

THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

ACCOG

TODAY

APRIL 2011



PREVENTIVE CARE

ESSENTIAL ASSESSMENTS
FOR WOMEN AT EVERY
STAGE OF LIFE

Ensuring the best patient care

We continue our broad effort to support our Fellows and advance our specialty through a variety of programs and initiatives. During our successful Congressional Leadership Conference (CLC) in early March, attendees made a record number of congressional visits, disseminating information about why we must repeal the Independent Payment Advisory Board, and promoting a bill to encourage states to establish Maternal Mortality Review Committees. We held a joint panel session with the president of the American College of Nurse Midwives, Holly Powell Kennedy, CNM, PhD. Our discussion focused on successful collaborative practice. Read more on page five.

This year marks the 25th anniversary of our Voluntary Review of Quality of Care Program (VRQC). This program is ACOG's hidden gem, and an example of how we are working to improve patient safety across the country. Years ago, I became involved in this important program and served as team leader. Read *ACOG Today's* interview with Program Director John S. Wachtel, MD, on page eight to learn how the VRQC is a valuable resource for your hospital's ob-gyn department.



Richard N. Waldman, MD,
President

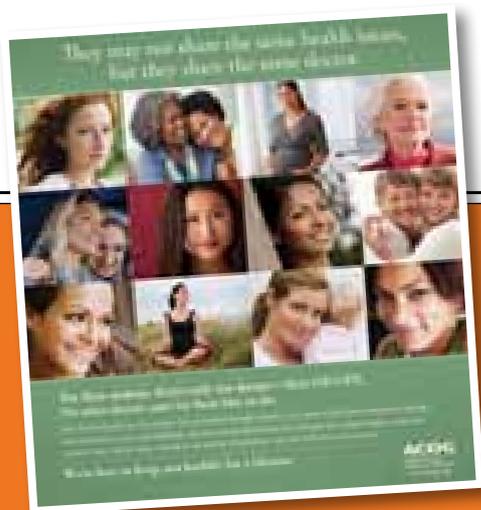
Among recent practice updates is our April Committee Opinion on primary and preventive care, a reminder to all of us that often the only doctor a woman sees is her ob-gyn, so we must take care of all aspects of her health. Read a summary on page six.

Another Committee Opinion from our Committee on Patient Safety and Quality explains how to prepare for emergencies and be effective in emergency response.

This document is described on page 10.

I look forward to seeing Fellows from across the nation at the ACM in Washington, DC, April 30–May 4. Don't miss the President's Program on Monday morning featuring Francis S. Collins, MD, PhD, director of the National Institutes of Health, covering the future directions of genomics, Roberto J. Romero, MD, discussing causes of preterm labor and cerebral palsy, and David A. Grimes, MD, exposing the horrific magnitude of misogyny as a major public health issue around the world.

Plan to attend the welcome reception on Sunday to reconnect with colleagues and friends, and join us on Tuesday for the president's dinner party, a festive event where we will honor retiring Executive Vice President Ralph W. Hale, MD, and his wife, Jane.



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Lifetime of care. Order this oversized poster developed by ACOG's Office of Communications for your office. Email communications@acog.org or call 800-673-8444, x2560. Complimentary, but supply is limited.

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ACOG Today's mission is to keep members apprised of activities of both The American Congress of Obstetricians and Gynecologists and The American College of Obstetricians and Gynecologists.

COVER: ILLUSTRATION SOURCE



inside

The AMA and you

“What does the American Medical Association (AMA) do for me?” This is a question we often hear from our members whenever we urge them to join or continue their membership in the AMA. There are a number of answers to this question, but I want to emphasize one important component: Scope of Practice Partnership (SOPP). The SOPP is a cooperative effort of the AMA and other leading national and state medical and national medical specialty societies.



Ralph W. Hale, MD,
Executive Vice President

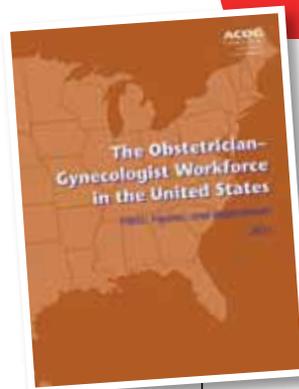
The SOPP was formed to protect patient safety and address legislative or regulatory expansions of scope of practice by non-physician health care professionals that may threaten the health and safety of patients. This goal is accomplished through a combination of legislative, regulatory, and judicial advocacy, as well as programs providing information, research, and education.

The SOPP has as its goal the protection of the health and safety of patients whose well-being may be threatened by health care practitioners who lack the education, training, or experience to perform procedures or services for which they seek licensure.

Involvement by the AMA in public policy is important in strengthening the

voice of ob-gyns in policymaking. To protect our patients, we need the help of the AMA and the SOPP. Please join or remain a member of the AMA and of your state and local society. Your involvement makes a difference to our partners, our specialty, and most of all, to the women we care for.

Ralph W. Hale MD



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NEW RELEASE

The Gynecologist Workforce in the United States: Facts, Figures, and Implications

Author William F. Rayburn, MD, MBA, explores evolving ob-gyn workforce issues projected to have a broad impact on physician satisfaction and patient access to care. Purchase hard copies from the ACOG online Bookstore at www.acog.org/bookstore (search for item #AA551), and at the ACOG Booth and Bookstore at the ACM, April 30–May 4, in Washington, DC. The book will be available beginning April 29 in an online format to members at no cost at www.acog.org/publications/obgynWorkforce.

Makena™ price reduction is inadequate PRICE REMAINS PROHIBITIVE

On April 1, K-V Pharmaceutical Company announced that it is reducing the cost of its drug Makena™ from \$1,500 per dose to \$690 per dose, clearly acknowledging the negative impact of their original pricing strategy. Although this may seem like a relatively significant price reduction, unfortunately it remains a woefully inadequate response. This “lower” price still remains prohibitively high for a safe and effective treatment that is currently available at a much lower price in the form of compounded 17 hydroxyprogesterone caproate (17P).

The College applauds the FDA’s statement that it will not prevent compounding pharmacies from continuing to produce valid prescriptions for 17P, a medication that has been safely used for years to help prevent preterm labor in certain high-risk pregnant women.



Although there are clear benefits to having an FDA-approved version of 17P, there is no evidence that Makena™ is more effective or safer than the currently used compounded version. In fact, the evidence used to obtain FDA approval for Makena™ relied primarily on data obtained using the compounded product.

The College, along with the Society for Maternal-Fetal Medicine, American Academy of Pediatrics, American College of Osteopathic Obstetricians & Gynecologists, National Medical Association, American Academy of Family Physicians, American College of Nurse-Midwives, and the Association of Women’s Health and Obstetric and Neonatal Nurses, will continue to collaborate to ensure that this medication is accessible and affordable to every pregnant woman who needs it. The US health care system simply cannot be expected to absorb the cost of Makena™ at its current prohibitive price without significant negative repercussions.

THE labor force

ACOG FELLOW RECEIVES ACGME COURAGE TO LEAD AWARD

The Accreditation Council for Graduate Medical Education (ACGME) has selected ACOG Fellow John R. Musich, MD, as a recipient of its Parker J. Palmer “Courage to Lead” Award. The award honors designated institutional officials who have demonstrated excellence in overseeing residency programs and fostering a superior environment for resident education.

Dr. Musich has dedicated his ob-gyn career to teaching. He recently retired from his post as vice president and director of medical education for William Beaumont Hospitals in Michigan, a position he held since 2002. From 1983–2004, he served as chair and residency director for Beaumont Hospital’s department of ob-gyn in Royal Oak, MI.

“There really is no better way to give back to the ob-gyn profession than by educating the physicians who will lead us into the future,” Dr. Musich said. “Few things are more gratifying than seeing young, eager students at the start of their careers and having the



John R. Musich, MD (left), receives congratulations from ACGME’s Chief Executive Officer Thomas J. Nasca, MD, MACP.

opportunity to take part in their training.” The William Beaumont Hospitals house 37 accredited residency and fellowship programs with more than 400 residents and fellows.

“I think our hospital system has one of the best educational records in the country for its size,” he said. “This award from ACGME is due in large part to what Beaumont became educationally while I was there and how

Beaumont enabled me to use my positions as a platform to contribute to medical education on a national level.”

He was awarded The College’s Distinguished Service Award in 2010. He served as chair and vice chair of District V and as a member of the Executive Board and Council of District Chairs. He was the Junior Fellow College Advisory Council advisor and a member of the Presidential Task Force on Resident Education. He was chair and program chair for the Council on Resident Education in Obstetrics and Gynecology.

Dr. Musich received his medical degree from the University of Minnesota in Minneapolis and completed his residency at the University of Michigan in Ann Arbor, followed by a fellowship in reproductive endocrinology at Beaumont Hospital. He was an examiner for the American Board of Obstetrics and Gynecology for 15 years and recently completed a six-year term on ACGME’s Institutional Review Committee.

Two ACOG Fellows on ballot for AMA June election

ACOG has endorsed and encourages our members to support two ACOG Fellows who are running for key positions in the AMA elections to be held in June at AMA’s annual meeting.

Mark S. Seigel, MD, a candidate for the AMA Council on Medical Services, is chair and legislative chair of ACOG’s Maryland Section and chair of the Committee on Ambulatory Practice Operations. He is secretary of the Physicians’ Electronic Health Record Coalition, chair of the Delegation of the Montgomery County Medical Society to the Maryland State Medical Society (Med Chi), member of the Small Practice Advisory Committee of the Chesapeake Regional Information System for our Patients (CRISP), and member of Med Chi’s Information Technology and Bylaws Committees. He was president of the Montgomery County Medical Society twice and president of the Maryland State Medical Society and Maryland Obstetrical and Gynecologic Society.



Mark S. Seigel, MD

John W. Spurlock, MD is running for the AMA Council on Constitution and Bylaws. He has served as chair of ACOG’s Armed Forces District Junior Fellows. His qualifications include serving as vice speaker of the Pennsylvania Medical Society, member of the Board of Trustees for the Pennsylvania Medical Society, and chair of the AMA’s Reference Committee on Amendments to Constitution and Bylaws in 2009.



John W. Spurlock, MD

ACOG Fellows meet with members of Congress

ACOG President Richard N. Waldman, MD, led more than 260 ACOG members from 49 states at ACOG's 29th Annual Congressional Leadership Conference (CLC), The President's Conference, in Washington, DC, February 27–March 2. The attendees, including more than 100 Junior Fellows, participated in 302 face-to-face meetings on Capitol Hill. After two days of policy discussions and advocacy training, ACOG Fellows and Junior Fellows carried two messages to their legislators:

Cosponsor the Maternal Health Accountability Act: CLC participants urged members of Congress to cosponsor legislation, introduced by Rep. John Conyers, Jr (D-MI), to encourage states to establish and run maternal mortality review committees (MMRs). MMRs examine pregnancy-related deaths to identify ways to improve maternal mortality rates. The bill would improve data collection and help eliminate disparities in maternal health outcomes.

Repeal the Independent Payment Advisory Board (IPAB): ACOG members urged cosponsorship of HR 452, legislation introduced by ACOG Fellow Congressman Phil Roe, MD (R-TN) to repeal (IPAB). IPAB hurts ob-gyns and patients because it can only recommend Medicare cuts—not any increases in premiums or copays, or changes in benefits—leaving physicians to shoulder most of the cuts.

Fellows and Junior Fellows at the CLC contributed almost \$70,000 to the Ob-Gyn-PAC at the annual PAC Party and Junior Fellow Section Officer Leadership Development reception, with 100% participation by the Junior Fellows attending the reception. “We are the future of our specialty and it is important that we help shape that future,” said Cynthia A. Brincat, MD, PhD, chair of Junior Fellow Congress Advisory Council, recognizing the value of the achievement.



ACOG Fellows from Colorado take a brief break in between Hill visits.



Rep. Nan Hayworth, MD (R-NY) (center), ophthalmologist and spouse of District II Chair Scott Hayworth, MD, pauses with the New York delegation after her presentation on *Legislative RX* at the President's Luncheon.



ACOG President Richard N. Waldman, MD (right), and then Vice President of Practice Activities and current Executive Vice President-designate Hal C. Lawrence III, MD, shared the stage with the president of the American College of Nurse-Midwives, Holly Powell Kennedy, CNM, PhD, to discuss the importance of collaborative practice in maternity care.



ACM highlight:
ACOG's peer review programs

Visit booth #1821 in the exhibit hall at the ACM to learn more about ACOG's peer review programs for both inpatient and outpatient women's health care. The **Women's Health Care Safety Certification for Outpatient Practice Excellence** is seeking innovators to participate in upcoming pilot site visits. The **Voluntary Review of Quality of Care Program** staff will be available to discuss how peer reviewers can help improve quality and safety in your hospital's ob-gyn department.

Learn more about the ACM at
www.acog.org/acm.

DISTRICT AND SECTION FELLOW OFFICER ELECTIONS **JUNE 1 NOMINATION DEADLINE**

Get involved! ACOG is seeking candidates for District and Section officers to serve the 2012–2015 term. Candidates must declare by June 1. To learn how to apply and whether your District or Section is holding an election in this election cycle, visit www.acog.org, click on **ACOG Departments**, and then on **District and Section Activities**. For more information contact Megan Willis, Fellow election coordinator at fellowelect@acog.org or 202-863-2531.



College updates screening recommendations for *preventive* care

The College has released an updated schedule of recommended routine screenings, lab tests, and immunizations for non-pregnant adolescents and women. The revised schedule groups the periodic health assessments by age range beginning at age 13 and takes into account individual risk factors that may warrant additional screenings or counseling.

“The purpose of the annual ob-gyn visit is to detect and treat any new or ongoing health problems, as well as to help prevent future ones from developing,” said Hal C. Lawrence III, MD, vice president of practice activities and current ACOG executive vice president-designate. “The College urges the US Department of Health and Human Services to include these screenings, tests, and immunizations included in our well-woman exam recommendations under the preventive services that it is considering for inclusion under the new health care law.”

The revised schedule addresses long-standing staples of the well-woman exam. No matter a woman’s age, there are certain components of the annual ob-gyn exam that are standard, including assessment of current health status, nutrition, physical activity, sexual practices, and tobacco, alcohol and drug use. Across age groups, the standard physical exam also includes height, weight, body mass index (BMI), and blood pressure. Annual breast and abdominal exams begin at age 19, and routine annual pelvic exams begin at age 21.

“Since the age a woman receives her first Pap test changed two years ago to age 21, and most women can have them less frequently than previously recommended, there’s this misconception that if you don’t need a Pap then you can skip the ob-gyn visit altogether,” said Dr. Lawrence. “Nearly every woman age 21 and older needs an annual well-woman visit with her ob-gyn, regardless of whether cervical cancer screening is done. The Pap test is just one part of staying healthy.”



The new Committee Opinion, *Primary and Preventive Care: Periodic Assessments*, includes information regarding which vaccinations are recommended, by age and risk group, including the flu shot, Hepatitis A and B, human papillomavirus (HPV), and measles. Annual testing for chlamydia and gonorrhea is recommended for all sexually active adolescents and young women up to age 25. HIV testing recommendations include annual testing for all sexually active adolescents, routine screening of women ages 19–64, and targeted screening for women with risk factors outside of that age range. Women from ages 21–30 should be screened every two years for cervical cancer. Most women age 30 and older who have had three consecutive negative cervical cytology test results may be screened once every three years, with certain exceptions.

“Periodic assessments offer an excellent opportunity for ob-gyns to provide preventive screening, evaluation, and counseling. Personal behavioral characteristics are important aspects of a woman’s health. Positive behaviors, such as

exercise, should be reinforced, and negative ones, such as smoking, should be discouraged,” said Cheryl Iglesia, MD, chair of The College’s Committee on Gynecologic Practice. “Because an ob-gyn is often the

only physician a woman will see on an annual basis, ob-gyns need to screen patients for psychosocial issues, including family relationships and domestic partner violence, as well as stress, sleep disorders, injury prevention, and substance abuse.”

The College’s recommendations serve as guidelines for ob-gyns, and they should be modified as necessary to meet individual patient needs. “For instance, we recommend that women have their first mammogram at age 40, and yearly beginning at 50, but a woman and her doctor may decide she needs a baseline mammogram before age 40,” said Dr. Lawrence.

Committee Opinion #483, *Primary and Preventive Care: Periodic Assessments*, is published in the April 2011 issue of the Green Journal, and is online under Publications at www.acog.org.

The College’s recommendations serve as guidelines for ob-gyns and they should be modified as necessary to meet individual patient needs.

ACOG helps define essential benefits under health care reform

The Affordable Care Act guarantees women access to preventive health benefits with no-cost sharing in private health plans and guarantees that all health insurance policies sold within newly forming state health exchanges cover maternity care. ACOG recently provided expert guidance to the Institute of Medicine, which is working with the US Department of Health and Human Services, to determine what women’s preventive services should be covered and how policies should be written to ensure access to the full range of maternity care.

Hal C. Lawrence III, MD, then vice president of practice activities and current ACOG executive vice president-designate, testified before the Institute of Medicine (IOM) Panel on Preventive Services for Women. He urged the IOM to include contraceptive counseling and services in the guaranteed preventive benefit package. “The US has the highest rate of

unintended pregnancy in the developed world. Approximately half of all pregnancies are unintended. In addition to the health impact, unintended pregnancies result in tremendous individual and societal consequences including family upheaval, nonattainment of educational goals, and financial burdens,” he told the panel. “It is essential that women have access to counseling that supports them in choosing a contraceptive method that is best for them and in using that method effectively.”

Dr. Lawrence urged that an array of other important care be provided without cost sharing, including well-woman visits, preconception care, counseling about and provision of family planning, routine HIV screening of women ages 19–64, and targeted screening for women with risk factors outside of that age range, and testing for HPV as part of cervical cancer screening.

Dr. Lawrence said ACOG believes screening

to identify intimate partner abuse is critically important. “Screening for domestic and partner violence is essential to the overall health of women, and we urge the IOM committee to include it in its final recommendations. Women living with abuse need to know they have options,” he said.

Arnold Cohen, MD, chair of the department of ob-gyn at Albert Einstein Medical Center, also testified on behalf of ACOG in front of the Committee on Determination of Essential Health Benefits, urging the IOM to reject definitions of “medical necessity” that allow health insurers to emphasize cost and resource utilization over quality and clinical care. He explained that essential benefits in women’s health have already been defined by ACOG’s body of work. “Our clinical and practice guidelines are relied upon by more than 54,000 practicing ob-gyns and women’s health care providers,” he said. “We urge you not to reinvent the wheel but to rely instead on ACOG’s widely available documents to define health care benefits and medical necessity.”



ACOG's hidden gem: The VRQC program

John S. Wachtel, MD, is the program director of ACOG's Voluntary Review of Quality of Care (VRQC) Program. He is an adjunct clinical professor in the Department of Ob-Gyn at Stanford University School of Medicine, immediate past chair of The College's National Patient Safety and Quality Improvement (PSQI) Committee, and chair of the District IX PSQI Committee. In honor of the 25th anniversary of the VRQC Program, *ACOG Today* spoke recently with Dr. Wachtel.



John S. Wachtel, MD

Please explain the purpose of the VRQC Program.

The purpose of the VRQC Program is to provide confidential peer review consultations to departments of ob-gyn, assess the quality of care provided, and offer recommendations on patient safety and improving the quality of care for women.

Why do you consider it "ACOG's hidden gem?"

The program is underutilized. Although we have done more than 275 reviews in the past 25 years, this represents only about 10% of hospitals that practice obstetrics in the US. Every ob-gyn department, no matter how outstanding its care, can benefit from a comprehensive review by the VRQC Program.

How did you get involved with the VRQC Program?

I have had a career-long interest in peer review, quality assurance, and quality improvement efforts. I began at the local level at Stanford Hospital, then became a consultant for the Medical Board of California, and eventually served on The College's national PSQI Committee. I was accepted as a VRQC reviewer in 1995 and became program director in 2009. Helping improve care at hospitals around the country perhaps has been my most rewarding professional activity.

The requests are as varied as the hospitals we review. Many hospitals want comprehensive department evaluations to ensure they are practicing within The College's guidelines. Some hospital systems want assurance that their member hospitals are providing safe and high quality care, even when no problems have been identified. Other times, a request can be related to a particular procedure, cesarean delivery rates, or a high incidence of non-medically indicated inductions. Before going on site, we always discuss the issues involved to ensure we have the right expertise as part of the team.

What is the composition of a review team, and does VRQC provide training?

We have a pool of approximately 26 physician reviewers, five nurse reviewers, and three medical writers from which we assemble a unique team for every site visit based on geographical diversity, availability, and the needs of the hospitals. Teams are usually composed of five members: three actively practicing ob-gyns, a nurse reviewer, and a medical writer. We can add a family physician, an anesthesiologist, and/or a certified nurse-midwife (CNM) reviewer, if such expertise is needed. Our ob-gyn reviewers must be board-certified Fellows of ACOG for a minimum of five years and experienced in peer review/quality assurance techniques. We have a rigorous

What are the most common reasons that hospitals request a review?

evaluation for all new reviewers, and we conduct training sessions every three years. Our next training session will take place this month in Washington, DC, just before the start of the ACM, on April 29–30.

How are the teams received when they arrive at the hospitals?

We begin every site visit with a meeting where the team is introduced and the entire process is explained. We want this to be a collegial experience during which the invited guests help the providers to achieve clinical excellence.

Can you describe the process for the report production?

Once the team leaves the site, the medical writer drafts a report based on the findings at the hospital and recommendations made by the team at the exit conference. The team carefully reviews and edits this draft to ensure consistency with current College guidelines. The complete report of all findings and recommendations is delivered to the hospital about eight weeks after the site visit.

What are the most commonly evaluated clinical problems?

Many of the reviews have a strong emphasis on obstetric procedures such as inductions of labor, cesarean delivery rate, VBACs, and operative vaginal deliveries. In gynecology, we often address inappropriate hysterectomies, inadequate pre-op workups, or new technology. Whether we are looking at obstetric or gynecologic concerns, the number-one patient safety issue is poor communication, which is evident in many ways.



What are the greatest strengths of the VRQC Program?

First and foremost, this is a purely voluntary process. Hospitals appreciate recommendations made by the team that are based on The College's guidelines. The fact that we have a nurse reviewer evaluating the quality of the nursing staff, as well as policies and procedures in the department, allows all members of the hospital staff to accept suggestions. Our attention to confidentiality and anonymity throughout the process is reassuring to those undergoing review.

How does the VRQC Program evaluate its impact on the hospital?

After every review, the hospital is asked to complete a comprehensive evaluation assessing the program, the process, and the individual reviewers. Again, after the final written report is provided, a second evaluation is requested to determine what recommendations were implemented, which were not, what barriers to implementation were encountered, and other issues. While it is very difficult to confirm improved patient outcomes and safety parameters in such a short time, especially with limited data collection available at many hospitals, the subjective feedback is overwhelmingly positive. On occasion, the team uncovers a critical problem requiring immediate attention, which the hospital corrects even before receiving the final report.

What are the future goals for the VRQC Program?

We hope more hospitals will benefit throughout the country by undergoing a review. The VRQC Program is also exploring possible ways to move into the physician office setting to help improve quality of care there.

An article by Abe Lichtmacher, MD, published in *Obstetrics and Gynecology Clinics of North America* (volume 35, March 2008, 147–162) includes further information.

Visit www.acog.org/goto/vrqc or email vrqc@acog.org to learn more about the VRQC Program.

All women should be offered cystic fibrosis screening, regardless of ethnicity

Preconception and prenatal cystic fibrosis (CF) carrier screening should be made available to all women of reproductive age as a routine part of obstetric care, according to a revised Committee Opinion issued by The College. In addition to an update of current guidance for CF screening practices, the document discusses counseling strategies, special reproductive health considerations for women with CF, and clinical management recommendations.

Cystic fibrosis is a progressive, multisystem disease that primarily affects the lungs, pancreas, and digestive tract. CF significantly shortens the lifespan of people affected by it—median survival is approximately 37 years. Because CF is caused by an inherited genetic mutation, carrier screening is recommended to identify couples at risk for having a child with the disease.

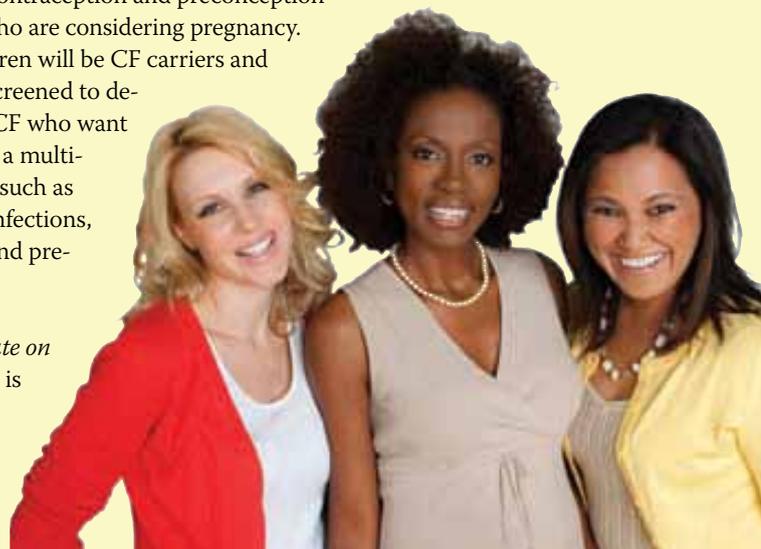
The incidence of CF is highest among non-Hispanic white individuals (roughly 1 in 2,500) and people of Ashkenazi Jewish ancestry. CF is considerably less common (but still occurs) in other ethnic groups. The College recommends that CF carrier screening be offered to all women of childbearing age, preferably before conception. Women who are CF carriers and their reproductive partners may need additional screening tests and referrals for genetic and reproductive counseling.

The College also recommends contraception and preconception consultation for women with CF who are considering pregnancy.

They should be told that their children will be CF carriers and that their partners should also be screened to determine carrier risk.

Women with CF who want to become pregnant can work with a multidisciplinary team to manage issues such as pulmonary function, weight gain, infections, and the increased risk of diabetes and preterm delivery.

Committee Opinion #486, *Update on Carrier Screening for Cystic Fibrosis*, is published in the April 2011 issue of the Green Journal and online under Publications at www.acog.org.



April is STD awareness month

More than 19 million cases of sexually transmitted diseases (STDs) occur in the US each year, with a disproportionate share among young people and racial and ethnic minority populations. Left untreated, STDs can cause serious health problems ranging from infertility to increased risk of HIV infection. To help stop these silent epidemics, the 2010 Centers for Disease Control and Prevention's Sexually Transmitted Diseases Treatment Guidelines advise healthcare providers on treatment, screening, and prevention. CDC revises the guidelines approximately every three to four years. The guidelines, and information on webinars, hard copy ordering, wall charts, pocket guides, and iPhone and eBook versions are online at www.cdc.gov/std/treatment/2010. Read about the 2010 changes as they pertain to adolescent females at www.acog.org. Click on ACOG Departments and then Adolescent Health Care.



Prevention of GBS infection

The College has issued revised guidelines for the prevention and treatment of perinatal group B streptococcal (GBS) disease. The document summarizes the 2010 US Centers for Disease Control GBS guidelines, which The College has endorsed, and highlights important changes in clinical practice for ob-gyns.

GBS is fatal in about 5% of babies who carry it. An estimated 10%–30% of pregnant women are infected with GBS and up to 2% will transmit it to their newborns during delivery. Many GBS infections occur between six hours and seven days of birth, though late-onset infections can develop. Infants born to black and Hispanic women and women younger than age 20 are at increased risk.

The College recommends that all pregnant women be screened for GBS at 35–37 weeks' gestation and that preventive antibiotics be given to women who test positive during labor. "National guidelines to prevent mother-to-infant GBS transmission have led to an 80% reduction in early onset sepsis in neonates," said Ronald S. Gibbs, MD, a member of The College's Committee on Obstetric Practice. "Unfortunately, despite these strides, GBS remains the leading cause of infectious mortality and morbidity among newborns.

"While the core recommendations are the same, the new document provides further direction for clinicians in implementing and improving prevention strategies," Dr. Gibbs added. Included are updated case scenarios for GBS screening and antibiotic treatment for women with preterm labor or preterm premature rupture of membranes; management plans for newborns at risk of early-onset GBS disease; and updated antibiotic regimens for women with penicillin allergy.

Committee Opinion #485, *Prevention of Early Onset Group B Streptococcal Disease in Newborns*, is published in the April 2011 issue of the Green Journal and is online under [Publications](http://www.acog.org) at www.acog.org.

Correction:

The March 2011 print edition inaccurately stated that colorectal cancer is the "third leading cause of death among US women." It is the third leading cause of **cancer** death in US women.

Preparing for clinical emergencies

The ob-gyn practices in an environment where true emergencies periodically occur, particularly in the inpatient setting. A new Committee Opinion released by The College explains how to prepare for emergencies, and how to use communication and teamwork to increase the effectiveness of emergency response.



Gregory W. Lau, MD

Whether severe shoulder dystocia, catastrophic surgical or obstetric hemorrhage, or an anaphylactic reaction to an injection in the office, all emergencies require prompt response. It is important for ob-gyns to prepare for these events by assessing potential emergencies that might occur, establishing early warning systems, designating specialized first responders, conducting emergency drills, and debriefing staff after actual events to identify strengths and opportunities for improvement. Having such systems in place may reduce or prevent the severity of medical emergencies.

Some emergencies are sudden and catastrophic, such as a ruptured aneurysm, massive pulmonary embolus, or complete abruptio placentae. These are best handled by rapid response teams (RRTs). "The criteria used to activate the RRT must be clearly defined among potential 'activators' well in advance of any emergency," said Gregory W. Lau, MD, a member of The College's Committee on Patient Safety and Quality Improvement. Preparation for in-hospital situations requires that emergency supplies be placed in locations well known to members of the RRT. "It is also important to ensure that all members of the RRT receive ongoing education and training, including experience with drills," said Dr. Lau.

While some emergencies are abrupt and unforeseen, many are preceded by a period of instability during which timely intervention may help avoid disaster. "All caregivers should realize that certain changes in a patient's condition, such as new onset difficulty with movement, can indicate an emergency that requires immediate intervention," noted Dr. Lau. "These changes include some events not usually understood as emergencies. It is imperative that bedside personnel be able to request immediate help without recrimination when such changes occur."

Committee Opinion #487, *Preparing for Clinical Emergencies in Obstetrics and Gynecology*, is published in the April 2011 issue of the Green Journal, and online at www.acog.org under [Publications](#).





Electronic health record incentives program open

First deadline is October 1

Ob-gyns and hospitals that wish to participate in the federal Electronic Health Record (EHR) Incentive Program, whether Medicare or Medicaid, must register online through the Centers for Medicare and Medicaid Services (CMS) website at: www.cms.gov/ehrincentiveprograms. Physicians who are eligible will receive Medicare or Medicaid incentives from CMS if they are “meaningful users” of a certified EHR.



Nefertiti C. DuPont, MD

Providers who choose to take part in 2011 must begin their 90-day reporting period by October 1. Eligible professionals can receive up to \$44,000 over five years under the Medicare Program. Although participation is voluntary, physicians who do not adopt certified EHR technology and do not use an EHR system in a meaningful way can face penalties in the form of Medicare reimbursement reductions beginning in 2015. The Medicaid EHR Incentive Program is voluntarily offered by states beginning as early as this year, depending on the state. Eligible professionals can receive up to \$63,750 over six years.

“Now may be the time for your practice to purchase and implement an EHR system,” said Nefertiti C. DuPont, MD, MPH, member of ACOG’s Committee on Professional Liability. “Technology has changed and it is evolving rapidly. Gone are the days when we can rely on paper charts to find and record patient information.”

“One of the biggest hurdles is the financial investment of

purchasing an EHR system,” said Patrice M. Weiss, MD, chair of The College’s Committee on Patient Safety and Quality Improvement, “but federal funds are intended to help practices and medical centers install and incorporate this new technology.”

The so-called “meaningful use” objectives provide basic standards that must be met to qualify for EHR incentive funds. “While these may seem confusing, most of the objectives are easily met with a good EHR system,” said Dr. DuPont. The core objectives of an EHR system include computerized provider order entry for medication orders, drug-drug and drug-allergy checks, electronic prescribing, patient demographics, patient problem lists, current and past vital signs, smoking status, clinic notes for office visits, clinical quality measures, electronic exchange of information to multiple providers, and security of patient data.



Patrice M. Weiss, MD

“There are pros and cons to EHR implementation, but it is my opinion that the benefits outweigh the burdens,” said Dr. DuPont. “Admittedly, it is not easy to transition to a new system, especially for those of us who are comfortable with our current office practices, but we may face more reductions in Medicare reimbursement if we don’t adopt EHRs.” EHRs efficiently handle a large amount of patient data, prescriptions, lab results, follow-up reminders, and evidence-based guideline recommendations for physicians.

“EHRs can reduce medication errors, increase adherence to practice guidelines, and improve immunization rates. On the business side, EHRs can decrease transcription costs, improve billing and coding, increase staff productivity, and improve laboratory test and imaging utilization,” said Dr. DuPont.

Learning to use EHR systems can be difficult. “The learning curve with this new technology is steep, so providers must be patient,” Dr. Weiss noted. Corrupted data and software incompatibility are a few of the known technology-related downsides to computerized record systems. “And, of course, when computer systems crash, as they sometimes do, access to the patient records will be affected,” she said. For these reasons, establishing an information technology (IT) department with round-the-clock staff support is important. Solo ob-gyn physicians who have smaller practices can purchase EHR systems with online support.

“Technology will continue to advance quickly. The transition to EHRs may be uncomfortable, but the time has come for many of us to embrace a paperless office which can improve the quality of care we provide,” said Dr. DuPont.

For information, visit www.acog.org and click on [Health Information Technology](#) under [Practice Management](#).

Committee Opinion #472, *Patient Safety and the Electronic Health Record*, was published in the November 2010 issue of the Green Journal and is online under [Publications](#) at www.acog.org.

ACM SESSIONS ON ELECTRONIC RECORDS

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SATURDAY, APRIL 30

The Ob-Gyn in the Electronic Age (SA304)
8:15 am–Noon

Robert Fagnant, MD
Fah Che Leong, MD

TUESDAY, MAY 3

EMRs for OBs and Health Reform (LT13)
12:15–1 pm

Mark S. Seigel, MD

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Raul Artal, MD

Raul Artal, MD
Chair, Committee on Scientific Program
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••• MAKING the Rounds

The following documents appear in the Green Journal and are online under Publications at www.acog.org.

Practice Bulletin

- **119 Female Sexual Dysfunction** (April 2011)

Committee Opinions

- **487 Preparing for Clinical Emergencies in Obstetrics and Gynecology** replaces #353 (April 2011)
- **486 Update on Carrier Screening for Cystic Fibrosis** replaces #325 (April 2011)
- **485 Prevention of Early-Onset Group B Streptococcal Disease in Newborns** replaces #279 (April 2011)
- **484 Performance Enhancing Anabolic Steroid Abuse in Women** (April 2011)
- **483 Primary and Preventive Care: Periodic Assessments** replaces #452 (April 2011)