

# NEWS

## Pennsylvania Section of ACOG District III

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A newsletter published exclusively  
for Pennsylvania OB-GYNs

Chair's Message

# News from the Chair

by Sherry L. Blumenthal, MD, FACOG



We have been very active both on the legislative front and with our action items.

The OBesity Project, Part I, The Problem, is now in a preliminary power point presentation, with the technical assistance of George Neubert, MD. We will be editing

and reformatting it, as well as allowing the contributors of the individual sections to make changes. We hope to present it at the ADM in October, and currently will have the opportunity if another scheduled speaker cancels. We also hope to make it part of the "Roadshow" and apply for the ACOG Recognition Award for a Section Project. Part II, Solutions, is the project for next year. The preliminary presentation was well-received by the District III Advisory Committee at the Interim District Meeting.

The PA Maternal Mortality effort, led by Ann Honebrink, MD, has stalled due to cancellation of their last meeting, but as you know, ACOG is pushing for a national program through the MOMS initiative. Philadelphia has started a consistent data collection process, which shows a rate of 40-70/100,000. We are not sure whether the closure of many delivery rooms in the city is creating a problem of access to care, and whether the increased numbers at the academic centers in Philadelphia are creating some safety issues. There is also the increased risk of complications with the indigent and uninsured population in the city. The numbers are much less in the rest of the state, about 10 per 100,000.

I have been in contact with physicians in District IX who have put together a program for handling legislative stress, i.e., the distress physicians feel both when they are sued and during the litigation process. I am also working with Patrice Weiss, MD, a former member of the PA ACOG Council who now lives in Virginia. She has taken up the cause of the "Second Victim." This issue is separate from handling legislative stress because of the immediate response of the physician to an adverse outcome. She will be doing a presentation at the ACM in May. We are arranging to have her present the topic at our June PA Section meeting and helping her to set-up grand rounds in the state.

During our April PA Section Advisory Council meeting, we had an excellent presentation about "Health Courts"

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**Note:** If you have an important announcement of interest to Pennsylvania ob-gyns, send it to Jan Reisinger at the PA Section of ACOG office.

# Maternal Mortality Review in Philadelphia: A Look Back

by Steve Smith, MD, PA ACOG Secretary



**“Life must be lived forward, but understood backward.”**

**Soron Kierkegaard**

The maternal mortality rate in the United States increased from 8.2 per 100,000 live births in 1990 to 12.7 in 2007, a 55 percent jump. Likely contributors are both enhanced identification and an actual increase in maternal deaths. In response to this troubling trend, ACOG, as part of the Making Obstetrics and Maternity Safer (MOMS) Initiative, urged the CDC to provide funds to states for implementation of maternal mortality reviews. In Philadelphia, the Philadelphia Department of Public Health reinstated a maternal mortality review. Each of the six academic institutions, the only institutions currently providing obstetric services in Philadelphia, is represented. The charge of the committee is to confidentially review every maternal death in the city, to identify causes and ultimately to develop strategies to address the issue.

The rebirth of this committee after a hiatus of almost 40 years roused my curiosity regarding the circumstances leading to the initial maternal mortality reviews in Philadelphia. Briefly, here is that story.

Eighty years ago, the Philadelphia community lamented the city’s maternal mortality rate. At the heart of the matter was a discrepancy between the maternal mortality figures published by the United States Bureau of Census and the Philadelphia Bureau of Vital Statistics. In 1919, the Census Bureau reported 73 maternal deaths per 10,000 live births compared to 63/10,000 for the Philadelphia Bureau. In 1927, the discrepancy remained, 76 vs. 67. A preliminary survey attributed the difference to the “greater accuracy and thoroughness with which the Bureau of the Census searches for and discovers deaths related to pregnancy and the puerperium.” When the discrepancy came to the attention of George P. Muller, President of the Health League of Philadelphia and incoming President of the Philadelphia County Medical Society, he appointed a Committee on Maternal Welfare to conduct an analysis of the maternal deaths. The work of the Committee, published in 1934, is notable not only for the committee’s findings, which provide a picture of the obstetrical care of the time, but also for the rigorous standardized procedure established to investigate each death.

The Committee, consisting of eighteen individuals representing the thirty hospitals providing obstetric services within the city limits, investigated every maternal death between 1931 and 1933 by reviewing the medical record, interviewing the physician or midwife and often interviewing the family. Each death was classified as obstetrical or non-obstetrical. If an obstetrical death was then deemed preventable, responsibility was assigned to the physician, the patient or the midwife and the avoidable factor was determined:

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# Legislative Report

by Lynne Coslett-Charlton, MD, Legislative Committee Chair



With the new administration in the Governor's office, we are happy to see movement in the Legislature of favorable tort reform legislation. HB 495 is a much needed liability reform bill that addresses physician apologies. Health care providers and patients will be able to have open conversation after an unforeseen outcome without

the fear that contents of the conversation could be used against them in a lawsuit. This bill easily passed in the House and we hope to see it come to vote in the Senate shortly.

Another bill headed to the Senate would modify Pennsylvania's joint and several liability law. If either HB 1 or SB 2 is passed, responsible defendants would only have to pay their share as long as a jury finds them less than 60 percent at fault.

We are also hopeful to find passage of legislation that will strengthen the certificate of merit requirements. Obstetricians and Gynecologists would of course, welcome more substantial reform, but can find promise in these small successes and hope in the support of an administration that recognizes our huge medical liability burden in Pennsylvania.

Pennsylvania once again had a strong showing at the National Congressional Leadership Conference held in Washington D.C. February 27 – March 1. Fellows and Junior Fellows met with our Senators and Congressmen urging them to support two important issues.

We asked our Legislators to support HR 452 to repeal the Independent Payment Advisory Board (IPAB). IPAB was created by the Patient Protections and Affordable Care Act passed into law in 2010. IPAB's mission is to recommend Medicare cuts to Congress, starting with physicians.

Our second ask is to support HR 894 that supports creation of state maternal mortality review committees. The Maternal Health Accountability Act would provide grants to States to establish Maternal Mortality Review (MMR) Committees. MMRs examine pregnancy-related and pregnancy-associated deaths in an effort to improve state maternal mortality rates. The bill would also improve data collection and projects to eliminate disparities in maternal health outcomes.

Unfortunately, Pennsylvania falls short in that we do not have a formal process for reviewing maternal deaths, although we are compliant with recommendations for data collection by the implementation of the standardized death certificate. Efforts are under way to reinvigorate MMR in Philadelphia and we hope that this can serve as a model for a formalized state system.

We are also actively following important legislation to protect women's access to care including family planning services, breast feeding in the workplace legislation, and are very hopeful to see HIV opt-out testing signed into law. We greatly appreciate the efforts of our many Senators and Representatives in Pennsylvania who make Women's Health a priority.



PA ACOG Representatives  
Fellows: Sherry Blumenthal, MD, Charles Castle, MD, Lynne Coslett-Charlton, MD  
Jr. Fellows: Donna Brown, MD, Holly Cummings, MD, Aasta Mehta, MD

# NRMP Updates and OBGYN Main Match 2011

by Mark B. Woodland, MS, MD, Education Committee Chair, Associate Dean GME, Drexel University College of Medicine

The NRMP has undergone many changes and new developments over the last year. Perhaps the most dramatic is the revamp of the post match “scramble” process. The NRMP has taken what use to be a frenetic, frantic, and disorganized process and added some structure through rules and regulations to the process, to not only assist unmatched students, but programs as well. It may also be proactive initiative to handle the potential situation of too many medical students for too few GME slots.

The 2011 Match Data published on March 17, 2011 showed that there were 3,637 programs offering 23,421 PGY1 positions (up from 22,809 in 2010, 22,427 in 2009, and 22,240 in 2008). There were 46,893 total applicants of which 24,413 were US seniors. Total “active” applicants this year was 30,589 compared to 30,543 in 2010, 29,888 in 2009, and 28,737 in 2008.

For OBGYN we had another very successful year. There were a total of 1,205 positions offered through the match and 98.9% of them filled in the 1st go around of the match. 74.1% were filled with US Seniors. In the West there were 167 positions in the match with only 4 unfilled spots, in the Central Region there were 277 positions offered and only 7 unfilled spots, in the South there were 356 positions offered and only 2 vacancies after the match, and in the Northeast corridor there were 405 positions offered and 0 unfilled spots.

The number of US senior matched to PGY1 positions in OBGYN has been relatively stable over the last few years as follows: 2011 = 893 (5.7%), 2010 = 915 (6.1%), 2009 = 879 (6.0%), and 2008 = 838 (5.8%).

Matched US Seniors	2011	2010	2009	2008
<b>PGY1 OBG</b>	<b>893 (74.1%)</b>	<b>915 (77.1%)</b>	<b>879 (74.2%)</b>	<b>838 (72.1%)</b>

The number of positions offered through the match has also been relatively stable over the last few years as follows:

Positions Offered	2011	2010	2009	2008
<b>PGY1 OBG</b>	<b>1,205</b>	<b>1,187</b>	<b>1,185</b>	<b>1,163</b>

Next year, the NRMP has made additional changes to the match. Match Day will occur on a Friday instead of a Thursday and the scramble process will be given more time over the week prior to match day. Additionally, more rules have been put in place to help unmatched students. Finally, the NRMP is actively soliciting feedback about making programs decide to be “all in” the match to gain more control and oversight of the process.

# OB/GYN's Offered Help with Office EMR Systems and Meaningful Use Compliance

by John Gallagher, MD, Division V Representative

Many PAACOG fellows have either implemented EMR's in their offices or are considering starting down the EMR path in the near future. This process can often seem intimidating, if not bewildering, to even the most seasoned computer veteran. But now there is both financial and technical help to guide us along the way.

In 2009, Congress passed the HITECH Act to stimulate implementation of Electronic Medical Records in physicians' practices. Included in this act were grants to "meaningful users" of \$44,000 over 5 years to Medicare providers (2011-2016) or \$63,750 over 6 years for Medicaid providers (2011-2021). Physicians can qualify for one or the other program, but not both. In addition, those practices that are not "meaningful users" will have an up to 5% adjustment made to their Medicare reimbursement beginning in 2018.

In order to help practices navigate these complex issues of designing, choosing and implementing functional electronic medical records (EMR), Regional Extension Centers (REC's) were created as non-profit organizations to assist physicians. These programs are funded through 2012, with possible continued funding based on success. They will offer education, technical assistance, guidance, and information on best practices to support and accelerate implementation of EMR's. Initially, this was to be at low cost to physicians, but is now available at no cost to primary care providers, including OB/GYN's. Rates for other specialists are below those offered by commercial entities. The particular focus of the REC's will be on individual and small group practices (fewer than 10 clinicians) which currently have the lowest rate of EMR implementation. Hospital based physicians are not eligible for this program. The one to one services the REC's offer include:

- Access to information, services, support and training to implement technology
- Evaluating certified EMR products offering the best value for the provider
- Training support and effective implementation of the system
- Optimizing clinical and administrative work flows to maximize the benefits of the system
- Sharing best practices for managing health information

These services are available to practices just starting out or those with existing systems wishing to maximize the effectiveness of their system to reach the goal of "meaningful use."

Pennsylvania is served by two REC's, one each based in Pittsburgh and Philadelphia and serving the two halves of the state. They can be contacted at [www.pareacheast.org](http://www.pareacheast.org) and [www.pareachwest.org](http://www.pareachwest.org). Much more information on services and contact information are available at these sites.

In addition to this program, the Centers for Medicare and Medicaid Services (CMS) has a new listserv about the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The listserv will provide timely, authoritative information about the programs, including registration and attestation updates, and details about the payment process. By subscribing to the listserv, CMS will keep you informed of upcoming deadlines and give you answers to questions and concerns that we have gathered from eligible professionals and hospitals in the field. New updates will be circulated on the listserv to keep you informed of any developments, and subscribers will be notified of any new Frequently Asked Questions that are published on the CMS EHR Incentive Programs' website. PA ACOG encourages you to let your colleagues know about the CMS EHR listserv, and to share its messages [Click here](#) to join the listserve and learn more.

The CMS EHR Incentive Programs website features the following resources:

- **Path to Payment**—Learn the necessary steps to receiving payments for the meaningful use of electronic health records.
- **Registration Guides**—Review a user guide of how to register and watch a video webinar that will help you navigate the registration website.
- **Meaningful Use**—Read more about the details of meaningful use and how to meet the requirements.

## Want more information about the EHR Incentive Programs?

Make sure to visit the EHR Incentive Programs website at <http://www.cms.gov/EHRIncentivePrograms> for the latest news and updates on the EHR Incentive Programs.

# PA ACOG Jr. Fellow Update

by Donna Brown, MD and Holly Cummings, MD

The Pennsylvania Junior Fellows have been very busy! In February, the Junior Fellow officers attended the Congressional Leadership Conference in Washington, and lobbied our Congressional representatives in support of the two official issues of the conference. Donna Brown, MD, Pennsylvania Junior Fellow Chair, Holly Cummings, MD, Pennsylvania Junior Fellow Vice Chair, and Aasta Mehta, MD, District III Junior Fellow Chair, all participated and left the conference feeling energized about the work we accomplished. We were also counted among the Junior Fellow contributors to the PAC – Junior Fellows contributed \$4,825 to the PAC during the weekend's events!

On April 23, we participated in the Sandy Sprint, a 5K race in Philadelphia in support of the Sandy Rollman Ovarian Cancer Foundation. Although the weather affected our turnout, we had a great time and raised money in support of ovarian cancer research. Hopefully the weather will be more cooperative next year!

We are also planning a service project in support of relief efforts in Japan. Donna Brown is slated to attend the annual Japan Society of Obstetrics and Gynecology meeting in April as the District III JSOG/ACOG Exchange representative. The meeting has been indefinitely postponed because of the earthquake and tsunami that occurred in March. Our relationship with JSOG is important, and we are eager to help our colleagues in Japan recover from disaster.

Earlier this month, Junior Fellows from District III attended the Annual Clinical Meeting in Washington, DC. Aasta Mehta, District III JF Chair, attended as part of the JFCAC. Nadia Gomez, District III JF Secretary-Treasurer, attended as the District III Burch Endowment Fund recipient. Donna Brown, Pennsylvania Section JF Chair, and Holly Cummings, Pennsylvania Section JF Vice-Chair, both attended as part of the Resident Reporter program. We were joined by the PGY-4 class from Abington and numerous other Junior Fellows from District III. We all had a wonderful time at the ACM and learned a lot.

Finally, we will be conducting our annual resident retention survey this spring, polling all graduating residents in the state to find out where they will be heading next to train or practice.

# Save the Date!

The 3rd Philadelphia  
Prenatal Diagnosis Update  
Conference and Obstetrics/  
Medical Complications of  
Pregnancy Meeting will be  
held June 10-11 at the Hilton  
Philadelphia City Avenue in  
Philadelphia.

Up to *15.25 AMA PRA  
Category 1 Credits<sup>TM</sup>*  
are available.

For more information  
call (215) 627-2229  
or email  
[prenataldiagnosis@gmail.com](mailto:prenataldiagnosis@gmail.com).

## News From the Chair

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by Ambia Harper, Chief Counsel for Common Good. Common Good is a non-profit which advocates for the Health Court concept, since getting caps nationally is too difficult. Ms. Harper has agreed to do a presentation for the Obstetrical Society of Philadelphia. She might also agree to be part of the "Roadshow."

With the attack on Planned Parenthood and Title X funding, I am investigating ways to support insurance companies offering contraceptive coverage to all women. In this political climate, a mandate requiring insurance companies in Pennsylvania to offer coverage at no additional cost may be doomed to failure. There is a possibility that The Affordable Care Act might act upon this nation-wide. Pennsylvania is very conservative in terms of women's reproductive rights; therefore, this issue is especially important in our state. A bill was just introduced in the PA Senate (SB 427) requiring coverage of contraceptive pills and devices that are FDA approved, if the insurance plan covers other FDA approved pills and devices. It is an excellent bill but will have many hurdles to overcome.

We now have a new Republican Governor, Tom Corbett, and new representatives and state senators. There is a Republican Majority in both houses. Governor Corbett has promised liability reform. So far we have successful "I'm Sorry" legislation to prevent an apology to the patient from being admitted as evidence in any legal action by the patient. Legislation on "Joint and Several," which is supported by vast segments of the business community, should be enacted soon.

The "HIV Opt-Out" Bill was re-introduced (it had support last session; however, never reached a vote). It just got through the Health and Budget Committee. We are working with an HIV action group (AAHIV) to help enact this as soon as possible. It has a good chance of passage now that the members of the legislature are more educated about the benefits of screening for mothers and neonates.

There have been several bills introduced in the PA Legislature, in the wake of the Gosnell scandal, regarding regulation of abortion clinics in the Commonwealth. The Department of Health was remiss in taking no action for years. We are examining the bills to see whether they add to the existing regulation to improve it, or whether the regulations in existence are sufficient if enforced. There is also the issue of whether there is a political agenda to make access to abortion harder, as has been the case in so many other states. (i.e. Virginia and South Dakota). It is important to keep in mind the ACOG position on abortion which states that all women should have equal

access to reproductive services and access to legal abortion.

We had a six person Delegation from Pennsylvania at the CLC in Washington, D.C. last month. We spoke with representatives of both Senators, and at least 10 members of the House of Representatives, specifically about the national agenda for the MOMS initiative and the repeal of the Independent Payment Advisory Board. The latter repeal seems to have bipartisan support among our congressional representatives.

We have also participated in taking action in the controversy caused by the FDA approval of Makena (17OH Progesterone) for lowering the risk of preterm birth in gravidas with a previous history of preterm delivery. The cost of the drug, \$1,500 per dose, could limit access to it for the highest risk women, and cause insurance rates to rise for those who have coverage. The current compounded dose runs about \$10-20 per dose, has no unexpected side effects, and seems to perform according to expectations. In response to the outcry by ACOG, SMFM, and the AMA, there has been a statement by the FDA that since compounded 17OHP is not equivalent to Makena (which contains preservatives), the compounded formula can be used. The manufacturer was also pressured to reduce the cost. In response, KV Pharmaceuticals has lowered their price, but the controversy continues.

## Maternal Mortality Review

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- a) lack of prenatal care
- b) negligence of patient or her friends
- c) induction of abortion
- d) error in judgment
- e) error in technic

So established the investigative procedure that would characterize maternal mortality review in the city for the next 40 years.

In the early 1930's, Philadelphia was home to five Class "A" medical schools and an Obstetrical Society that claimed some of the specialties most prominent names within its membership. The majority of mothers gave birth in a hospital, a dramatic change compared to just 10 years before (70% in 1933 compared to 30% in 1921). Yet the committee's findings indicate a rather primitive practice of obstetrics, certainly comparable to the rest of the country, but below the standards of western European countries where the maternal mortality rate was about 3.5 to 4.5 per 1000. From 1931 to 1933, the maternal mortality rate in Philadelphia was 7.09 per 1000 total births (717/99,579). One woman died in every 141 births. The primary obstetric causes of death were septic abortion (25.3%), puerperal sepsis (18.6%), albuminuria and eclampsia (13.3%), accidents of labor (12.4%) and hemorrhage (9.7%). Fifty-seven percent of the deaths were judged preventable with the physician responsible in 57 percent due to either an error in judgment or error in "technic" and the patient responsible in the remaining cases primarily because of "lack of cooperation."

The committee defined the problems as fourfold: 1) self-induced and criminal abortions; 2) errors of judgment on the part of the medical profession; 3) lack of appreciation of the need of prenatal care by the laity; and 4) failure of hospitals, organized medicine and allied agencies to grasp fully their responsibilities and opportunities. With the findings in hand, the committee emphasized to the physicians of Philadelphia that, not only was it their responsibility to raise their own standards of obstetric practice, but that it was their responsibility to educate the lay public about the dangers of induced abortion and the necessity of adequate maternity care. Specific recommendations and obligations were assigned to the groups, agencies and institutions responsible for maternal care. The Obstetric Society of Philadelphia was charged with the responsibility for the annual review of puerperal morbidity and mortality in each hospital. The society also established a speakers' bureau in order to provide education to both the medical profession and lay

public. Through these efforts, a 30% reduction in maternal mortality was noted over the next year.

The committee's final recommendation was the continuance of the survey. Through a grant of \$200 made by the County Medical Society, "a voluntary survey of hospital puerperal deaths" continued. The committee included a representative from each of the hospitals providing obstetric care and followed the same standardized approach to case review. This was the birth of the monthly maternal mortality review meeting, which would continue for the next 40 years.

Thanks to Owen Montgomery for his input.

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