Preterm Birth: The Role of Progesterone in the Treatment of Women At Risk for Preterm Delivery
Haywood L. Brown, MD
F. Bayard Carter Professor and Chair Obstetrics and Gynecology Duke University, Durham, NC

Preterm birth is defined as delivery before 37 completed weeks gestation and is a leading cause of infant mortality in the United States. While the rate of spontaneous preterm birth has decreased over the past decades, there remains a significant disparity in preterm birth rates between black women and white and Hispanic women.

Clearly, the strongest risk factor for recurrent preterm birth is a prior preterm birth, which confers a risk for recurrence of 1.5 to 2.0 fold depending on how early the prior preterm birth occurred. Other factors playing a role in recurrence are a short pregnancy interval of less than 18-24 months, low pre-pregnancy weight, smoking and substance abuse.

Irrespective of risk factors and ethnicity, prophylactic treatment with progesterone has been shown to decrease the risk for subsequent preterm birth in those women with a prior history of a spontaneous preterm birth. Beginning with the study by Meis et al (NEJM 348;2379, 2003) where women with a prior preterm birth from either preterm premature rupture of membranes or preterm labor were prescribed weekly intramuscular injections of 250 mg 17 hydroxyl progesterone (17-OHP) from 16 weeks to 36 weeks and compared to the placebo, the reduction in risk of recurrent preterm birth cannot be refuted. In that landmark study, the risk reduction for recurrent preterm birth was .66 compared to placebo, with only 36.3% of women delivering prior to 37 weeks, and the risk reduction for delivery prior to 32 weeks was .58 or 11.4%. As such, it is considered the standard of care to offer 17-OHP to any woman with a prior idiopathic singleton preterm delivery. The data on multiples and progesterone prophylaxis is less clear because the mechanism for preterm delivery is likely different.

What about those women found to have a short cervix on ultrasound or clinical examination? In 1996, Iams et al (NEJM, 1996) showed that a cervical length below the 10th percentile (<2.6 cm) between the 24th and 28th week had a relative risk for preterm delivery of 6.19:1. As such, a short cervix of fewer than 2.5 cm prior to 24 weeks without a history of a prior cervical surgery is considered a risk factor for preterm delivery. Studies by Hassan et al (Ultras Obstet Gynecol 2011;38:18) showed a risk reduction compared to placebo of .55 for preterm birth prior to 33 weeks with vaginal progesterone, with only 8.9% of women who were found to have a short cervix on ultrasound and no risk factors delivering prior to 33 weeks. For those women with a prior history of preterm birth and a short cervix, the risk reduction was .77 for delivery prior to 33 weeks or 15.8% compared to 20.6% for those receiving the placebo.

Other studies have shown a risk reduction for preterm birth with vaginal progesterone in women with a short cervix found on transvaginal ultrasound and no prior history of preterm birth. The studies have employed varying dosages and formulations of vaginal progesterone. Furthermore, the risk reduction for neonatal morbidity, including respiratory distress syndrome, was significantly better for those women treated with vaginal progesterone with an asymptomatic short cervix in the systematic review and
**Preterm Birth** Continued from page 1

meta-analysis. Finally, in a meta-analysis of three randomized trials published by Berghella in 2011, in women with a spontaneous preterm birth, singleton gestation and a short cervix <2.5 cm, cervical cerclage was associated with a significant reduction of preterm birth before 37, 32, 28 and 24 weeks. Cerclage should be considered an option for treatment of women found to have an asymptomatic cervix shorter than 1.5 cm at <24 weeks. The bottom line for management of women with a prior history of idiopathic preterm birth prior to 37 weeks from either preterm labor or preterm premature rupture of membranes is to offer IM injections of 17 hydroxyprogesterone caproate, 250 mg starting at 16–20 weeks and continuing until 35–36 weeks. This medication was approved by the FDA for this purpose in 2011 and is marketed as Makona. If on cervical screening, a cervical length of 5 cm is found prior to 24 weeks, then vaginal progesterone should be offered. This medication (Crimone) fared less favorably with the FDA and was declined for approval by the FDA in 2012, but will surely be revisited. The drug, however, is available in various forms for use in women at risk for preterm delivery with a short cervix. The value of routine cervical length screening is still controversial. But, as an MFM specialist, I tend to lean toward this option if we are to tackle the obvious racial disparity in preterm birth and infant mortality.

**Meet Our New Face of Communications: Rachel Bevels**

I am a Georgia native from the sprawling suburb of Suwanee. I am the middle child of three and, to my chagrin, the shortest in my family. My childhood was spent reinventing myself every half-year or so. I’ve graced the rosters of nearly every sports league, summer camp, studio, and club. I was involved in karate, ballet, gymnastics, soccer, art, acting, creative writing, sewing, 3 foreign languages, church camp, various philanthropies, honors organizations, science club, violin, clarinet, piano, singing, and, subsequently, the rare triffest: orchestra, chorus, and marching band. My parents are saints for driving me to more places than any kid needed to be going. To reward them for their role as chauffeurs, I then went away to college. An almost nine-hour drive away. I have always enjoyed writing, despite experimenting with many other hobbies, and graduated from the University of Richmond in 2013 with a Bachelor of Arts in English and Journalism and a minor in creative writing. At Richmond, I worked on the university newspaper as Editor-in-chief of the literary magazine, and an American Academy of Poets prize recipient. Since college, I’ve been working in the field of communications for a non-profit doing publications work similar to this - making newsletters, brochures, posters, and flers. I am excited to have joined the team at the Georgia OB/Gyn Society as Marketing and Communications Coordinator and to be supporting such an important mission. Though the world will continue to change around us, our health will always remain a priority. I look forward to learning more about the OB/Gyn field and to hopefully meeting many of you in the future.

**Journal Watch**

**Ovarian Stimulation Protocols & Ectopic Pregnancy**


**National Trends and Outcomes in Embryo Donations**


**Inadequate Evidence for Pelvic Exam Screening**

USPSTF statement; 2016 Jun 28

**Stop using rectal misoprostol for the treatment of postpartum hemorrhage caused by uterine atony**

Robert L. Barbieri, MD

**Updated Practice Recommendations for Contraceptive Use**

MMWR; ePub 2016 Jul 29; Curtis, et al.

**Postpartum Long-Acting Reversible Contraception**

Obstet Gynecol; 2016 Aug; Committee on Obstetric Practice, et al.

**Zika**

Local transmission of Zika has happened in the US. This could act to happen in Georgia, too. All patients (pregnant and non-pregnant) should be:

- screened for possible exposure to Zika
- tested or referred for testing as guided by GA DPH
- educated on Zika and how it could impact their reproductive plans
- given information on Zika prevention, including travel precautions, avoiding mosquito contact, contraception to prevent unintended pregnancy and condoms/substitution to prevent sexual transmission

Beyond pregnant patients to the Health and Human Services Zika Toolkit at http://www.hhs.gov/cfda/ pdfs/zikatoolkit.pdf.

Guidance for pregnant women can be found at http://www.cdc.gov/ mnm/ volumes/65/wm/mnm529e1. html? s_cid=mnm529e1_ e.

**Editor’s Column**

**What A Year!**

As one begins a new experience, it is common to pause and anticipate the pathway(s) of the adventure before moving forward. As ventures are concluded, it is fitting to take a moment to reflect on what took place during the journey. This is the second time in as many years that I’ve had the opportunity to address you as Editor of the GOGS Newsletter, and capture highlights of the previous year. This year has passed so quickly, yet been so eventful. We have witnessed some of the best and worst of times in our practices, cities, state, nation, and the world. When I left the GOGS meeting last year, Trump was the winning hand in a game of bid whist. Clinton was the leading member of the funky soul and rock music group, Parliament-Funkadelic. Today, both Trump and Clinton are United States presidential candidates, and the option of one or the other as the elected head of state makes me sigh. I would much prefer a great game of cards while listening to the Funkadelics!

As I conclude my term as Editor, I remain excited about the capacity for positive change in our nation, although I am disheartened by the current state of human affairs. During this past year, we have witnessed more mass murders, suicides, and homicides than I can recall during my lifetime. Closer to home and my heart, the profession that I love and to which I have given my devotion for decades was negatively labeled and described as being plagued with sexual predators, in both local (AJC.com) and national news. Do I believe everything that I see and hear in the news? No. Do I believe that there is some modicum of truth in most of what is reported? Yes. And, while the origins of this particular newsy piece came back to offer explanations and apologies to those of us in the field (who maintain integrity and professionalism in the practicing of our craft), the misbehavior by physicians was heavily touted. The reputations of worthy colleagues were discolored and tainted. It concerns me greatly that things could become worse before they get better. Nonetheless, I remain focused and positive about our world, and moreover, the small part that we play daily in making it great.

Despite the numerous distractions, members of our Society have continued to work tirelessly to support our mission and the goal of better healthcare for all mothers and babies in our state. The Society’s efforts have led to an increase in Medicaid funding for the second year in a row.

**Continued on page 4**
Editor's Column: What A Year! Continued from page 3

The Global Obstetrical Fee (for obstetricians) has increased by $338.61 per delivery. Additionally, the Society's recent contract with Sterling Risk Advisors and the Doctors Company will reduce Med-Mal costs for all Georgia OB/GYNs.

As the good news goes, Georgia is one of the first states in the nation to implement an immediate post-partum Long-acting Reversible Contraception (LARC) program.

Through the leadership of Drs. Melissa Kottke and Alan Joffe, we have trained and continue to train obstetricians throughout the state on the safe insertion of intrauterine devices and contraceptive implants immediately following delivery, and other related surgeries.

However, the maternal mortality numbers (in Georgia) are still in need of great improvement. To that end, Dr. Michael Lindsey is heading our review committee and working diligently to help us understand how we might improve our outcomes. Dr. Lindsey will share his findings in a clinical session [on Friday, August 26], during the upcoming annual meeting in Sea Island, Georgia. Noteworthy, in similar regards to the recent signing of HB-649 by Governor Deal. This new law (i.e., Georgia Lactation Consultant Practice Act) is a further attempt to improve the state of maternal/fetal health in Georgia.

As physicians, we are responsible for the healthcare and well-being of America's citizenry. As professionals, we are leaders in our neighborhoods, towns, cities, and state. As leaders, we have opportunities every day to make a positive difference that will inform, and foster wholesome living for our patients and their families. We avow to be non-prejudiced and unbiased in our adherence to an oath that requires us to "do no harm." As such, much is required of us in the course of a day, week, month, and certainly a year. That's why the annual meeting can be so important. It provides not only opportunities for professional growth and personal development, but also a chance to kick back, relax, inhale quietly, and enjoy time away from the demanding routines of work. I am looking forward to it!

I understand that not everyone will be able to leave the offices, waiting rooms, emergency rooms, and hospitals to join us at the Cloister, Sea Island this month. Someone must always stay behind to provide ongoing care for the mothers and babies. But, those who can come, should come! Those who cannot be there in person can still "pay their respects" by joining the Society or maintaining membership in the Society for a nominal annual fee of only $200. The global OB fee increase, lobbied for by our Society, should more than cover your GOGS membership dues! And, you'll have enough money left over for a veggie burger and diet coke at your favorite Bar/Grille along the beach. Visit the GOGS website to register online for the 65th Annual Meeting, today.

http://gaobgyn.org/resources/registration/#3...and, I will see you at The Cloister!

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This program is available to your practice free of charge.

The Georgia Chapter of the American Academy of Pediatrics is accredited by the Medical Association of Georgia to offer continuing medical education for physicians. The Georgia Chapter of the American Academy of Pediatrics designates this live activity for a maximum of 3 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity. This continuing medical education activity was approved by the Georgia Nurses Association, as accredited by the American Nurses Credentialing Center’s Commission on Accreditation.

PAA will be attending the upcoming 2016 GOGS Annual Meeting August 25-28

Stop by our booth and learn how your practice can realize significant savings on IUDs and more.

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Physicians’ Alliance of America

Early Language Exposure Is Critical For Brain Development

Georgia’s Talk With Me Baby Initiative

The best predictor of a baby’s future academic achievements is not parental income, or level of education, or ethnicity, but rather the number of words spoken to the baby and the amount of time spent in active engagement from birth to 3 years of age. Just as food nourishes a growing child’s body, language interactions nourish a child’s brain. According to a study by Hart and Risley, both quantity and quality of language are essential for vocabulary development, which is predictive of third grade reading proficiency; children who cannot read by the end of third grade are four times more likely to drop out of high school. The Georgia’s Talk With Me Baby (TWMB) Foundation found that two-thirds of Georgia’s children are not achieving third grade reading proficiency.

Georgia’s Talk With Me Baby (TWMB) is dedicated to making sure every child born in Georgia receives essential language nutrition as a strong foundation for cognitive ability, social-emotional competency, school readiness, third grade reading proficiency and high school graduation, and ultimately lifelong success. TWMB is aggressively implementing capacity-building strategies in early childhood by training staff in health care settings, public health and NICU clinics, and early learning centers. TWMB uses everyday environments in which families, infants, and young children interact with health care and early childhood education systems.

Research from Pacific Lutheran University suggests that sensory and brain mechanisms for hearing are developed at 30 weeks of gestational age, and babies' brains are already absorbing information before birth. TWMB encourages OB/GYNs to discuss with their patients the importance of early exposure to language for babies. For materials for your practice and additional information, contact Kimberly.Ross@dph.ga.gov, or visit https://dph.georgia.gov/talkwithmebaby or http://www. talkwithmebaby.org/contact.

TWMB is guided collectively by a team of leaders from the Georgia Department of Public Health and Department of Education, Emory University’s School of Nursing and Department of Pediatrics, the Marcus Autism Center at Children's Healthcare of Atlanta, the Atlanta Speech School’s Rollins Center for Language and Literacy, and Get Georgia Reading—Georgia’s Campaign for Grade Level Reading.
2016 GOGS Golf Tournament

On a sunny day May 18 at St. Ives Country Club in Johns Creek, doctors gathered for lunch and a great day of golf. Dr. Kelly Manahan was this year’s speaker and gave a presentation on screening recommendations for the gynecologist. Afterward, golfers hit the course and others attended our first-ever fashion show and exercise class. It was so fun we plan to do it again next year, May 18, at Bear’s Best in Suwanee.

This year’s tournament was held in memory of our colleague Dr. Burk.

In Memoriam

The golf tournament is dedicated in fond memory of

Dr. Billy Don Burk

GOGS President (1992-1993)
Avid golf player
Beloved father, friend and colleague

Dr. Caryln Bonk,
GOGS 2015-2016 President.

Dr. Sylvester McRae
and Edwin Bello.

Dr. Jeffrey Korotkin,
GOGS Golf Tournament Chairman.

Dr. Margaret Schaufler
and son Gray Schaufler enjoy lunch.

Luncheon speaker, Dr. Kelly Monahan,
Gynecologic Oncologist at Cancer Treatment Centers of America (CTCA).

Teams eagerly await the shot-gun start.

Heading to the first tee!

The winners' board.

Drs. Eric Silver, Thomas Sharon, and Brett Sadlecek won 2nd net score.

The team of Dr. Eric Silver, Dr. Thomas Sharon, and Brett Sadlecek won 2nd net score.

Paul Sullivan, Joe Thomas, Shawn Smith, and Brad Troha won 1st net.

In Memoriam

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Beloved father, friend and colleague

1930-2016

Dr. Kelly Manahan, Dr. Mike Scott, Elizabeth Shreiner and Kurt Shreiner.

Drs. Jeff Korotkin, Richard Robbins, and Joel Engel.

Drs. Mike Mojcik, Gary Walker, and Bill Haberstroh; and David Crane.

Dr. Joel Todino, Wade Monk, Dan Sweitzer and Jeff Thompson, all from Floyd Medical Center, played to honor Dr. Burk.

J. Jill presented “Dress 101 for the On-the-Go Doc” to non-golfers.

Mike Smith; Drs. John Lue, Phillip Hudley, and Al Scott.

Drs. Dawn Mandeville, Stephen Ayres, and James Harper; and Wade McKenzie.

Dr. John Moore, Dr. Mike Scott, Elizabeth Shreiner and Kurt Shreiner.

Drs. Dale Beuesman, Richard Robbins, and Jeff Korotkin; and Darren Leber.

Drs. Leroy Moyer, John Song, and Joel Engel.

Drs. Sylvester McRae and Edwin Bello.

Dr. Jeffrey Korotkin, GOGS Golf Tournament Chairman.
Breastfeeding is one of the most effective preventive measures to protecting the health of a baby. According to the 2012 National Immunization Survey, 73.7% of Georgia moms initiated breastfeeding but only 18.9% of infants were exclusively breastfed for six months or longer.

About 1 in 3 moms reported that they stopped breastfeeding because they thought they were not producing enough milk, that their milk dried up, or that breast milk alone did not satisfy her baby.

The American Academy of Pediatrics (AAP) recommends exclusive breastfeeding for six months, followed by continued breastfeeding as complementary foods are introduced, with continuation of breastfeeding for one year or longer as mutually desired by mom and baby.

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How Can Georgia PRAMS Help Providers?

The Georgia Pregnancy Risk Assessment Monitoring System (PRAMS) is a Georgia Department of Public Health surveillance project funded by the Centers for Disease Control and Prevention. PRAMS collects state-specific population-based data on maternal knowledge, attitudes, behaviors, and experiences before, during, and shortly after pregnancy. Each month, a random sample of 100-200 mothers is drawn from Georgia birth records. Mothers are contacted by mail or telephone (for non-responders) within two to six months after delivery.

As a provider, you can use PRAMS data to determine who is at highest risk of never breastfeeding their infant, who would benefit most from targeted guidance (e.g., non-Hispanic Black moms, moms under 20 years of age, and moms with no college degree), and reasons for early breastfeeding cessation. Given that August is Breastfeeding Awareness Month, we have provided information on breastfeeding initiation (ever breastfeeding her infant) and duration (mothers with infant six months of age who were still breastfeeding at survey completion) as well as helpful resources.

How Can Health Care Providers Help?

- Educate mothers on the benefits of breastfeeding:
  - Helps mothers contract more quickly after delivery
  - Helps mother lose pregnancy weight and maintain desired weight
  - Reduces risk of developing premenopausal breast, ovarian, and endometrial cancer
  - Take steps to promote, protect, and support breastfeeding in your practice by implementing the Georgia 5 STAR ten steps!

- Submit a written breastfeeding policy
- Train all health care staff in skills to support successful breastfeeding
- Inform/Educate all pregnant women about benefits/management of breastfeeding
- Skin-to-skin immediately after birth for one hour or until the first breastfeeding is completed
- Show mothers how to breastfeed and how to maintain lactation if they are separated from the infant(s)
- No supplemental formula unless medically indicated
- Practice rooming-in
- Breastfeeding on demand; educating mothers regarding cue-based feeding
- No artificial nipples/pacifiers

Breastfeeding Initiation and Duration

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Breastfeeding Initiation</th>
<th>Breastfeeding Duration</th>
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<tbody>
<tr>
<td>NH White</td>
<td>32.7</td>
<td>75.3</td>
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<tr>
<td>NH Black</td>
<td>21.6</td>
<td>77.5</td>
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<tr>
<td>Hispanic</td>
<td>56.8</td>
<td>84.7</td>
</tr>
<tr>
<td>NH Other</td>
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</tr>
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<tr>
<td>&lt;20</td>
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<td>68.0</td>
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<tr>
<td>20-29</td>
<td>29.6</td>
<td>82.1</td>
</tr>
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<tr>
<td>No College</td>
<td>27.1</td>
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</tr>
<tr>
<td>College Graduate</td>
<td>68.0</td>
<td>84.7</td>
</tr>
</tbody>
</table>

*Percent of mothers whose infant was at least 6 months at survey completion and were still breastfeeding.

Active support from health care providers can increase the proportion of mothers who want AND continue to breastfeed!

DCH to extend existing Medicaid CMO services through June 30, 2017

The Georgia Department of Community Health will exercise the second of two six-month extension options for Medicaid Care Management Organization (CMO) services with Wellcare of Georgia, Amerigroup Community Care and Peach State Health Plan for the period January 1, 2017 through June 30, 2017. In 2015, the Department of Administrative Services (DOAS) posted a request for proposals (RFP) for new contracts with CMOs for the Georgia families and Georgia Families 360 programs. DOAS issued a notice of intent to award new contracts to Wellcare of Georgia, Amerigroup Community Care and Peach State Health Plan, as well as one new vendor, CareSource. The DOAS decision on the winning bidders for the new CMO contracts was appealed. For information regarding the appeals process, please contact Donna Harris, DOAS State Purchasing Division at donna.harris@dph.ga.gov.

News from Around the State

Components of the CATAPULT model include: (1) Committing to participating; (2) Assessing work practice or system; (3) Training or being trained; (4) Activating; (5) Creating a plan of action; (6) Promoting understanding; (7) Leveraging data systems; and (8) Testing and implementing. Read about the launch here: https://dph.georgia.gov/blog/2016-03-02/dph-launching-new-catapult-model-diagnose-condition-care-chronic-conditions.

Rural Coding Boot Camp

West Rome Baptist Church in Rome, GA, September 22-23, 2016. See a detailed overview of the AMA’s 2016 CPT Professional Edition from the perspective of community health, how CPT codes are naturally aligned with services typically provided by FQHCs and look-alikes. Understand the difference between clinical documentation, professional coding, and medical billing. Learn about the guidelines that appear before and after key coding sections that are generally accessible to providers and coders/billers in their EHRs and encoder software. Review the CPT, including guidelines, appendices, and modifiers with focus on level of visits and preventive services. *Approved for 11 Continuing Education Units by the AAPC and ARHPC Register at https://ruralhealthcoding. site-ym.com/page/BootcampInfo.

Neonatal Abstinence Syndrome Reporting

You may recall that effective Jan. 1, 2016, Neonatal Abstinence Syndrome (NAS) was added to the list of conditions that are reportable by law to the Georgia Department of Public Health. GA DPH appreciates not only your adherence to this new reporting requirement, but also your questions and feedback regarding this added condition. NAS is a condition that results from the abrupt discontinuation of chronic fetal exposure to substances that were used or abused by the mother during pregnancy. Having NAS means that notifiable conditions provides the opportunity to: 1. Access the incidence of NAS in Georgia and trends over time 2. Identify opportunities for timely intervention and education 3. Better characterize risk factors for NAS in Georgia 4. Assess capacity to address maternal addictions and provide multidisciplinary care for the child/family affected by substance abuse Based on your feedback, DPH has clarified the reporting process and updated its reporting database to improve data quality. The criteria for reporting NAS has been simplified to include at least one of the following: a newborn with withdrawal symptoms and/or a newborn with a positive drug screen. Reports should be submitted within seven days of identification. Cases can be reported electronically through the web-based State Electronic Notifiable Disease Surveillance System (SENDSS) at sendss.state.ga.us/. As with all notifiable disease data reported to the DOH, reporting NAS remains confidential in accordance with Georgia law, Code Sections 31-12-2 and 31-5-5. Frequently asked questions (FAQ) related to NAS can be found at: dph.georgia.gov/NAS.

DPH Health Systems Symposium

Georgia Department of Public Health is excited to announce that its 2016 Health Systems Symposium will be August 18-19 in Stone Mountain. The two-day event, to be held at the Atlanta Evergreen Marriott Conference Resort – located at 4021 Lakeview Drive - is designed to provide attendees with a full day of quality improvement action training, as well as mini breakout sessions and workshops on health system change topics such as: role of pharmacists in systems change, community health workers, emerging trends, and Georgia success stories. Registration information is available on a first come, first served basis and can be accessed at https://dph.georgia.gov/webform/health-systems-conference-2016. Questions? Email shana.scott@dph.ga.gov.

Pelvic Exam Evidence Rule Insufficient

A July 2016 statement from the US Preventive Services Task Force (USPSTF) indicated that there is insufficient evidence for pelvic exam screening in asymptomatic, non-pregnant adult women. 18 years of age and older, because there are not at increased risk for specific gynecologic conditions. The draft recommendation says: • The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic, non-pregnant adult women. • The statement does not apply to pelvic examinations performed for the purpose of screening for gynecologic disorders, for which the USPSTF had already issued a recommendation.

Pre-op Documentation Coding

Steve Adams of InHealth Professional Services outlined on his website key features that need to be present in every pre-operative medical evaluation: • Reference to the request for a preoperative medical evaluation • The specific medical condition you were asked to address during the preoperative evaluation (e.g. from a cardiovascular or respiratory standpoint); and • Proof that you have returned your opinion and advice to the requesting provider All claims must be accompanied by the appropriate ICD-10 code for preoperative examination (i.e., Z01.810 – Z01.818). Additionally, you must document on the claim the appropriate ICD-10 code for the condition that prompted surgery. If there are other diagnoses and conditions affecting the patient, you should also document those on the claim. To learn more about preventive coding recommendations, visit www.thecodingeducator.com.

Georgia DPH takes on prediabetes and diabetes

Diabetes is a leading cause of death in Georgia. With healthcare costs and treatment, the development of more severe complications from diabetes can be avoided. DPH’s Diabetes Prevention Program (DPP) and Diabetes Self-Management Education Program (DSME) aim to lower the number of diabetes-related deaths through increased awareness of factors that lead to the disease and its side effects. The DPP is run by the CDC and is focused on preventing type 2 diabetes through lifestyle changes, such as eating healthier and exercising regularly. The DSME is for people who have been diagnosed with type 2 diabetes and want to better control their glucose levels through knowledge, skills, and lifestyle changes. To learn more about the programs or becoming accredited, email alliance.smith@dph.ga.gov or call 404-657-6636.

DPH unveils mini-grants Building Capacity to Address Infant Mortality for GA

From DPH: “This mini-grant supports capacity and coalition-building activities among organizations in the six perinatal regions in Georgia. The mini-grants/collaboratives focused on infant mortality will help to bring heightened awareness, increase access to resources, enhance legitimacy on the urgency surrounding the need to improve infant mortality, and improve working relationships in the community they serve.” Applicants to the program are eligible to receive $10,000 to assist coalition building in their perinatal region. The $10,000 must be used to develop partnerships with a diverse group of community stakeholders (with more than 50% minority membership) to develop a realistic, measurable plan of action to address infant mortality in their community, and to implement that plan. Recipients must also participate in monthly conference calls with the DPH. The six successful applicants will be diverse and will represent: • A mission to reduce infant mortality • Diverse organizational classifications • A variety of geographic areas, including rural and medically underserved regions • Services to culturally diverse populations Email Renee Johnson, Perinatal Health Project Director at Renee.johnson@dph.ga.gov for an application.

P Gulf News from Around the State

New Department of Public Health program, CATAPULT

CATAPULT is aimed at creating a standardized and systematic approach to the diagnosis and quality of care for hypertension, diabetes, and other chronic conditions across the state.

Annual Immune Georgia Conference

“Bringing the science of immunize into practice” is this year’s theme for the 6th Immune Georgia Conference scheduled for Friday, September 9 at the Stone Mountain Peachtree Hotel and Conference Center. Learn the latest recommendations and best practices in immunization communication service for travelers, expectant mothers, and children. To register, visit: http://www. immunizegeorgia.com/register. For additional information, contact 404-367-2766 or immunizegeorgia@golin.com.

Annual Georgia Perinatal Association Conference

The Annual Conference will be September 21-23, 2016 at the King & Prince Golf & Beach Resort in St. Simons Island, GA. Don’t wait; register today for the GPA conference. Register online at https://georgiaperinatal.org/upcoming-events/annual-conference/.

An annual event for Friday, September 23rd and September 24th at the Georgia DPH building in Atlanta. From DPH: "This mini-grant supports capacity and coalition-building activities among organizations in the six perinatal regions in Georgia. The mini-grants/collaboratives focused on infant mortality will help to bring heightened awareness, increase access to resources, enhance legitimacy on the urgency surrounding the need to improve infant mortality, and improve working relationships in the community they serve.” Applicants to the program are eligible to receive $10,000 to assist coalition building in their perinatal region. The $10,000 must be used to develop partnerships with a diverse group of community stakeholders (with more than 50% minority membership) to develop a realistic, measurable plan of action to address infant mortality in their community, and to implement that plan. Recipients must also participate in monthly conference calls with the DPH. The six successful applicants will be diverse and will represent: • A mission to reduce infant mortality • Diverse organizational classifications • A variety of geographic areas, including rural and medically underserved regions • Services to culturally diverse populations Email Renee Johnson, Perinatal Health Project Director at Renee.johnson@dph.ga.gov for an application.
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