting.

In the spirit of change, I plan to introduce a number of new facets this year, one being at this year's golf tournament. In my observation, the Georgia OBGyn golf tournament has traditionally been highly male-dominated, lacking in female participants. However, one of the few women golfers I know is my partner, Dawn Mandeville, who also happens to be the best golfer I know, male or female. Because of this experience, I generated a solution to attract non-golfers to the GOGS golf tournament; by introducing an alternate "Doctor's Day Out" activity for those who plan not to participate in the golf tournament.

The actual day of the golf tournament will start the same as it has in the past.

All attendees will lunch and learn with an educational lecture. The twist is, when the golfers make their way to the course, those who are not participating in golf will have the option of reveling in a fashion show & trunk sale, followed by an hour-long circuit exercise class. We're calling this itinerary of events, "The Fashion and Fitness Fanfare".

Please join us on May 18th, 2016 for either the Golf Tournament or The Fashion & Fitness Fanfare. I invite all physicians and their spouses to attend either event. I also welcome suggestions for future activities, which will hopefully give busy docs the opportunity to decompress and have fun with their colleagues.



Dr. Dawn Mandeville

I believe that togetherness is where creativity flourishes. And it is with creativity and innovative ideas that we will work to tackle gender-specific, as well as general industry concerns in the Georgia OBGyn community. Opportunities where we can gather at leisure are few; designating this afternoon in May as one of them could start one of many positive trends we aspire for.



## Editor's Column

### Why Don't More Georgia Physicians Run for Public Office?

The 2016 U.S. presidential election is scheduled for November 8, and it's hard to turn on any media source without being bombarded with evidence of ongoing debates and political promises from candidates. While nothing would suit me more than to avoid discussion of politics in America altogether, I find myself tuned in to issues that are close to my heart and home. As a practicing physician, I am well aware of legislative changes that have and will continue to impact the healthcare and well-being of my patients, and my way of work. Recently, I pondered the issues of medicine and healthcare in our state, musing over how political outcomes might be better served [or different], if there were more physicians in politics.

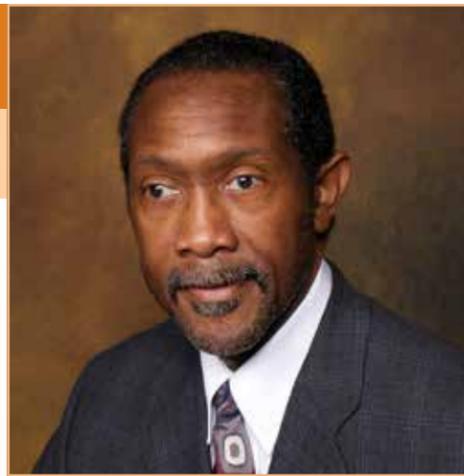
For the first time in my lifetime, America has a physician running for the Chief Executive Office. A quick look at U.S. history confirms that zero of the 44 American presidents came to the office with prior professional experience in medicine. *The fact that 25 of our 44 presidents were attorneys is a discussion for another time.* Presently, I like knowing [or believing] that there are physicians in Congress, with firsthand knowledge of the issues that doctors confront every day. According to the Congressional Research Service report, there are 17 physician members in the 114th Congress, which includes 14 representatives and three senators. Representative Tom Price, MD is an Orthopedic Surgeon and an official from our state. <https://www.fas.org/sgp/crs/misc/R43869.pdf>

Closer to home and active in our state legislature are three physician members of the Georgia General Assembly: Senator Dean Burke (R-Bainbridge), Senator Ben Watson (R-Savannah) and Representative Betty Price (R-Roswell). The overall membership of our state legislature [mimics that of the federal congress], and is comprised largely of attorneys, educators, businessmen, farmers, etc. Each year commencing the second Monday of January, members of the Georgia General Assembly gather under the Gold Dome to decide the fate of the citizens of Georgia. It is amazing to me that 180 members of the Georgia House of Representatives and 56 Georgia Senators have the

power to influence and moreover determine the health and welfare of more than 10 million people in the state of Georgia.

I have wondered why there are not more physicians that run for public office. It certainly is not difficult to qualify. The requirements to run for office in both houses are minimal, and include: 1) an age requirement of 21 for the House, 25 for the Senate, 2) U.S. citizenship, 3) two years as a citizen of Georgia, and 4) legal residency in the district that one seeks to represent. I would submit that most Georgia physicians meet these requirements.

As physicians, are we too busy with our individual practices [particularly in rural areas where there is already an insufficient number of providers], to be away from our communities for 40 legislative days? Are we so intent and committed to maintaining the Hippocratic Oath that we shy away from being drawn into the world of self-serving hypocrisy that can flourish under the Gold Dome? Do we detest the kind of political duplicity that has allowed many of our geographically critical hospitals and L&D units to close, and failed to fund healthcare in the underserved areas of our state? I don't have answers to these questions, but I am concerned enough to ask them. Those of us who work in the trenches every day are often mislabeled as whining physicians, who are concerned more about reimbursements than the welfare of our state. Emphatically, I say not so! I still believe that as physicians we are the most caring,



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and compassionate parts of our communities. Perhaps, it is in our communities that the majority of us will provide our best service to the state, and make the most profound impact on its citizenry. Perhaps the majority of us are doing exactly what we are called and sworn to do.

As you read this editorial, let's be reminded that there are a number of physicians spending their time, energy, and money lobbying daily under the Gold Dome. Perhaps you were one of them who recently spent "Doctor's Day" at the Capitol lobbying our elected officials to protect the health and welfare of the citizens of Georgia. If that's you, I say thank you! For the rest of us, it could be that our talents are better used behind the scenes, where the rubber meets the road, caring for the needs of our patients, rather than serving in the political arena.



## Medicaid Perinatal Case Management in Local Health Departments



In response to an alarming number of infant deaths, the Georgia Department of Public Health (DPH) has made reducing the infant mortality rate a statewide priority. Data compiled by DPH using birth and death records for 2013 indicate that out of 128,511 births, there were 13,766 preterm births (10.7%), 931 infant deaths and more than 100 maternal deaths. Forty-six percent of all births in Georgia are within families assisted by Medicaid. In our last newsletter, we featured a story about Medicaid Presumptive Eligibility (PE) coverage for prenatal services to ensure you were well informed about reimbursement and to encourage acceptance of women as early in pregnancy as possible. In addition to the early medical care, patients may also need other support services.

Local health departments are uniquely positioned to assist pregnant women in early access to prenatal care and other services to improve birth outcomes. Pregnant women in need of Medicaid coverage may apply at their local health department and, if eligible, receive PE coverage immediately following completion of the application. It also serves as an opportunity for Public Health nurses to provide early intervention through the Medicaid Perinatal Case Management

(PCM) program, open to all pregnant Medicaid members.

PCM nurses in Public Health assist patients with accessing needed medical, nutritional, social, psychosocial, educational, and other support services. Services may start as soon as PE coverage is approved. Many health departments see patients on the same day to either begin services or to set up an appointment.

Services start with a comprehensive assessment. This includes a medical assessment; review of nutritional, psychosocial, and health education needs; and a reproductive life plan discussion. Based on the assessment, an initial care plan is developed and referrals are made. Referrals may include anything from smoking cessation to housing resources. Collaboration with local resources plays a key role in identifying help for patients in need. Public Health has also partnered with the Medicaid care management organizations (CMO). The initial

assessment, care plan, and reproductive life plan are all shared with the CMO selected by the patient to insure continuity in case management.



In DPH's South Health District, PCM nurses have partnered closely with all the OB/GYNs in the area for close to 30 years to connect women to prenatal care as early as possible. Before the initial visit

ends, the PCM nurse calls the physician selected by the patient to schedule the first prenatal appointment. Any immediate medical needs found during the assessment are also shared during the call, allowing the physician's office to prioritize high risk patients and get them into care quickly. **The strong and trusting relationships between the local OB/GYNs and public health nurses have resulted in improved birth outcomes in this area, which once had one of the highest infant mortality rates in the state.**

If you would like to get involved or for more information on the pregnancy related resources provided through the Department of Public Health and local health departments, please contact the Georgia Department of Public Health Maternal and Child Health Director, Michelle Allen, at (404) 463-2579 or visit the DPH website at [dph.georgia.gov/pregnancy-resources](http://dph.georgia.gov/pregnancy-resources).



### New Codes for IUDs

	HCPCS Code	Description
<b>Liletta</b>	J7297	Levonorgestrel Releasing Intrauterine Contraceptive System, 52 mg 3 years
<b>Mirena</b>	J7298	Levonorgestrel-releasing intrauterine contraceptive system, 52mg, 5 year duration

# Zika Virus Epidemic Now an International Crisis

Continued from page 1



These patients should be followed-up with prenatal ultrasounds and amniocentesis considered based on the results of maternal testing or ultrasound findings suggestive of cranial or intracranial abnormalities. All Zika testing requests must be coordinated by the Georgia Department of Public Health (DPH). If you have questions about testing or Zika virus infection, please contact the Epidemiology Program at DPH at 404-657-2588 (during business hours) or 1-866-PUB-HLTH (after-hours). Currently, all blood and amniotic fluid samples are being sent to the CDC for analysis. The Georgia Public Health Lab expects to begin testing for Zika virus infection within the next two weeks to provide expedited test results.

The Regional Perinatal Centers can also be of assistance in obtaining consultation for pregnant women, appropriate testing and follow up. The CDC has made available an updated list of countries in the hot-zone for Zika virus infection on its website ([www.cdc.gov/zika](http://www.cdc.gov/zika)), and also provides excellent guidance for counseling women of reproductive age considering travel to or residing in areas of ongoing Zika virus transmission. There is currently no vaccine available to prevent Zika, although efforts are underway to develop one. However, it is suggested that once a person has the infection, the individual will likely be protected from future Zika infections.

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2. The ACOG-SMFM Joint Practice Advisory: Interim Guidance for Care of Obstetric Patients During a Zika Virus Outbreak. <http://www.acog.org/About-ACOG/News-Room/Practice-Advisories/Practice-Advisory-Interim-Guidance-for-Care-of-Obstetric-Patients-During-a-Zika-Virus-Outbreak> MMWR/ January 29, 2016 / 65(3);63-67

**Websites:**

- ACOG [www.acog.org](http://www.acog.org)
- Society for Maternal Fetal Medicine [www.smfm.org](http://www.smfm.org)
- CDC [www.cdc.gov/zika](http://www.cdc.gov/zika)

# Preventing Pregnancy Loss in Georgia

The deafening silence after the delivery of a stillborn baby takes an emotional toll on women, families and healthcare providers. In 2013, over 1,000 Georgia families were faced with the tragedy of losing a child before he or she could take her first breath. Both nationally and in Georgia, these unintended pregnancy losses are now more common than infant deaths.<sup>1,2</sup> In Georgia, the fetal mortality rate is 36% higher than it is nationally, and the disparity between non-Hispanic Black and non-Hispanic White women exceeds that at the national level.<sup>1,2</sup>

In 2011, The Lancet published its first Stillbirth Series, a call to action to address a public health crisis that had been neglected worldwide.<sup>3</sup> A follow-up series was made available online on January 18th, 2016, which highlighted success, but also demonstrated that there is still much work to be done<sup>4</sup>:

- Since 2000, the US stillbirth rate has only declined by 0.4% – ranking in the bottom 5 of 49 high-income countries worldwide
- The risk of stillbirth is at least twice as high for women living in the poorest communities

- Stigma continues to add to the trauma experienced by families who have a stillbirth
- Current bereavement care is inadequate
- Poor data quality hampers research efforts to identify ways to reduce stillbirth rates and disparities

The problems identified in the Lancet Stillbirth Series hit close to home, as they address many of the struggles we have right here in Georgia. In an effort to engage key stakeholders in a discussion around stillbirths in Georgia, Emory University hosted a symposium on January 19th entitled "Preventing Pregnancy Loss in Georgia." The event was attended by



medical professionals, students, faculty, state and federal health officials, as well as parent advocates. Highlights from the symposium include:

- A description of **stillbirth as a child health issue**: an understanding of very preterm stillbirths is required for the prevention of very preterm birth
- A **panel of families who experienced a stillbirth** shared stories of their losses and the profound impact that those experiences have had on them and their surviving children

- Use of preconception care and centering pregnancy to improve health outcomes
- The importance and complexity of fetal autopsy and placental pathology:
  - Invaluable insight for the management of a woman's health and subsequent pregnancies
  - Autopsy rates remain low due to a shortage of trained



Preventing Pregnancy Loss Symposium



**Lauren Christiansen-Lindquist, PhD, MPH**  
Deputy Director,  
Center of Excellence in Maternal and Child Health Education, Science and Practice  
Instructor,  
Department of Epidemiology  
Rollins School of Public Health  
Emory University

pathologists and a lack of insurance coverage for these tests

- Efforts to improve stillbirth data quality:
  - The National Center for Health Statistics (NCHS) will remove 39 underperforming items from the report of fetal death
  - NCHS is developing e-learning training for clinicians and non-clinicians on the importance of collecting high quality medical and health data for stillbirths
  - NCHS will release cause of fetal death data for the very first time later this year
  - Expansion of birth defects surveillance programs to include stillbirths has been shown to improve stillbirth surveillance, compared to using vital records alone
  - The Centers for Disease Control and Prevention's Division of Reproductive Health plans to fund a site to expand the Pregnancy Risk Assessment Monitoring System (PRAMS) to include women who experienced a stillbirth in May 2016

Stillbirth is an important and under-recognized public health issue. It is our hope that by bringing together clinicians, researchers, bereaved families, and other important stakeholders, we can finally break the silence around stillbirth.

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1. Georgia Department of Public Health. Online Analytical Statistical Information System. Available at: <https://oasis.state.ga.us/> Accessed February 4, 2016.
2. MacDorman, M. F. and E. C. Gregory (2015). "Fetal and Perinatal Mortality: United States, 2013." *Natl Vital Stat Rep* 64(8): 1-24.
3. Froen, J. F., et al. (2011). "Stillbirths: why they matter." *Lancet* 377(9774): 1353-1366.
4. Flenady, V., et al. (2016). "Stillbirths: recall to action in high-income countries." *Lancet*.

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# Create a **Safe Sleep Environment** for Baby

Did you know that the features of your baby's sleep area can affect his/her risk for **Sudden Infant Death Syndrome (SIDS)** and other sleep-related causes of infant death, such as suffocation?

**Reduce the risk** of SIDS and other sleep-related causes of infant death by **creating a safe sleep environment** for your baby.

## How can you make a **safe sleep environment**?



▶ Always place baby **on his or her back** to sleep for all sleep times, including naps.



▶ Have the baby **share your room, not your bed**. Your baby should not sleep in an adult bed, on a couch, or on a chair alone, with you, or with anyone else. Try room sharing—keeping baby's sleep area in the *same* room next to where you sleep.



▶ Use a **firm sleep surface**, such as a mattress in a safety-approved\* crib, covered by a fitted sheet.



▶ Keep soft objects, toys, pillows, crib bumpers, and loose bedding **out of your baby's sleep area**.



▶ Dress your baby in **no more than one layer of clothing more than an adult would wear** to be comfortable, and leave the blanket out of the crib. A one-piece sleeper or wearable blanket can be used for sleep clothing. Keep the room at a temperature that is comfortable for an adult.



**Safety-approved\* portable play yards** can also provide a safe sleep environment for your baby. When using a portable play yard, always place baby to sleep on his or her back and keep toys, pillows, and blankets out of the play yard. These actions help reduce the risk of SIDS and other sleep-related causes of infant death.

\*Visit the U.S. Consumer Product Safety Commission website for more information about safety-approved baby sleep areas: <http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/cribs/>



Learn more about ways to reduce the risk of SIDS and other sleep-related causes of infant death at <http://safetosleep.nichd.nih.gov>

Questions? Visit [www.dph.ga.gov/safetosleep](http://www.dph.ga.gov/safetosleep)



## Healthy Behaviors Program

The Healthy Behaviors Program rewards members for taking small steps that will help them live healthy lives. For simple tasks like completing primary care provider (PCP) visits, prenatal visits, and certain health checkups (see the table below), members can earn rewards which are placed on reloadable Visa® debit cards. The more services members complete, the more they can earn.

Healthy Behavior Program	Focus Area	Activity Criteria	Incentive Type	Incentive Value
Healthy Pregnancy	Prenatal care visits	Attend 6 or more prenatal visits before the birth of the baby	Reloadable prepaid card	\$20
	Postpartum care visit	Attend 1 postpartum visit 21–56 days after the birth of the baby	Reloadable prepaid card	\$30
	Completion of both	Completion of prenatal and postpartum visits	Stroller or portable playpen	Members who complete both receive the incentive plus a stroller or portable playpen
Well Women	Cervical cancer screening	Completion of office visit for an annual cervical cancer screening (Pap smear) (ages 21–64)	Reloadable prepaid card	\$25
	Screening mammogram	Completion of annual screening mammogram (ages 40–65)	Reloadable prepaid card	\$25

Providers can encourage their patients to participate in the Healthy Behaviors Program by signing and including their provider ID on applicable activity reports.

For more information on WellCare's Healthy Behaviors Program, please contact your Provider Relations representative or call Provider Services at WellCare Health Plans, Inc.

**1-855-538-0454 or [www.wellcare.com](http://www.wellcare.com)**

# News from Around the State

## First Case of Zika Virus Infection in Georgia Confirmed

Georgia DPH confirmed the first case of travel-related Zika virus infection in the state of Georgia. The patient was a non-pregnant woman who had recently returned to the state following a December trip to Colombia. The woman has since made a full recovery. The CDC conducted the testing, and is now in the process of examining several other Georgia residents who've recently traveled to countries in the hot-zone for Zika infection. Worries over Zika transmission is high, as the CDC has since reported three new cases of Zika infection in the U.S. spread solely through sexual contact with an infected partner that has traveled to an area of ongoing Zika infection. For continuing updates and information about Zika outbreaks, visit [www.cdc.gov/zika](http://www.cdc.gov/zika).



## ACOG 2016 Annual Clinical and Scientific Meeting - May 14-17th, Washington DC

ACOG's 2016 Annual Clinical and Scientific Meeting will take place Saturday, May 14th - Tuesday, May 17th at the Walter E. Washington Convention Center in Washington, D.C. 'Taking Charge of Healthcare' is the reigning theme for this year's convention, which will bring to light new scientific research and clinical methods in the advancement of women's healthcare. The program features intensive discussion points in the areas of family planning, menopause, high-risk obstetrics and more, also incorporating live telesurgery and cutting-edge clinical sessions. For further conference details, and to register, visit: <http://www.acog.org/About-ACOG/ACOG-Departments/Annual-Meeting>.

## 27th Annual Breastfeeding Conference Kicks off At Emory

The Emory University Regional Perinatal Center, Division of Neonatal-Perinatal Medicine will hold the 27th Annual Conference on Breastfeeding Monday, March 14th - Tuesday, March 15th, 2016 at the Emory Conference Center, 1615 Clifton Road, Atlanta. Maximum of 12.0 AMA PRA Category 1 Credits are available for this session. Event is open to all lactation professionals, consultants and community. Pre-registration by March 4th is required for attendance. For further details, contact Jane Hamilton at [JHamil2@emory.edu](mailto:JHamil2@emory.edu) and/or (404)-778-1464.

## 32nd Annual Perinatal Update 2016 - March 9,10,11

The 32nd Annual Perinatal Update from Memorial Hospital Savannah will take place Wednesday, March 9th, Thursday, March 10th and Friday, March 11th at the Westin Savannah Harbor Golf Resort and Spa, 1 Resort Dr. in Savannah, GA. The program offers

in-depth discussions in how to care for and stabilize premature and critically ill infants, and transporting them to Memorial Hospital. The perinatal outreach program at Memorial Health offers annual courses in neonatal resuscitation, fetal monitoring, perinatal bereavement and neonatal intensive care, as well as neonatal transport. For further details on the conference and registration, visit their website or contact Memorial University Medical Center at 912-350-3574.

## GHA Pushes Safe-to-Sleep Program for Hospitals

The Georgia Hospital Association requests that all birthing hospitals in the state adopt a hospital-based safe-to-sleep program. Unsafe sleep environments are the third leading cause of infant mortality in Georgia and are among the most preventable deaths. Questions about the 'Implementing A Hospital-Based Safe-to-Sleep Program' can be directed to Terri Miller, MPH, CHES at (404) 657-2904 and/or [terri.miller@dph.ga.gov](mailto:terri.miller@dph.ga.gov).

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The Georgia Obstetrical and Gynecological Society  
presents

# The 2016 Golf Tournament

*with The Fashion & Fitness Fanfare*



Wednesday, May 18th, 2016  
**St. Ives Country Club**  
Johns Creek, Georgia



**Don't miss out!**  
**Register by April 20th!**

*Fashion & Fitness Fanfare*  
activity for  
**Non-Golfers!**



### Golf Tournament

GOGS President : Cathy M. Bonk, MD  
Chair: Jeffrey H. Korotkin, MD

**Registration Fee: \$85 - GOGS Members  
\$110 - Non GOGS Members**

**Registration begins at 10:30a.m.  
Shotgun Start: 01:30p.m.**

**Hors D'oeuvres and beverages  
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03:30p.m. - 4:30p.m.  
This hour-long exercise class will give you an  
all-intensive workout while having loads of fun!

For more information or further details about the 2016 Golf Tournament events, contact Nicole Reaves at (770)-904-5298 and/or [nreaves@gaobgyn.org](mailto:nreaves@gaobgyn.org).



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or mail it to the Society's office.*



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*Ensuring women's care, now and forever*

***We believe that by caring for women, we are also caring for the next generation.*** Thus in an effort to enhance the delivery of health care to women in the state, The Georgia OBGyn Foundation was born. Spearheaded by OBGyn physicians from across the state, The Georgia OBGyn Foundation's mission is to strengthen the health and wellbeing of women by providing collaborative solutions for OBGyn needs.

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Enter "**Georgia OBGyn Foundation**" as the destination.

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