Based on recent reports from both the Centers for Disease Control and Prevention as well as March of Dimes, Georgia unfortunately ranks among the states with the highest maternal and infant mortality and morbidity.

Over the last several years, the state of Georgia has embarked on a number of initiatives to improve our status. These initiatives have included the establishment of a Maternal Mortality Review Committee, educating hospitals throughout the state on the AIM (Alliance for Innovation on Maternal Health) safety bundles, and establishing Levels of Maternal and Neonatal Care designations for Georgia hospitals.

In order to continue to tackle Georgia’s maternal and infant mortality rates, another area we can focus on is obstetric ultrasound. The performance of ultrasound during pregnancy is a routine part of prenatal care. For many patients, a basic obstetric ultrasound, CPT 76805 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester > or = 14 weeks 0 days), is all they will need during their pregnancy. This particular study is within the scope of practice for both general obstetricians, maternal-fetal medicine subspecialists, as well as many radiologists.

Unfortunately, with the growing number of high-risk pregnancies, more and more patients need higher level ultrasound studies throughout their pregnancies. One such study is CPT 76811 (Ultrasound, pregnant uterus, real-time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination). Ultrasound code 76811 is not intended to be the routine scan performed for all pregnancies. Rather, it is intended for a known or suspected fetal anatomic/genetic abnormality (i.e., previous anomalous fetus, abnormal scan this pregnancy, etc.) or increased risk for fetal abnormality (e.g., advanced maternal age, maternal diabetes, fetus at risk due to teratogen exposure, abnormal prenatal screen, etc.). Thus, the performance of CPT 76811 should not be expected in a general obstetrics practice. However, if concerns arise for a high-risk pregnancy, then performance of CPT 76811 should be expected in referral practices with special expertise in the identification of and counseling about fetal anomalies.

The 76811 includes all of the components of the 76805, plus a detailed fetal anatomical survey. The following are fetal and maternal anatomical components for the 76811:

**General:**
- Fetal number
- Fetal presentation
- Fetal cardiac activity (FHR in M-mode)
- Amniotic fluid assessment
- Placental location, appearance, relationship to internal cervical os
- Placental masses
- Placental cord insertion site
- Gestational age and fetal weight assessment
- Maternal anatomy- uterus, adnexa, cervix

**Evaluation of the head, face, neck:**
- Lateral ventricles
- Third and fourth ventricles, if indicated
- Choroid plexus
- Midline falx
- Cavum septum pellucidum
- Corpus callosum, if indicated
- Cerebellum, integrity of lobes, vermis
- Cisterna magna measurement
- Nuchal thickness measurement
- Integrity of cranial vault
- Examination of brain parenchyma, (e.g. for calcifications)
- Orbits, if indicated
- Lens
- Nose
- Upper and lower lip integrity
- Palate
- Tongue, if indicated
- Facial profile and nasal bone measurement
- Ear position, size, if indicated
- Maxilla/mandible
- Evaluation of the neck (e.g. for masses)

Continued on page 9
life has not always been easy for Anjanette Shaw. Anjanette has always had difficulty carrying her pregnancies full-term, women's health issues that needed her attention, and financial hardships. She is ever grateful for the assistance she has received throughout her life from the Southeast Health District (SEHD) through multiple services to aid and support her and her family. The SEHD's mission is to promote and protect the health of people in Southeast Georgia, wherever they live, work, and play, by uniting with individuals, families, and communities to improve and enhance their quality of life. We will be sharing her successful journey with public health in the SEHD.

Anjanette's first introduction to the health department took place with her first immunizations as a young child. From then on, she began to learn how the health department is an invaluable resource to the community. All throughout her life she was provided services by compassionate members of the community.

With each of Anjanette's pregnancies, she was enrolled and followed in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC provided her with nutrition education, provision of vouchers to purchase healthy food options, and healthcare referrals.

Upon birthing her children, Anjanette chose to breastfeed, and WIC also provided her with loaner breast pumps. WIC's Breastfeeding Peer Counselors encouraged and supported Anjanette through some difficulties she faced with breastfeeding.

Anjanette breastfed all her children for various lengths of time. When she was no longer able to breastfeed, WIC provided the specific formula needed and instructed her on how to feed her infant, including how to notice her child's cues that signaled hunger.

One of Shaw's sons was born prematurely at 25 weeks gestation due to preeclampsia. Her daughter was born at 30 weeks gestation. These babies were enrolled in First Care, a public health program that provides home visits by a registered nurse to monitor and assist babies and their families. Shaw's daughter who was born at 30 weeks gestation was also screened through the Early Hearing Detection and Intervention (EHDI) Program. Infants who are born prematurely are at a higher risk of hearing loss. Thankfully, no hearing loss in Shaw's daughter was detected.

Her children who were born prematurely later transitioned to Children 1st. This program assists parents in accessing various services and strives to ensure children are healthy and ready for school entry by the age of five. Due to developmental concerns by the Public Health nurse, the child was also referred and enrolled in Babies Can't Wait (BCW). The BCW program promotes coordination between families, primary care providers, and other team members. A highly skilled team of physical therapists, occupational therapists, speech/language pathologists, special instructors, service coordinators and others work together with children and their families to provide intervention services, trainings, resources, and referrals in the community that meet the families' needs and that benefit the child's development up to age 3.

Anjanette has also been a faithful patient of the women's health clinic. During one of her women's health visits in 2018, Anjanette learned she was pregnant. Her nurse immediately set up appointments with WIC, as well as with an OB-GYN, who would assist Anjanette in having quality, early prenatal care. During this visit, Anjanette found out she was anemic and received information concerning recommendations for prenatal vitamins and folic acid supplements that would ensure a healthier mother and fetus during this pregnancy.

Due to Anjanette's complicated prenatal history, she was referred by her physician to Perinatal Health Partners (PHP) for her last three successful pregnancies. PHP provides high-risk pregnant women and their infants with in-home medical assessments, nursing care coordination and health education that results in the reduction of maternal and infant

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Anjanette Shaw and Her Family

Ware County Health Department Nursing Staff
(From left to right) Gina Burke, Connie Barefield, Dale Parvis, Becky Pittman, Megan Moore, Felicia Ellis, Kaley McBath, Dana James
Anjanette Shaw’s Journey with Public Health (Continued from page 3)

successful pregnancy, she changed to another OB-GYN who would refer her to PHP. Her last baby was born at full term. During her postpartum phase she developed a severe headache, vision changes and epigastric pain. She sought care immediately. Anjanette stated, “I would have just stayed home and ignored the symptoms if my nurse hadn’t taught me what to look for.” Anjanette has relied on Public Health for her health and her children’s health and well-being throughout their lives. Through these programs, she was able to receive the assistance she needed with her high-risk pregnancies, counseling for breastfeeding support, nutritious food for her children, care for her women’s health needs, immunizations for her and her family as well as an immeasurable amount of support and counseling. It is through programs like these offered by Public Health that underserved communities are given the opportunity to receive the assistance that they need and the attention and care they deserve for themselves and their families, which contributes to healthier communities for us all.

Perinatal Health Partners Staff
(from left to right) Becky Mitchell - Perinatal Health Coordinator, Sheila Kennedy and Esmeralda Gomez - Perinatal Health Partner Nurses

morbidity/mortality. When Anjanette became pregnant with her last baby she went to a provider who refused to make a PHP referral. A few weeks later, growing concerned and recognizing that the program and partners played such an essential factor in her prior

CareSource is the only non-profit managed care plan to provide services to Georgia Medicaid PeachCare for Kids® and Planning for Healthy Babies enrollees who receive services through the Georgia Families® program. We bring innovative thinking and services to health partners and members. Find out more about us.

Let’s talk! (855) 202-1058
GAProviderRelations@CareSource.com

Plan to Attend the Georgia OB/GYN Society Legislative Day at the Capitol on March 5, 2020
Meet your state legislators and top government officials and learn how the state government and legislature impacts your practice and OB/GYNs in Georgia: Join us under the Gold Dome!

Who Should Attend
The meeting is open to all obstetricians, gynecologists, residents and medical students. We will be joined at the meeting by our MD and DO colleagues in family medicine, internal medicine, and pediatrics. Opportunities for corporate support also exist. Registration begins January 2020.

For More Information
Visit the Society’s website at www.gaobgyn.org or contact Nicole Reaves at nreaves@gaobgyn.org or call directly at 770-904-5298.

Georgia OB/GYN Society
2925 Premiere Pkwy
Suite 100
Duluth, GA 30097
770-904-0719

March 5, 2020
8:30AM – 2:30PM
The Georgia Freight Depot
and
Georgia State Capitol

THURSDAY

Hosted by Patient-Centered Coalition of GA:
Georgia OB/GYN Society
Georgia Academy of Family Physicians
Georgia Osteopathic Medical Association
Georgia Chapter-American College of Physicians

Save the Date

NEW LOCATION
Maternal and Child Health Section of the state’s Department of Public Health, but the state legislature is looking into the problem.

Concern over the nation’s rising rate of maternal injury and death has prompted The Doctors Company to review closed claims to identify potential sources of patient injury and provide tools for enhancing safety in OB/GYN, known to be a high-risk specialty.

Of 11,299 total claims and suits closed and coded between 2013 and 2017, 490 were obstetric related. Maternal injury accounted for 94 of those cases, or 20 percent of the obstetric claims. The remainder were neonatal injuries. (For more on neonatal injuries, see The Doctors Company’s Clauses for Obstetrics Closed Claims Study.)

Though they make up just less than a quarter of all claims, maternal injury claims were important to study because about 700 women die from complications related to childbirth in the U.S. each year, according to data from the Centers for Disease Control and Prevention.

In Georgia alone, 101 women died from complications related to childbirth in 2017, 490 were obstetric related. Therefore, The Doctors Company focused on postpartum hemorrhage and preeclampsia/ eclampsia because of the high percentage of these claims that resulted in serious injury or death.

Postpartum Hemorrhage

In claims with a final diagnosis of postpartum hemorrhage, injuries included:
- Death: 40 percent
- Organ loss—uterus: 40 percent
- The need for surgery: 27 percent
- Multisystem failure: 13 percent

Since operative deliveries can include vaginal deliveries with the use of forceps or vacuum extraction, as well as cesarean sections, patients may assume that those techniques caused or contributed to the hemorrhage, when in many cases that is not so. So, the allegations in a liability case are not always helpful in understanding what happened.

Therefore, The Doctors Company uses physician reviewers to help us understand the factors that lead to patient injury. In the hemorrhage claims, these experts found that three out of every four claims had a technical performance factor (53 percent) were due to complications and not due to negligence. Only a quarter of the claims with this factor were due to substandard care.

Selection and management of therapy was a factor in 47 percent of maternal injury claims. (More than one factor can lead to an injury.) This often refers to a delay in recognizing a problem and taking the necessary steps to correct it.

The cause of a hemorrhage is not always known, but if there is negligence it is most likely to involve a delay in recognition and intervention. Additional factors contributing to patient injury from hemorrhage include conditions affecting the caregiver, such as distractions, multitasking, and interruptions. Those were a factor in 20 percent of the claims.

Staff issues, such as those involving physician coverage, were a factor in 13 percent of injuries.

Discussion

Accurate blood loss assessment: In some of the hemorrhage cases, patients were observed having continued bleeding after delivery, but the measures taken were not adequate. It was clear that in many cases the nurses and physicians providing care did not recognize the extent of the bleeding soon enough. A contributing factor was that blood was absorbed in blankets and towels so that it was difficult to quantify unless those items were weighed before and after blood absorption. It is only from accurately assessing the blood loss that clinicians can recognize the problem early and intervene in the most effective manner. Routinely weighing blood-absorbent materials is the standard of care, yet many institutions do not follow this practice, and instead wait until clinicians perceive excessive blood loss.

Communication: Timely communication among clinicians is essential for early interventions. Closed-loop communication confirms that both parties share understanding of the situation, which increases the chances of an adequate response to patients’ crises.

Communication between clinicians and patients and their families is also crucial. Some maternal injuries are unavoidable with the best of care, and regardless of the cause, physicians and hospitals should communicate openly with patients who suffer unexpected outcomes. Honesty is important, and that includes explaining the results of internal investigations. Even when the care provided was appropriate, physicians and hospitals must take the time to help patients understand what happened. When negligence has caused patient harm, physicians and healthcare organizations are usually willing to negotiate settlements and provide compensation.

Risk Mitigation Strategies

To prevent maternal injury and death, The Doctors Company recommends that healthcare providers and hospitals consider the following steps:

1. Adopt best practices from the American Congress of Obstetricians and Gynecologists (ACOG) patient safety in labor.
2. Institute proper triage and screening tools so early warning signs are not missed.
3. Create a culture of patient safety.
4. Practice simulation to be ready for unexpected, rare events.

Additionally, a successful program to reduce maternal mortality, first tried in California, could be adopted in other states. The California Maternal Quality Care Collaborative, an organization of more than 200 hospitals, helped to reduce California’s maternal mortality by 55 percent between 2006 and 2013, while the national mortality rate continued to rise. The Collaborative has accomplished this by providing hospitals with access to near-real-time benchmarking data through its online Maternal Data Center. The Center links state birth certificate data with each hospital’s patient discharge data to generate perinatal performance metrics and quality improvement insights.

Maternal morbidity was reduced by 20.8 percent between 2014 and 2016 among the 126 hospitals participating in projects to reduce maternal hemorrhage and preeclampsia.

Initiatives like this should be considered in every state to improve the quality of care to pregnant women. Doing so enhances the chances of safe deliveries, healthy infants, and healthy mothers who retain their ability to provide the care that these families need.

The guidelines suggested here are not rules, do not constitute legal advice, are not designed to produce a successful outcome. The ultimate decision regarding the appropriateness of any treatment must be made by each healthcare provider considering the circumstances of the individual situation and in accordance with the laws of the jurisdiction in which the care is rendered.

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To view this article in full, including case studies, visit: https://obgyn.org/articles/georgia-maternal-mortality-second-highest-in-nation/
Evaluation of the chest:
- Presence of aneuces
- Lungs
- Pleural effusion
- Integrity of both sides of the diaphragm
- Ribs, if indicated

Evaluation of the heart:
- Cardiac location and axis
- Four-chamber view
- Outflow tracts
- Three-vessel view
- Three-vessel trachea view
- Short access high/low magnetic septum and Doppler flow
- Aortic arch
- Ductal arch
- IVC/SVC

Evaluation of the abdomen:
- Integrity of abdominal wall
- Stomach (presence, size, situs)
- Bowel
- Gallbladder
- Liver

Evaluation of the spine:
- Cervical, thoracic, lumbar, sacral spine in transverse and sagittal views
- Integrity of spine and overlying tissue

Evaluation of extremities:
- Number, size, and architecture of upper and lower extremities
- Anatomy and position of hands

Evaluation of genitalia:
- Gender (whether or not parents wish to know sex of child)

Spleen
- Kidneys and renal arteries
- Bladder
- Adrenal glands
- Umbilical cord vessel number
- Umbilical cord abdominal wall insertion site
- Ascites
- Masses

Evaluation of the chest:
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- Anatomy and position of hands

Evaluation of genitalia:
- Gender (whether or not parents wish to know sex of child)

If fetal anomalies are noted on the 76811 ultrasound examination or there are other risk factors for increased risk of fetal cardiac anomalies (e.g., maternal diabetes or maternal history of congenital heart defect, etc.), a fetal echocardiogram may be necessary (CPT code 76825 and 76820).

Certain pregnancies can be affected by intrauterine growth restriction or fetal anemia which may require additional specialized Doppler studies such as UA Dopplers (CPT 76580) or MCA Dopplers (CPT 76821).

It is of the utmost importance that these particular studies are performed by individuals with advanced training in fetal imaging including, but not limited to, completion of a maternal-fetal medicine fellowship, AIUM certification, and other ACOG or SNPM-approved courses. Practices that perform these studies must have both trained sonographers as well as credentialed physicians who can read the ultrasound images. Ultimately, it is the physician who is responsible for the interpretation of the findings.

If a general obstetrician recognizes that a patient is in need of one of the specialized studies noted above, referral to the appropriate subspecialist would be recommended. This will ensure that all of our patients receive the appropriate level of care for their particular situation. Together we can make Georgia a safer place for both mothers and babies.
The postpartum period. Giving pregnant women continuous Medicaid coverage for at least one year postpartum can help improve disruption from prepregnancy to postpartum. This is especially concerning given that one in three pregnancy-related deaths occur in the postpartum period.¹ Giving pregnant women continuous Medicaid coverage for at least one year postpartum can help improve maternal health outcomes.

The Georgia Obstetrical and Gynecological Society, the state membership association for OBGyn physicians with more than 1,000 physician members, is seeking a detail-oriented part-time accountant to oversee the organization’s financial accounting. This is a part-time, hourly position (up to 30 hours a week) with flexible business time hours. The staff of the nonprofit association provides leadership and services to physician members such as newsletter and communication, education and conferences, support of volunteer board of directors and partnership grant activities relating to women’s health. This new team member will become part of a small dedicated staff aimed at activities to improve women’s healthcare in the state. Not suited for accounting business firms and please no phone calls or drop-ins.

Qualifications and Requirements:
- 4 year accounting degree
- 5 years accounting experience
- Advanced experience with Sage accounting software, MS Office programs
- Extensive knowledge of US generally accepted accounting principles
- Some knowledge of HR and payroll
- History of working with government grants desirable
- Attention to detail and deadline oriented
- Excellent organizational, problem solving, project management and communication skills
- Knowledge of non-profit organizations a plus
- Flexibility
- Some travel and overnight for annual meeting each August

Please submit resume and cover letter to nreaves@gaobgyn.org  
No phone calls or drop-ins will be accepted