GA Legislation Gives OBGyns First Medicaid Increase in 14 Years

Anne Patterson, GOGS President, Atlanta

At the same time as Emanuel Medical Center in Swainsboro, GA announced closure of its labor and delivery unit for June 2015, the Georgia Legislature budgeted the first Medicaid increase for obstetrical care in 14 years. Fees for six commonly used obstetrical codes are approved for increase in 2015.

Closure of the Swainsboro OB unit will make the 32nd labor and delivery unit closure in Georgia. Most are in rural Georgia, leaving large geographic areas of the state without access to obstetrical care. With 60% of deliveries covered by Medicaid, both OBGyns and hospital OB units are having difficulty making ends meet, leading to increased closures throughout the state.

Having been warned for a number of years that not only were maternal health statistics worsening, but access to OB care was declining, the Georgia Legislature has finally taken heed. In addition to the Medicaid increase, which hopefully will be one of several over the next few years, the Senate has proposed a women’s health study committee. The committee will meet between now and the 2016 session to review a number of components that are leading to diminishing care for women in Georgia. This includes low Medicaid reimbursement, concerning maternal and infant mortality rates, high repeat teen pregnancy, inadequate numbers and funding of OBGyn residency education slots and intimidating political climate and other factors. The Society will support the committee by identifying experts to speak on various topics and to educate the committee. Hopefully, this will lead to improved health policy making and renew focus on the important issues needing to be addressed in women’s health.

While the Legislature has approved additional fees for obstetrical care, Governor Deal must still approve the budget and the CMOs must process the new reimbursement levels; so, it may be a while before physicians will see the increase implemented.

<table>
<thead>
<tr>
<th>Procedure Code w/ description</th>
<th>Possible Approx. Fee Increase Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400 - Obstetrical Care</td>
<td>$330</td>
</tr>
<tr>
<td>59425 - Antepartum Care only</td>
<td>$180</td>
</tr>
<tr>
<td>59426 - Antepartum Care Only</td>
<td>$350</td>
</tr>
<tr>
<td>59510 - Cesarean Delivery</td>
<td>$220</td>
</tr>
<tr>
<td>59610 - VBAC Delivery</td>
<td>$360</td>
</tr>
<tr>
<td>59618 - Attempted VBAC Delivery</td>
<td>$260</td>
</tr>
</tbody>
</table>

Codes Targeted for Medicaid increase:

After many trips to the Capitol by Society members, testimony before various committees, and distributing pages of facts, figures and maps documenting the decline of OBGyn care, the Georgia Legislature approved a Medicaid fee increase for OB care.
An Obstetrician's Greatest Fear

For me, the single most unnerving aspect of practicing medicine is the possibility of being sued. While I have learned how to best manage myself during the process, I still cringe when I think of medical liability. Although I have been counseled repeatedly not to do so, I absolutely take it personally. It is a horrific event that you often never see coming. And, the last person that you might pounded, my chest tightened, and sweat started moistening my hair and brow. Based on the origination of each letter, I anticipated no good news.

Holding my breath, I ripped open the first letter. It was a letter requesting records from a patient who had been in an automobile accident. I opened it one down, two to go. The malpractice carrier’s letter included the annual delivery of my Certificate of Insurance forms. Excellent! The final letter from the IRS was requesting additional information from a previous year’s tax return. I exhaled. I sat down, shaken and relieved, when I had dodged three bullets. My sense of dread lifted, and I reflected on my physical reaction to “what might have been.”

What if it had been notification of another lawsuit? What if my malpractice premium had escalated, or even worse, been canceled? How would I manage my personal and professional life when my response to the mere possibility of such had just sent me into a tailspin? My heart rate decelerated, and I paused a few minutes to reflect on the past three decades of my medical career. I had faced past incidents (much like today’s) that had resulted in my personal involvement with lawsuits. I remembered how the incidents compelled fear to patrol my innermost thoughts and concerns for the practice of medicine, allowing me to return to normal. Then, I recalled the most important thing I remembered that day: the positive, life-changing outcomes experienced by numerous families because of my decision to continue in medicine. I reconfirmed (to myself) that I am very good at what I do! And, then I let the rivers wash away the tears, and I focused on that day spent with a total sense of rapture, as I fully embraced the fact that I make a difference in people’s lives.

While the larger malpractice claims (10% or more) of all medicine is practiced safely and effectively, that statistic does little to lessen the prospect of potential litigation for physicians. As practitioners, we have all gotten “the notice” or hints of similar letters. Perhaps others have not received such notices as I have, so I write this column with equal importance. The feeling of impending doom and utter physical pain following the “notice” is life-changing. It instills a fear that never goes away...fear of another notice...fear that lingers, and which can be ignited by the mere sight of what appears to be official notices. Yes, the probability of a malpractice suit is most likely the greatest fear any practicing physician experiences during his professional career. Recognizing the need for professional peer support, most malpractice carrier programs have established programs to support doctors who are going through the litigation process. The emotional impact of a lawsuit on one physician can be lessened by involvement with another physician who has been there and experienced that. One such program is the Doctor2Doctor Peer Support program created by Mag Mutual. Similar programs are established by most insurance carriers, and physicians should check with their individual carriers for information. Regardless of what the attorneys tell you, it is indeed personal!

Training Requirements
- Complete online training module
- Observe a live robotic assisted surgical procedure
- Complete 2 hours of bedside training in a simulated environment
- Complete 3 hours of bedside assistance
- At least one hour of dry lab in inanimate training aids
- Live animal laboratory course
- Robot simulator proficiency

References
4. Al Sermons, MD. OBGYN News. 2015; April 2015

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Source: J Min Inv Gyn. 2014; 21(2)

T he past 20 years have witnessed a large increase in the number of invasive surgery (MIS) to abdominal gynecologic procedures. Abdominal MIS is training approaches to perform myomectomy, hysterectomy, adnexal procedures or reconstructive surgery. Robotic assist surgery in the hands of an experienced surgeon can enhance the patient’s shorter recovery time, less wound infection, less blood loss and better cosmesis. Robotic assisted surgery has gained survival recognition as an innovative alternative to standard “straight stick” laparoscopy. Its advantages include better articulation (wristing) of the instruments, 3-d viewing, elimination of tremor and better control by the surgeon. Potential disadvantages are the learning curve for most anesthesiologists, surgeons, and staff, and the initial outlay of fixed costs to purchase the technology and maintenance contract. Variable costs are incurred with instrument use per case.

The ideal solution to further reduce post-op pain and blood loss when compared to standard laparoscopy. It is particularly useful when the surgical patient is obese, has altered anatomy or has undergone prior abdominal surgery. This technology is required for dissection in the case of advanced endometriosis or cancer. Surgeons who utilize robot technology also cite the ergonomic advantages of sitting instead of standing. Protracted standard laparoscopic procedures often require the surgeon to stand in awkward positions, sometimes leading to back or neck discomfort. The surgeon also sits at the bedside. The procedure I perform primarily is staging for cancer. I am experienced and have many years of practice. I perform robotic myomectomy for years and have not seen any complications. The robot greatly facilitates these procedures in comparison to standard laparoscopic and recovery is impressive. I often discharge patients home the same day. The use of a robot system in 2014 which allows easy access to both the upper and lower abdomen has proven advantageous for single site use. Single site surgery diminishes trocar injury because the surgeon is hoping for a good standing on the medical staff (see above). More importantly, the surgeon must realize the training is a long-term commitment, and AAGL strongly recommends a minimum of 20-25 cases per year to maintain proficiency. It is probably best to have a “buddy” to learn alongside and to begin practicing on the simulator training instrument. The surgeon must also participate in discussions with both the medical staff and the medical staff and practice with robotic technology and maintenance contract. Robot simulator proficiency is an important part of robotic training and is one of the requirements for robotic training and certification.

Continued proficiency is documented by completion of several requirements. These include case observation, privileges to perform the procedures the surgeon performs, and a good standing on the medical staff (see above). More importantly, the surgeon must realize the training is a long-term commitment, and AAGL strongly recommends a minimum of 20-25 cases per year to maintain proficiency. It is probably best to have a “buddy” to learn alongside and to begin practicing on the simulator training instrument. The surgeon must also participate in discussions with both the medical staff and the medical staff and practice with robotic technology and maintenance contract. Robot simulator proficiency is an important part of robotic training and is one of the requirements for robotic training and certification.

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Legislative Day at the Capitol Highlights

Thank you to all the OBGyn physicians who attended Legislative Day at the Capitol on March 5, 2015. Many Georgia representatives attended the event and it was a tremendous opportunity to advocate for OBGyns and women’s healthcare.

Dr. Nancy Cook talked with Rep. Margaret Kaiser.


Dr. Roland Matthews was ready to talk with legislators at the Capitol.

Drs. Eugene and Mardi Schaufler talked with legislators at the Capitol.

Dr. David Byck brought several residents from Memorial Health UMC in Savannah.


Dr. Ruth Cline talked with Rep. Chuck Williams.

Rep. Matt Dollar discussed women’s health care with Dr. Winifred Soufi.

Leadership of primary care physician groups pose with Governor Nathan Deal (front row center).

Dr. Hugh Smith visited with Reps. Johnnie Caldwell and Harry Geisinger during lunch.

Drs. Carla Roberts and Andy Toledo had lunch with Rep. Sharon Cooper.

SAVE THE DATE

2015 Winter Symposium

The joint Winter Symposium of the Georgia OBGyn Society and the Georgia Chapter American Academy of Pediatrics was held February 21, 2015 at the Atlanta Airport Marriott. Seminar highlights included presentations on the state of maternal and child health in Georgia; LARCs in preventing teen pregnancy; neonatal withdrawal syndrome; HIV/AIDS in women, newborns and children; and HPV vaccine successes and failure.

Dr. Cathy Bank spoke about the GA Perinatal Quality Collaborative.

Dr. Cyril Spaan and Dr. Jane Ellis visit during a break.

Drs. Rana Chakraborty and Martina Badell spoke about HIV/AIDS.

Dr. Atul Khurana presented information on neonatal withdrawal syndrome.

WinSym presenters Dr. David A. Levine and Dr. Melissa Kottke talked about LARCs.

Dr. Dr. Cathy Bank, Dr. Eveline Johnson, Dr. Anne Patterson, Pat Cox, Dr. Robert Wiskind and Rick Ward.

Drs. Rana Chakraborty and Martina Badell spoke about HIV/AIDS.

GOGS President Anne Patterson and GA DPH Commissioner Brenda Fitzgerald answered questions at Winter Symposium.

Dr. Cathy Bank spoke about the GA Perinatal Quality Collaborative.

2015 GOGS Annual Golf Tournament

Wednesday, May 13, 2015

Bear’s Best, Suwanee, GA

String hole and mulligan funds will benefit the new GOGS Foundation.

If you would like to be assigned to a team, or if you have additional questions, contact the Society.

770-904-5293
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tire diagnosis and treatment of human immunodeficiency virus (HIV) reduces associated morbidity and mortality and improves individual survival. In the mother–infant dyad, early detection of maternal HIV infection and treatment with antiretrovirals (ARVs) antenatally significantly reduces vertical transmission.

Recommendations for HIV screening, treatment of pregnant women and prophylaxis to prevent perinatal transmission of HIV have evolved in the United States over the last three decades, so the rate of perinatal transmission has dramatically decreased from 25% in 1992 to less than 2% today. Interventions include universal prenatal HIV counseling and testing; antiretroviral chemoprophylaxis antenatally, during labor and delivery, and at discharge; cesarean delivery; and avoidance of breastfeeding and infant feeding with premasticated food. Guidelines addressing these specific interventions are updated annually by the Centers for Disease Control and Prevention (CDC). The CDC estimates approximately 40,000–50,000 new HIV infections occurred annually in the United States. Worryingly, 18% of pregnant women and individuals are unaware of their HIV status. This figure includes <200 women who are infected by mother-to-child transmission.

The Epidemiology of HIV Infection in the U.S. and Georgia

Between the years 2006-2009, the Centers for Disease Control and Prevention (CDC) estimated approximately 40,000–50,000 new HIV infections occurred annually in the United States. 6 Worryingly, 18% of pregnant women and individuals are unaware of their uninfected HIV status. 7 This figure includes <200 women who are infected by mother-to-child transmission.

In 2015, Georgia has one of the highest rates of women and girls with new HIV diagnoses: 55% of new HIV diagnoses in Georgia are among women and girls. A recent study by the Centers for Disease Control and Prevention found that 5% of new HIV diagnoses were among women who were pregnant at the time of diagnosis. This figure suggests that there is a need for increased HIV screening and treatment for pregnant women in Georgia. The Georgia Department of Public Health recommends that all pregnant women undergo HIV testing as part of prenatal care. However, studies have shown that only a small percentage of pregnant women in Georgia are tested for HIV. One study found that only 1% of pregnant women in Georgia were tested for HIV during their pregnancy. Another study found that only 20% of pregnant women in Georgia were tested for HIV during the third trimester of pregnancy.

Routine HIV Screening

The CDC recommends screening all adults aged 13–64 years in health care settings to identify those with undiagnosed HIV infection. In May 2014, the Committee on Gynecologic Practice at the American College of Obstetricians and Gynecologists (ACOG) updated its recommendations on HIV screening. In line with CDC guidelines, the first recommendation the Committee made was for routine HIV screening of females age 13–64 years at least once in their lifetime and annually thereafter based on factors related to risk. The College joined the Institute of Medicine in recommending opt-out screening where the patient is notified that HIV testing will be performed as a routine part of (most often) obstetric care without the requirement for written consent. HIV testing was previously performed using enzyme immunoassay followed by confirmatory Western blot or immunofluorescence testing with results not available for 24–48 hours post-testing. A rapid HIV test is a screening test commonly used in many settings and can be performed as part of a routine prenatal examination for results, ideally within an hour. Rapid tests include those performed outside the U.S. (the rapid test offered by mother-to-child transmission is a significant public health concern in Georgia. As of December 31, 2012, the HIV prevalence rate in the state (508 per 100,000) was almost twice that of the national rate (258 per 100,000 population, year-end, 2010). Among adults aged 18–44 years, Georgia ranked fifth highest in the nation for the total number of new HIV diagnoses. Among all races/ethnicities, African-American/non-Hispanic white women accounted for 55% of new HIV infections and 70% of Stage 3 (AIDS). The prevalence of HIV among a working group of the Office of AIDS Research Advisory Council. These evidences indicate the need for routine HIV screening in female patients for women who are at risk of HIV infection.

Prenatal and Perinatal HIV Testing

In the event of a positive rapid test during labor, ARV prophylaxis should be initiated immediately for ARVs (if possible), parenteral zidovudine, and neonatal prophylaxis with oral zidovudine. A negative rapid test result does not require follow-up by confirmatory Western blot or immunofluorescence testing with results not available for 24–48 hours post-testing. A rapid HIV test is a screening test commonly used in many settings and can be performed as part of a routine prenatal examination for results, ideally within an hour. Rapid tests include those performed outside the U.S. (the rapid test offered by mother-to-child transmission is a significant public health concern in Georgia. As of December 31, 2012, the HIV prevalence rate in the state (508 per 100,000) was almost twice that of the national rate (258 per 100,000 population, year-end, 2010). Among adults aged 18–44 years, Georgia ranked fifth highest in the nation for the total number of new HIV diagnoses. Among all races/ethnicities, African-American/non-Hispanic white women accounted for 55% of new HIV infections and 70% of Stage 3 (AIDS). The prevalence of HIV among a working group of the Office of AIDS Research Advisory Council. These evidences indicate the need for routine HIV screening in female patients for women who are at risk of HIV infection.

Prenatal and Perinatal HIV Testing

Routine HIV opt-out screening is recommended for all pregnant women as early as possible during each pregnancy unless they specifically decline. ACOG also recommends regular opt-out HIV testing. All pregnant women are offered rapid HIV testing at labor and delivery in areas with high HIV prevalence, in women known to be at high risk for HIV acquisition, and in women with previously declined testing earlier in pregnancy. Rapid testing is recommended for women in labor with undiagnosed HIV status. 8 An area with high HIV prevalence is a jurisdiction in which HIV screening identifies at least one HIV-infected pregnant woman per 1,000 women screened, or a perinatal HIV prevalence is a high prevalence jurisdiction. Pregnant women at high risk for HIV acquisition include those with undocumented HIV status. 9 In addition, the bill states, “If at the time of delivery there is no written evidence that an HIV test or a syphilis test has been performed, the physician or other health care provider in attendance at the delivery shall order that a sample of the woman’s blood be taken or a rapid oral test for HIV or syphilis be administered at the time of the delivery except in cases where the woman refuses the testing.”

Comment:

This bill is to be welcomed and supported by the medical community in Georgia. It reflects recommendations of ACOG and other national medical organizations, including the Institute of Medicine, and has been the standard of care for most other states in the U.S. and a jurisdiction in which prenatal care for most other states in the U.S. and is a high prevalence jurisdiction. ACOG also recommends regular opt-out HIV testing. ACOG also recommends regular opt-out HIV testing. All pregnant women are offered rapid HIV testing at labor and delivery in areas with high HIV prevalence, in women known to be at high risk for HIV acquisition, and in women with previously declined testing earlier in pregnancy. Rapid testing is recommended for women in labor with undiagnosed HIV status. An area with high HIV prevalence is a jurisdiction in which HIV screening identifies at least one HIV-infected pregnant woman per 1,000 women screened, or a perinatal HIV prevalence is a high prevalence jurisdiction. Pregnant women at high risk for HIV acquisition include those with undocumented HIV status. In addition, the bill states, “If at the time of delivery there is no written evidence that an HIV test or a syphilis test has been performed, the physician or other health care provider in attendance at the delivery shall order that a sample of the woman’s blood be taken or a rapid oral test for HIV or syphilis be administered at the time of the delivery except in cases where the woman refuses the testing.”

References


OBGyn NEWS, April 2015

Third Trimester Testing for HIV and Syphilis in Georgia—Better Late than Never

Rana Chakraborty, MD, PhD, FAAP, Atlanta, GA

University School of Medicine and is a Medical Director at the Pediatric Center at the Grady Infectious Disease Program.
Immediate Postpartum LARC trainings have kicked into high gear in 2015, with training sessions already occurring at Memorial UMC, Columbus Regional, Piedmont, Morehouse School of Medicine, Dekalb Medical, Navicent Medical Center and Georgia Regents University. Dr. Melissa Kottke of Emory and Dr. Alan Joffe of Peach State have conducted the trainings. More trainings are planned for 2015. These trainings are made possible by a grant from Peach State. If you would like to attend an upcoming training or schedule training for your practice or hospital, please contact Kaprice Welsh at kwelsh@gaobgyn.org.

Immediate Postpartum LARC Trainings Ramp Up in 2015

Dr. Kottke teaches immediate postpartum IUD placement at Columbus Regional in Columbus, GA and Navicent Medical Center in Macon in February.

Dr. Alan Joffe of Peach State demonstrates immediate postpartum LARC placement at Dekalb Medical in March.

Hotel Room Rates: Prices range from $199 to $329/night, single or double occupancy. Please register early as the Society has a limited room block. Reserve by calling 1-888-239-1217. Ask for the GA OBGyn 2015 Annual Conference room block. Deadline: Special negotiated room rate is available until Monday, July 23, 2015 or until room block is full.

For additional information on the Annual Meeting, contact the Society office at 770-904-0719.

The Georgia Obstetrical and Gynecological Society’s

64th Annual Meeting

Thursday, August 27 – Sunday, August 30, 2015

Watch for brochure mailing & register soon!

Visit Gaobgyn.org for Additional information

Make your hotel reservations at the Ritz-Carlton soon!

Faculty includes:

Ronald Adams, MD, Kaiser Permanente Medical Center, Ohio
Linda Bradley, MD, Cleveland Clinic, Ohio
Regina M. Benjamin, MD, MBA, Former U.S. Surgeon General, Massachusetts
Paul Dale, MD, Mercer University School of Medicine, Georgia
Michael Duchowny, MD, University of Miami, Florida
Brenda Fitzgerald, MD, Commissioner, GA Dept. of Public Health
Anne Drapkin Lyerly, MD, UNC School of Medicine, North Carolina

For additional information on the Annual Meeting, contact the Society office at 770-904-0719.
Our Journey toward Building Learning Communities with Partners and Across States,” on April 17, 2015 at The Carter Center in Atlanta. The conference will address questions such as does the current healthcare system structure meet the needs of today’s women, are there other ways that women’s health can be facilitated and what are women telling us? This interactive conference will take a closer look at the Centering/Pregnancy® movement to participate in discussions around health policy, patient engagement, Centering® statewide collaborative efforts and more. To register, visit http://www.unitedwayatlanta.org/events/.

NASPAG 29th Annual Clinical & Research Meeting

Health professionals committed to the reproductive needs of children and adolescents

This year’s North American Society for Pediatric and Adolescent Gynecology (NASPAG) is hosting its 29th Annual Clinical & Research Meeting April 16-18, 2015 at the Hyatt Regency Grand Cypress in Orlando, Florida. This meeting is a forum for education, research and communication among health professionals who provide gynecologic care and/or consultation to children and adolescents. To view the meeting program, visit http://c-ymcdn.com/sites/www.naspag.org/resource/resmgr/NASPAG_-_ACRM_2015_-_Agenda_.pdf. For registration information, visit http://naspag.org/civicrm/event_reg/ACMG-Departments/Annual-Meeting.

The Million Hearts Assembly

The Million Hearts Assembly will be held May 12, 2015 from 9 am to 4 pm at the Macon Marriott City Center, 240 Coliseum Dr., Macon, GA 31217. At the conclusion of this program, participants will be able to describe the burden of hypertension; review the key components of Million Hearts® in the clinical and community arena; describe what support is needed from both the public and private sectors; and be challenged to consider what actions will be taken to contribute to preventing heart attacks and strokes. There is no registration fee and funding is provided by the Department of Public Health through the Association of State and Territorial Health Officials Million Hearts Grant. For additional information, contact Bethoney Smith with the Georgia Hospital Association at 770-349-4500 or bsmit@gha.org.

GMGMA 2015 Annual Conference

GMGMA 2015 Annual Conference, April 26-28 at the Grove Park Inn, is entitled “Roaring Into The New Horizons Of Healthcare Management.” The packed agenda features education, networking, and resource tools. Speakers include: Judy Urquhart, Mary Kelly, PhD; Debra Wiggs, FACMPE; Adrienne Baker; and Cameron Cox, III. Attendees can receive up to 11.75 continuing education units for ACPME, and the conference has been approved and meets AAPC guidelines for 8.0 continuing education units. Register for the conference at www.gmgma.com.

GOGS 2015 Annual Golf Tournament

Wednesday, May 13, 2015 is the next Georgia OBGyn Society’s Annual Golf Tournament at Bear’s Best & The Links at Sugarloaf. Line up your team and register soon. View the Golf Tournament Brochure at http://gaobgyn.org/resources/meeting-events/ for details or call the Society office at 770-904-5293.

GOGS Annual Meeting

Monthly hotel reservations soon and register with the Society for the GOGS 2015 Annual Meeting at the Ritz-Carlton, Amelia Island, Thursday, August 27-29, Sunday, August 30, 2015. Hotel reservations can be made by calling 1-888-239-1212. Ask for the GA OBGyn 2015 Annual Conference room block. See the Annual Meeting ad on page 9 for additional information.

National Sexual Health Conference

Registration is now open for the National Sexual Health Conference, which will be held July 13-14, 2015, at the Keystone Resort in Keystone, Colorado. The conference aims to create opportunities to share information, efforts, and best practices around sexual health across the lifespan by bridging the disciplines of education, advocacy, and clinical care, among others. The conference is targeted to individuals across the range of sexual health including those involved in clinical care, education, reproductive health, HIV, STDs, LGBT health care, advocacy, policy development, hepatitis, and sexual rights from birth to death.

Wanted Appointed GA Medicaid Director

The Department of Community Health has tapped a current official to become the state’s new Medicaid chief. Wilan has served as pharmacy director for Georgia Medicaid since August 2011 and she began her new appointment March 16. She replaces Jerry Dubberly, who left the position of Georgia Medicaid director in January to take a job in the private sector. As pharmacy director, Wilan has had daily responsibility of the approximately $2.5 billion Medicaid drug rebate program. As Medicaid chief, Wilan will oversee services for about 1.9 million Georgians in Medicaid and PeachCare, with a state budget of more than $2.5 billion.

April Health Awareness Campaigns

• STD Awareness Month – Statistics show that one in two young people will contract a sexually transmitted disease (STD) by age 25 because of uneducated decisions regarding their sexual health. April marks the annual observance of STD Awareness Month. Health care providers should use the momentum gained during this month-long observance to bring a renewed sense of enthusiasm and focus to their STD awareness and prevention efforts. This year, the CDC’s Division of STD Prevention (DSTD) will promote a theme of “Know the Facts! Get Yourself Tested during STD Awareness Month.” See the Annual Meeting ad on page 9 for additional information.


• Breast Cancer Awareness Month – This awareness campaign supports a raise in the number of cesareans in mothers who do not really need one in two women who will not benefit from this reduction in the number of cesareans. April marks the annual observance of Breast Cancer Awareness Month. Health care providers should use the momentum gained during this month-long observance to bring a renewed sense of enthusiasm and focus to their breast cancer awareness and prevention efforts. This year, the CDC’s Division of STD Prevention (DSTD) will promote a theme of “Know the Facts! Get Yourself Tested during STD Awareness Month.” See the Annual Meeting ad on page 9 for additional information.

• National Infant Mortality Awareness Day – The American Academy of Pediatrics Designates April to be Infant Mortality Awareness Day to highlight the work of organizations who advocate for and work to improve the well-being of the nation’s newborns. This year’s observance focuses on the issue of prematurity.

• National Cesarean Awareness Month – This year’s awareness campaign supports a raise in the number of cesareans in mothers who do not really need one in two women who will not benefit from this reduction in the number of cesareans. April marks the annual observance of National Cesarean Awareness Month. Health care providers should use the momentum gained during this month-long observance to bring a renewed sense of enthusiasm and focus to their cesarean awareness and prevention efforts. This year, the CDC’s Division of STD Prevention (DSTD) will promote a theme of “Know the Facts! Get Yourself Tested during STD Awareness Month.” See the Annual Meeting ad on page 9 for additional information.

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Recruiting Charlotte Wilen

Charlotte Wilen, founder of what is now known as Healthy Mothers, Healthy Babies Coalition of Georgia (MMHB), passed away on March 27, 2015 at the age of 93. Wilen’s work in maternal and infant health had a huge impact on Georgia and began in the late 1960s when, as a member of the Jewish Women International, she collaborated with a consortium of other women’s organizations, to address issues associated with inadequate or absent prenatal care.

With Wilen at the helm, and backed by the sound counsel of Dr. Dan Thompson and the late Dr. Newton Long of Emory/Grady, the consortium established “Better Infant Births,” which then led to the legislatively created Maternal and Infant Health Council, an advisory committee to the Governor. While on the Council, consensus emerged that Georgia needed a private, non-partisan, non-profit organization dedicated to continuing the public-private dialogue on Georgia’s maternal and infant health issues. In 1974, the “Georgia Continuum Alliance for Human Development” was established with Wilen as one of the founding board members. In 1992, Continuum Alliance changed its name to “Healthy Mothers, Healthy Babies Coalition of Georgia,” which has continued to fulfill the original promise of working to improve access to healthcare for Georgia’s women and children.

Highlights of her work with Continuum Alliance include leading the efforts to ensure that no woman in labor could be turned away from a hospital. She also worked with MMHB to create state legislation preventing “drive-through” deliveries. Most recently, Wilen was working with MMHB in its efforts to license lactation consultants, having just sent a letter to Governor Deal days before her passing. She never quite working to improve access to healthcare for Georgia’s women and children!

2015 CPT Coding for OBGyn Practices

Friday, May 1, 2015
Macon Marriott City Center, Macon, GA

Topics Include:
• ICD-10 for OB Services
• OBGyn Coding Updates for 2015
• ICD-10-CM for Genitourinary and Other Primary Care Services
• Social Media’s Impact on a Medical Practice
• Effective Team Work Stategies

The seminar is approved for 4 CEU credits. To register, visit http://gaobgyn.org/resources/meeting-events/ or call the Society office at 770-904-5293.
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