

Experts develop national plan to improve preterm birth

OB-GYNS ARE VERY FAMILIAR WITH THE OCCURRENCE OF preterm birth, but their efforts to prevent it have been frustrated by a continued increase in the preterm birth rates. There are no tests to accurately predict preterm birth, and the main interventions focus on delaying delivery until antenatal corticosteroids can improve fetal lung maturity.

The Surgeon General's Conference on the Prevention of Preterm Birth, which was mandated with the 2006 passage of the federal PREEMIE Act, gathered experts in June to develop a national agenda to better understand and help prevent preterm birth and to raise awareness of the issue. Currently, 12%

of US births are preterm—nearly 500,000 babies.

ACOG was actively involved in the conference, with several Fellows chairing and participating in the six working groups that developed national recommendations. Hal C. Lawrence, MD, ACOG vice president for

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2009 postgraduate courses announced

POSTGRADUATE COURSE director Tod C. Aeby, MD, wants ob-gyns to become reenergized about their specialty and to learn new concepts in a collaborative and interactive environment. His ACOG postgraduate course “Reawakening the Excitement of Obstetrics and Gynecology,” which was first offered this past summer, will return in 2009 as part of ACOG's postgraduate course schedule (see the full listing on page 5).

“Sometimes people get a little down on life as an obstetrician-gynecologist. There are social issues, medicolegal concerns, and eco-

nomic pressures. We want to remind them about the fun parts of what we do,” said Dr. Aeby, generalist division director at the University of Hawaii.

Postgraduate courses offer ACOG Fellows and Junior Fellows the opportunity to learn new techniques and practice management skills, get updated on the latest clinical guidelines, and discuss management of different types of cases, all while interacting with colleagues from around the country.

Dr. Aeby's course, which will take place Aug 27–29, 2009, in La Jolla, CA, will provide updates and management strategies for

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EXECUTIVE DESK

ACOG's positions advocated
at AMA meeting

THIS SUMMER, I ATTENDED THE American Medical Association Annual Meeting, where your ACOG delegation, led by Chair Kathleen Fitzgerald, MD, worked hard on your behalf to make certain that AMA positions reflect ob-gyn practice needs.

Examples of this included a report from the AMA Council on Ethical and Judicial Affairs that would have made it unethical to accept any funding for education. The report was referred back to the committee for further review. The CEJA report on expedited partner therapy, which ACOG objected to last November, was received and changed to reflect current practice. There was extensive discussion on the future of health care and the two presidential candidates' positions. Scope of practice by lay midwives was discussed, and ACOG's position in opposition was approved. Also, there was model legislation related to home deliveries supporting the ACOG position against home births. Physician reentry, parental leave for residents and Fellows, abstinence-only education, and minors and sexually transmitted diseases were other key issues on the agenda. Finally, discussion returned on restrictions on ultrasound and who could bill for services.

Any one or all of these issues could have had a direct impact on the practice of ob-gyn. However, because ACOG still has a significant number of members in the AMA, none of the outcomes were adverse to our current practices. ACOG needs to maintain a strong position in the AMA if we are to continue to protect ob-gyn practices. Please consider this when you receive your next solicitation for AMA membership. We need you to become a member to help ACOG protect your practice environment. ♀



Ralph W. Hale, MD, FACOG
Executive Vice President



IN MEMORIAM

William James Burgess, MD
Brampton, ON • 4/08

Gildardo Castillo Camara, MD
Mexico City • 5/08

Steven L. Fielding, MD
Cedar City, UT • 5/08

Lourdes T. Lim, MD
Grove City, PA

John E. Mackey, MD
Bloomington, IN

John Michael Murphy, MD
Port Huron, MI • 6/08

Robert I. Pfeffer, MD
Irvine, CA • 7/08

Frederick G. Porter, MD
Plymouth, MI

Michael H. Ross, MD
Golden, CO

Susan L. Sipes, MD
Appleton, WI • 5/08

Dorothea L. Souza, MD
Medford, MA

Edmund M. Stapleford, MD
Waynesboro, PA • 6/08

Daniel Thanos, MD
Columbus, OH • 5/08

Correction

David R. Ware, MD, of Hope, AR, was incorrectly listed in the "In Memoriam" list in the April issue of *ACOG Today*. Dr. Ware has not died. ACOG apologizes for this error.

**Obstetrics & Gynecology
HIGHLIGHTS**

The September issue of the
Green Journal includes the
following ACOG documents:

**Depot Medroxyprogesterone Acetate and
Bone Effects**

(Adolescent health and gynecologic Committee
Opinion #415, new)

The Uninsured

(Underserved women Committee Opinion #416,
revised)

**Addressing Health Risks of Noncoital Sexual
Activity**

(Adolescent health and gynecologic Committee
Opinion #417, new)

For more information, see page 13.

**Prenatal and Perinatal Human Immunodeficiency
Virus Testing: Expanded Recommendations**

(Obstetrics Committee Opinion #418, revised)

For more information, see page 13.

Fetal Lung Maturity

(Obstetrics Practice Bulletin #97, revised)

Each issue of the Green Journal now lists the latest ACOG documents (and their website address) that have been reaffirmed by their respective committees. Documents are reviewed by ACOG on a routine basis and are either revised, withdrawn, or reaffirmed as is.

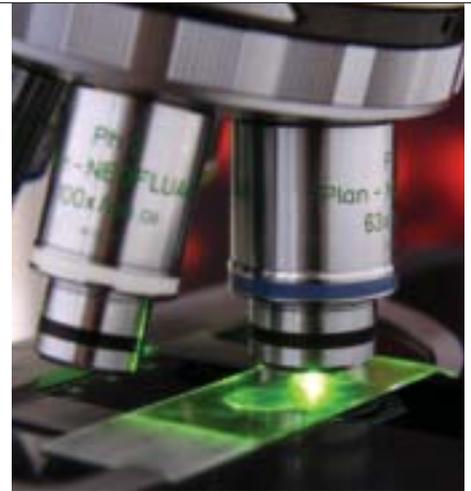
October 1 deadline

ACOG research grant applications

APPPLICATIONS FOR ACOG RESEARCH FELLOWSHIPS AND AWARDS ARE due October 1. Applicants must be ACOG Fellows or Junior Fellows. All research fellowships and awards are contingent upon funding. ♀

info

- On the ACOG website, www.acog.org, under “Education,” click on “Research Fellowships and Awards”
- Lee Cummings: 800-673-8444, ext 2577; lcummings@acog.org



THE FOLLOWING AWARDS ARE AVAILABLE:

- ▶ ACOG/Abbott Nutrition Research Award on Nutrition in Pregnancy, \$25,000 grant
- ▶ ACOG/Bayer HealthCare Pharmaceuticals Research Award in Long Term Contraception, \$25,000 grant
- ▶ ACOG/Bayer HealthCare Pharmaceuticals Research Award in Contraceptive Counseling, \$25,000 grant
- ▶ ACOG/Boehringer Ingelheim Pharmaceuticals Inc Research Award on Female Sexual Dysfunction, \$10,000 grant
- ▶ ACOG/Eli Lilly and Company Research Award for the Prevention and Treatment of Osteoporosis, \$15,000 grant
- ▶ ACOG/Kenneth Gottesfeld-Charles Hohler Memorial Foundation Research Award in Ultrasound, one \$10,000 grant or two \$5,000 grants
- ▶ ACOG/Hologic Research Award for the Prevention of Cervical Cancer, \$15,000 grant
- ▶ ACOG/Merck and Company Research Award on Adolescent Health Preventive Services, \$15,000 grant
- ▶ ACOG/Merck and Company Research Award on Immunization, \$15,000 grant
- ▶ ACOG/Ortho Women's Health & Urology Academic Training Fellowships in Obstetrics and Gynecology, two one-year fellowships with a \$30,000 stipend
- ▶ Warren H. Pearse/Wyeth Pharmaceuticals Women's Health Policy Research Award, \$15,000 grant

2009 postgraduate courses announced

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important women's health topics, covering issues such as the challenges of the medical marriage; how to apply time, stress, and practice management principles; management of personal finances; and how to handle challenging patients. Course faculty will be Fellows James T. Breeden, MD; Frank W. Ling, MD; and Valerie M. Parisi, MD; and psychiatrist Donald E. Rosen, MD.

Part of the course instruction will be determined by the participants themselves. Participants are encouraged to register early; then, they will be asked to submit suggested topics they want covered in the course.

The course is designed around adult-learning theory. Rather than providing only lectures, the course will use small-group sessions to stimulate discussion.

“The participants are broken up into small groups; you toss out a patient scenario, and

the small groups discuss their assessment and management plans,” Dr. Aeby said. “People who know about the topic help out their colleagues. Faculty facilitators are listening to the discussions and answering questions. They are also ready with mini lectures to make sure the information is accurate and up-to-date.”

The three-day course is organized so that the first half of the morning focuses primarily on medical issues, leaving the second half of the morning for more personal topics such as finances and relationships. Spouses and partners are encouraged to attend these latter discussions. ♀

info

- More information on the 2009 courses will be online later this year. Check the ACOG website, www.acog.org. Under “Meetings” click on “Postgraduate Courses and CPT Coding Workshops”

2009 POSTGRADUATE COURSES

Emerging Issues in Office Practice: Sexuality, Body Image, and Psychological Well-Being

February 12-14
St. Thomas, US Virgin Islands

Quality and Safety for Leaders in Women's Health Care

March 26-28
Washington, DC

Reawakening the Excitement of Obstetrics and Gynecology

August 27-29
La Jolla, CA

21st Century Obstetrics (in conjunction with the District I and District III Annual Meeting)

October 16-18
Lake Buena Vista, FL

Practical Obstetrics and Gynecology

November 12-14
Las Vegas

Update on Cervical Diseases

December 3-5
New York City

Hands-On Transvaginal Ultrasound

December 10-12
Chicago

ACOG's future leaders gather in DC

ACOG CULTIVATED THE future of the College in August when approximately 30 Junior Fellows and young physicians gathered for the biennial ACOG Future Leaders in Obstetrics and Gynecology Conference.

The College selects a group of Junior Fellows in practice and Fellows who have been in practice less than five years to attend the event, where they hone their leadership skills and learn the ins and outs of ACOG and how to become more active in the College. Each ACOG district is invited to send up to three participants. ACOG President Elect Gerald F. Joseph Jr, MD, was a special guest.

ACOG Executive Vice President Ralph W. Hale, MD, FACOG, initiated the conference 12 years ago at the request of the Council of District Chairs.

"ACOG strongly believes in the Junior Fellows and young physicians," Dr. Hale said. "They are the future of our College, and this conference gives them a unique opportunity to interact with their colleagues, learn new leadership techniques, and hear how they can get involved in ACOG committees, legislative efforts, and media outreach." ♀

ACOG Executive Vice President Ralph W. Hale, MD, FACOG, discusses the College's strategic plan with the future leaders.



Mistie P. Mills, MD, then-Junior Fellow chair of District VII, and Cole D. Greves, MD, from District II, work on an interpersonal skills assessment.



Adrian Puello, MD, from District III, listens to a presentation about the functions and structure of the College.

ACOG LEADERS ON CAPITOL HILL



ACOG Executive Vice President Ralph W. Hale, MD, FACOG, provides testimony in July to the House Committee on Small Business on the benefits and challenges of implementing electronic medical records in small practices.



ACOG Deputy Executive Vice President Albert L. Strunk, MD, speaks at a Senate press conference in July to support the Melanie Blocker Stokes MOTHERS Act, which would increase research and public education for postpartum depression. Next to him are Sens. Robert Menendez (D-NJ) and Debbie Stabenow (D-MI).

ACOG joins women's cancer campaign

ACOG WILL JOIN FORCES with the nation's leading cancer advocacy groups in a landmark television event and education initiative called *Frosted Pink with a Twist*. With nearly 261,000 women expected to be diagnosed with a woman's cancer in the US this year, *Frosted Pink with a Twist* aims to provide cancer education, encourage dialogue, celebrate survivorship, and empower women to become advocates for their health.

As a *Frosted Friend* partner, ACOG will be instrumental in helping to educate and raise awareness of cancers primarily affecting women.

The campaign will include a unique television special in October that will combine sports, entertainment, and health awareness by bringing together the 2008 US men's and women's Olympic gymnasts with today's top music stars and a host of celebrities.

Frosted Pink with a Twist will air on ABC on Sunday, October 12, from 4 to 6 pm Eastern Time. It will be hosted by Olympic Champion Mary Lou Retton and will highlight the



current world all-around women's gymnastics champion, Shawn Johnson, and other stars of the men's and women's US Olympic gymnastics teams. The show will reair on cable stations throughout October.

In addition, the campaign website (see "info" below) will provide important resources for women. ♀

info

- communications@acog.org
- www.frostedpink.org



DECEMBER 30 DEADLINE

ACOG accepting applications for Issue of the Year

ACOG IS SEEKING A THOROUGHLY researched and referenced background paper of 50–100 pages on the 2008–09 Issue of the Year: "Establishing an Office-Based Patient Safety Program." The program's components should include:

- ▶ What resources are needed
- ▶ How to initiate the program
- ▶ How to involve the office staff and get their acceptance
- ▶ How to monitor the program once it is established

Any Fellow or Junior Fellow may apply. The award carries a stipend of \$10,000; the winner receives \$5,000 on selection and \$5,000 upon completion. Transportation costs of up to \$1,000 are also provided for the winner to attend a future Executive Board meeting to give a brief presentation.

How to apply

Send a narrative letter (not more than two typed pages), outlining your approach, along with your CV to Lee Cummings, ACOG, 409 12th Street SW, Washington, DC 20024-2188. ♀

info

- Contact Lee Cummings: 800-673-8444, ext 2577; lcummings@acog.org

Take ACOG practice management survey

ALL PRACTICING OB-GYNS OF ACOG are urged to complete the 2008 Socioeconomic Survey, which will assess the impact of the economic environment on ob-gyn practice and track important trends in practice structure, workload, and finances.

ACOG will use the survey findings to provide reports to the membership about the economics of ob-gyn practice, as well as to guide advocacy and educational efforts. Documenting the impact of rising practice costs and declining reimbursement will help immeasurably with the College's efforts to effect positive change for ACOG Fellows and their patients.

This year's survey includes new questions about electronic medical records and health information technology. Reports will be made available to all ACOG members on topics such as ob-gyn practice arrangements, workload, and productivity. ♀

info

- Access the survey on the ACOG website, www.acog.org. Under "Practice Management," click on "Practice Management and Managed Care" and then click on "Members Encouraged to Participate in 2008 ACOG Socioeconomic Survey"
- Questions: James Scroggs, 800-673-8444, ext 2447

Begin using new codes October 1

FOLLOWING ARE NEW, EXPANDED, AND REVISED ICD-9-CM CODES that are of interest to ob-gyns and that take effect October 1. HIPAA requires providers to use the medical code set that is valid at the time the service is provided. Therefore, physicians must cease using discontinued codes for services after the new codes become effective October 1. For the full list of new ob-gyn codes, visit the ACOG website (see “info” below). ♀

info

- On the ACOG website, www.acog.org, click on “CPT Coding” in the “Quick Links” box on the left side of the home page
- Questions and comments: coding@acog.org or fax to 202-484-7480
- For the latest ACOG publications on coding: www.acog.org/bookstore/Coding_Resources_C56.cfm

Pain and other symptoms associated with female genital organs—vulvodynia

A new subcategory (625.7) will be created to capture coding for vulvodynia:

- ▶ 625.70: Vulvodynia, unspecified
- ▶ 625.71: Vulvar vestibulitis
- ▶ 625.79: Other vulvodynia

Current condition complicating pregnancy—cervical shortening

A new code (649.7) will be added to include cervical shortening as a current condition complicating pregnancy. A fifth digit is required to reflect the current episode of care (eg, antepartum, delivery, or unspecified episode of care).

Suspected fetal conditions not found

The title of category 656 (other fetal and placental problems affecting management of mother) will be revised to include the terms “known or suspected.” Furthermore, a new category (V89) will be created to capture “other suspected conditions not found.”

These changes will take place to allow coding for problems that are suspected but not found in order to reflect why a certain service or procedure was performed. For the new codes in the V89 category, visit the ACOG website (see “info” above).

Abnormal Pap smears of cervix, vagina, and anus

Cervical Pap smear:

The code for nonspecific abnormal Papanicolaou smear of cervix (795.0) will be expanded to include a satisfactory cervical Pap smear that is lacking a transformation zone. Code 795.07 will read: Satisfactory cervical smear but lacking transformation zone.

Vaginal Pap smear:

The code for abnormal Papanicolaou smear of vagina and vaginal HPV (795.1) will be ex-

panded to more accurately reflect the terminology used in the Bethesda System, including low- and high-grade squamous intraepithelial lesions and a positive HPV test of the vagina. For the new 795 codes, visit the ACOG website (see “info” above).

Anal Pap smear:

A new subcategory (796.7, abnormal cytologic smear of anus and anal HPV) will be created to code for anal Pap smears and a positive HPV test of the anus. These codes will include the Bethesda System terminology and parallel the cervical and vaginal Pap smear codes. For the new 796 codes, visit the ACOG website.

Prophylactic use of agents

A new subcategory (V07.5) will be created to capture the prophylactic use of drugs that affect estrogen receptors and estrogen levels. The new codes in this series will be accompanied by a listing of drugs that may be used. The list is not intended to be all-inclusive. The new codes will be:

- ▶ V07.51: Prophylactic use of selective estrogen receptor modulators (SERMs); Prophylactic use of raloxifene (Evista), tamoxifen (Nolvadex), and toremifene (Fareston)
- ▶ V07.52: Prophylactic use of aromatase inhibitors; Prophylactic use of anastrozole (Arimidex), exemestor (Aromasin), and letrozole (Femara)
- ▶ V07.59: Prophylactic use of other agents affecting estrogen receptors and estrogen levels. Prophylactic use of estrogen receptor down regulators fulvestrant (Faslodex), gonadotropin-releasing hormone (GnRH) agonist goserelin acetate (Zoladex), leuprolide acetate (leuprorelin) (Lupron), and megestrol acetate (Megace)

Personal history of in utero surgery

To capture personal history of a mother or fetus that has undergone in utero surgery, the following codes will be implemented:

- ▶ V15.21: Personal history of undergoing in utero procedure during pregnancy
- ▶ V15.22: Personal history of undergoing in utero procedure while a fetus
- ▶ V15.29: Surgery to other organs

Supervision of high-risk pregnancy

Two new codes will be created to reflect high-risk pregnancies:

- ▶ V23.85: Pregnancy resulting from assisted reproductive technology
- ▶ V23.86: Pregnancy with history of in utero procedure during previous pregnancy

Routine ultrasound screening

The code for screening for malformation using ultrasonics (V28.3) will be revised to enable coding for routine ultrasound screening of malformation(s) using ultrasound: Encounter for routine screening for malformation using ultrasonics.

Antenatal screening

The code for other specified antenatal screening (V28.8) will be expanded to enable coding for more precise antenatal screening:

- ▶ V28.81: Encounter for fetal anatomic survey
- ▶ V28.82: Encounter for screening for risk of preterm labor
- ▶ V28.89: Other specified antenatal screening

Acquired absence of uterus and/or cervix

A new category will be created to code for acquired absence of cervix and uterus (V88.0). These codes will allow coding of persons who have had a total hysterectomy, partial hysterectomy with a remaining cervical stump, or cervicectomy with remaining uterus. The new codes will be:

- ▶ V88.01: Acquired absence of both cervix and uterus
- ▶ V88.02: Acquired absence of uterus with remaining cervical stump
- ▶ V88.03: Acquired absence of cervix with remaining uterus

Nurse-doctor combo for patient intake pays off

IMPROVE EFFICIENCY. REDUCE risk of error. Enhance patient satisfaction. Suppose you put a group of labor and delivery clinicians and administrators in a room and asked them to come up with ways to accomplish these things. The suggestions might range from meal service in the family lounge to computerized lab order entry.

But at the Hospital of the University of Pennsylvania, an L&D committee came up with an idea for a no-cost, low-tech, high-reward change. The committee proposed changing the process for one of the most basic aspects of patient care: taking the patient history.

Begun about a year ago, the initiative called for a team approach to taking the patient history—having both the physician and nurse together for the initial patient encounter. Although it is a relatively minor change, it has brought about important improvements.

“Before, when a patient in labor was admitted, the resident would write up the history and physical,” said Junior Fellow Sindhu Srinivas, MD, MSCE, a maternal-fetal medicine fellow at Penn who serves on ACOG’s Committee on Professional Liability. “Now the resident waits for the nurse, and they go in together. The nurse is there when the physician explains the plan of care to the patient, and the nurse is well aware of the plan.”

“Communication is a big problem at any facility,” said Penn charge nurse Meghan Maloney, RNC, BSN. “Patients were often asked the same questions—in triage, by the physician, by the nurse, by anesthesia, and sometimes by a medical student. A lot of times the patient would say ‘don’t you people talk to each other?’”

Efficiency boosted

Ms. Maloney and Dr. Srinivas initiated the idea of the team history approach. They both serve on a professionalism subcommittee in Penn’s L&D unit, which has about 4,000 deliveries a year.

In addition to complaints from patients

who were asked the same questions multiple times, another problem was delays in starting medication. The unit has a computerized order entry system, so the physician would order Pitocin, for example, but the nurse might not be aware of it for up to an hour later.

“Things get started a lot earlier now,” Ms. Maloney said. “I can get an admission done in 10 minutes and start their medication. Before, it could take an hour. It’s definitely more efficient.”



“I can get an admission done in 10 minutes and start their medication. Before, it could take an hour. It’s definitely more efficient.”

—Meghan Maloney, RNC, BSN

In implementing team history taking, the resident physician and nurse have to coordinate when they are going to go in the patient’s room to do the intake.

In practice, this usually means that one of them has to wait a few minutes while the other one is finishing a task.

“It might create a delay at the outset of five minutes, but the efficiency at the back end totally outweighs the slight delay,” Dr. Srinivas said.

Implementing plan met resistance

Dr. Srinivas acknowledges that the initiative initially met some resistance.

“Everyone thought it was a good idea, but when it came to implementation, it wasn’t that easy. It takes a while for people to feel comfortable with changing the process.”

Ms. Maloney agreed: “It’s hard for people to change their ways. They [physicians] don’t want to wait for the nurse. Sometimes there is some stress when you’re not ready to do something when someone else is.”

She thinks the team approach is gradually becoming more accepted and pointed out that the new residents who began in July are very receptive to it, given that it was already in place when they started training.

When the plan was first proposed, one objection raised was that a delay in taking the history would not be acceptable in some situations—what about the patient who is seizing over in triage? Dr. Srinivas reports that this was addressed by preparing a very specific plan for how the team history would be implemented, including exceptions.

More patient-focused

In the team history approach, the physician, nurse, and patient are together when the plan of care is discussed.

“Before, we would get an order in the computer, but the patient might not be aware of it,” Ms. Maloney said. “This way, the patients know about it and can ask why we are doing this. They can be a part of their plan of care, which is one of the National Patient Safety Goals of the Joint Commission.”

Dr. Srinivas adds that the new approach also ensures that the consent process is witnessed.

“It’s definitely more patient-focused,” Ms. Maloney said. “The patient feels like she’s being cared about. It’s no big deal for us, but it’s a huge deal for the patient.” ♀

info

→ ssrinivas@obgyn.upenn.edu

NOVEMBER 30 DEADLINE

Submit essays for Junior Fellow contest

JUNIOR FELLOWS ARE ENCOURAGED to share their thoughts on “Ob-Gyn ... The Day I Made a Difference” for this year’s Junior Fellow essay contest. Essays are due November 30.

Submissions should provide reflection on a day that you felt you made a difference. The experience could have been a clinical, political, social, public, or international event that affected your outlook on medicine and ob-gyn as a career.

Essay participants must be Junior Fellows. Essays should be between 500 and 750 words. No specific names of patients should be mentioned.

One winner will be selected from each district to receive \$500. A national winner will be selected from the winning district essays and will receive an additional \$500 and an expenses-paid trip to the 2009 Annual Clinical Meeting in Chicago. ♀

info

→ On the ACOG website, www.acog.org, click on “Junior Fellows” in the “Quick Links” box on the left side of the home page



Mexico Section recruits Junior Fellow leaders throughout the country

FACED WITH A POPULATION of more than 100 million and with approximately 400 to 500 ob-gyn residents graduating each year in Mexico, a primary challenge of the Junior Fellow officers in the ACOG Mexico Section is being able to connect with ob-gyn residents throughout the country.

To improve collaboration with and awareness of ACOG, the Mexico Section began recruiting one ob-gyn resident from each of seven regions to serve as a Junior Fellow representative.

“We’re trying to outreach to several different residency programs. Mexico is a country of 100 million people, and having one Junior Fellow chair and one vice chair is not enough,” said Mexico Section Junior Fellow Chair José Tirán-Saucedo, MD. “We want our residents to know that ACOG exists and what it provides to the members.”

Dr. Tirán estimates that only about 15% of residents are aware of ACOG. So, about a year and a half ago, Dr. Tirán began traveling around the country—supported by District VII—to recruit resident representatives. He received help from Mexico Section Chair Jesús G. Lozano-De la Garza, MD, and Mexico Junior Fellow Vice Chair Omar Dueñas-García, MD. They started with 20 leading residency programs and currently have representatives in four of the seven regions.

District VII approved funding the representatives to attend the Annual District Meeting, which, this year, will be held in Cabo San Lucas, Mexico, September 26–28, with Districts VIII and XI.

The new residency representative program will increase awareness of ACOG throughout

the country, get more residents in Mexico involved in the College, allow the section to better recruit officers, and make it easier for the section to gather information about residents, medical students, and residency programs throughout Mexico. Dr. Dueñas is also developing a Spanish-language web page on the ACOG website for the Junior Fellows in Mexico.



Mexico Section leaders at a District VII meeting: Fellow Luis C. Uribe-Ramírez, MD; Chair Jesús G. Lozano-De la Garza, MD, and his wife, Laura; Junior Fellow Chair José Tirán-Saucedo, MD, and his wife, Monica; and Junior Fellow Álvaro Santibañez, MD

As more ob-gyns in Mexico become involved in ACOG, there are profound educational benefits.

“In my personal experience, I have learned so much from the Fellows in the district,” Dr. Tirán said. “Residents will have access to Practice Bulletins and other documents. We can provide residents with information on how to publish their research in the US and give them information on US residencies. In the end, we can improve the quality of care, and our colleagues in the US can learn from the different things we are doing down here in Mexico.” ♀

info

→ On the ACOG website, www.acog.org, click on “Junior Fellows” in the “Quick Links” box on the left side of the home page

Ob-gyns can use data to set benchmarks

Ongoing national survey of new mothers generates valuable data

WHAT PERCENTAGE OF women smoke during pregnancy? How many take prenatal vitamins? What's the average hospital length of stay? How many births take place in hospitals? What's the rate of unintended pregnancy?

Clinicians, journalists, researchers, and policy-makers all use the answers to these and countless other pregnancy-related questions, but where does the information come from? The fact is, national statistics about maternal behavior and attitudes before and during pregnancy were not available before the early 1990s. That's when data from PRAMS, a surveillance project begun in 1987, began coming out. PRAMS stands for Pregnancy Risk Assessment Monitoring System, a federally funded data collection program implemented in states and coordinated by the Centers for Disease Control and Prevention.

Not all states take part in PRAMS. States must meet certain requirements to be able to participate and must first undergo a trial period.

Some states, such as California, have their own perinatal data collection network and do not participate in PRAMS, and, therefore, their data are not included in the national database.

Thirty-seven states plus New York City and a South Dakota-Yankton Sioux Tribe collaborative currently participate in PRAMS. All use a core set of 55 identical survey questions, but each state adds other questions on topics of interest to them. The states choose the additional questions from a standardized list of validated questions, thus ensuring uniformity.

Many groups use unique population-based data

Health agencies and nonprofit organizations use the PRAMS data set to help shape all kinds of programs, from breastfeeding support and contraceptive education to smoking cessation and education about folic acid intake.

PRAMS AT WORK

Alabama: PRAMS data showed rates of women who smoked before, during, and after pregnancy. A successful intervention program was created.

Maine: PRAMS data allowed a breastfeeding coalition to establish state breastfeeding goals.

Utah: PRAMS data were used to develop a media campaign to educate women about the importance of early and adequate prenatal care. Prenatal care rates increased substantially.

For more success stories, visit www.cdc.gov/prams.



Ob-gyns can use PRAMS data to set benchmarks for their practices, providing clinicians with reasonable expectations of achievement. For example, a state's PRAMS survey may show that 30% of respondents took folic acid supplementation prior to pregnancy, while a review of an individual practice's patient records might indicate that only 15% of reproductive-age women were counseled about folic acid supplementation.

Fellow William M. Callaghan, MD, MPH, offers an example of how he and his colleagues in the CDC's Division of Reproductive Health used the PRAMS data to analyze the association between weight gain and preterm birth rates for women with differing initial BMIs: "We had data on prepregnancy weight and other variables because the PRAMS data set contains data elements from the birth certificate as well as data from the questionnaire. We found that very lean women who don't gain a lot of weight have increased risk of preterm birth, and women with very high weight gain had approximately twice the odds of very preterm delivery, regardless of prepregnancy BMI."

Dr. Callaghan notes that the data are a public resource and anybody can have access. The PRAMS website (see "info" below) has information about what data are available by year,

instructions for how to propose a concept, and the contact person for each state.

Your OB patient may receive PRAMS survey

Every month, participating state health departments send a questionnaire to a sample of women who had a live birth two to four months previously. The states use birth certificate registries to identify the survey recipients, and each state samples between 1,300 and 3,400 women a year. Up to three written surveys are mailed, and telephone interviews are used with nonresponders.

In 2004, when 30 states were participating in PRAMS, 27 of them achieved a 70% response rate, and four of the 27 had rates of 80% or higher. Typically, if the response rate is below 70%, the state's data are not included in multistate analytic datasets available to researchers.

Acknowledging that 70% is a high response rate, Dr. Callaghan said, "Women like to tell their story—it's one of the reasons PRAMS has a good response rate. PRAMS is the only system that obtains the woman's perspective about her experience in pregnancy." ♀

info

→ www.cdc.gov/prams

Experts develop national plan to improve preterm birth

► PAGE 1

practice activities, cochaired the working group on professional education and training.

“Building upon the 2006 Institute of Medicine report on preterm birth, the Surgeon General’s conference developed a list of action items that we hope the federal government and health organizations will begin to work on,” Dr. Lawrence said. “Research is a key component. Before we can solve the problem, we need to better understand the underlying causes of the rise in preterm birth.”

“It’s clear that preterm birth is a multifactorial condition,” said ACOG Fellow George R. Saade, MD, chief of maternal-fetal medicine at the University of Texas Medical Branch and co-chair of the working group on biomedical research. “It depends on whether it is late preterm birth or early preterm birth. We need more research focusing on the complex system biology and multidisciplinary approaches.”

Late preterm birth

Late preterm births make up 71% of all preterm births, according to the ACOG Committee Opinion *Late-Preterm Infants* (#404, April 2008). These infants—born between 34 weeks and zero days and 36 weeks and six days of gestation—are often mistakenly believed to be as physiologically and metabolically mature as term infants. However, mortality rates for late preterm infants are three times higher than for term infants, according to the National Center for Health Statistics. Furthermore, these infants have much higher morbidity rates before initial hospital discharge and higher hospital readmission rates in their first few months of life.

According to ACOG, deliveries should not be performed before 39 weeks without a medical indication. The conference experts pointed out that there are misconceptions that preterm birth—especially late preterm birth—is not a significant problem. Therefore, the conference experts recommended that the curricula of all medical specialties include information on the risks and consequences of preterm birth and that health care providers be encouraged to

question scheduled deliveries before 39 weeks if no medical indication is evident.

nate with our audience.

“Everybody needs to be a part of the public awareness campaign, from family members and patients, all the way up to policy-makers and legislators, who can certainly help with this.”

The epidemiological research working group recommended that the US make strengthening its vital records system a national priority to better track the problem of preterm birth. States need assistance in adopting the newest standard birth certificate. The experts also recommended that first-trimester ultrasound become a routine part of prenatal care to better determine gestational age.

Next steps

Acting Surgeon General Steven K. Galson, MD, MPH, will assess the conference findings. The US Department of Health and Human Services will then submit a report to Congress.

“We as a society need to realize that preterm birth is a major cause of mortality and morbidity and a significant contributor to the increase in health care expenditures. In the ’60s, we had a war on cancer, and I think we need to do the same for preterm birth,” Dr. Saade said. “The problem is that society views pregnancy as a happy physiologic event. Nobody views pregnancy as a disease, and the impact of these preterm births can be devastating. We need to realize that pregnancy is a window to future health and can tell us a lot about the long-term outcome of both mother and baby. Prevention of many of the chronic diseases and long-term morbidities should start in the womb.” ♀

“We as a society need to realize that preterm birth is a major cause of mortality and morbidity and a significant contributor to the increase in health care expenditures.”

—George R. Saade, MD



Raising awareness

ACOG Fellow Nelson L. Adams III, MD, pointed out that there is a lack of awareness among women and society as a whole about the possibility of preterm birth. Dr. Adams cochaired the public communications and outreach working group and is the immediate past president of the National Medical Association and chair of the ob-gyn department at Jackson North Medical Center in North Miami Beach, FL.

“To increase awareness, we need a national education and action campaign that explains what we know about preterm birth and how to reduce it,” Dr. Adams said. “We need to communicate poignant stories that will reso-

WWW.NBCAM.ORG



Breast cancer resources

Materials are now available to help you promote National Breast Cancer Awareness Month in October. The official website has a wealth of information for you and your patients, including promotional materials such as sample press releases, public service announcements, and proclamations.

Discussing STD risks of noncoital sex with patients

A NEW COMMITTEE OPINION addresses the risks associated with noncoital sexual behavior, which includes oral sex, mutual masturbation, and anal sex. *Addressing Health Risks of Noncoital Sexual Activity*, which was published in the September issue of *Obstetrics & Gynecology*, presents specific counseling strategies for practitioners.

Noncoital sexual behaviors are common in both adults and adolescents and commonly occur with—not instead of—coital behaviors, including among teen girls. The prevalence of oral sex among adolescents jumps dramatically in the first six months after initiation of vaginal intercourse, suggesting that both are often initiated at the same time and with the same partner, according to the Committee Opinion.

Certain sexually transmitted diseases can be transmitted during noncoital sexual activity. STD risk and prevention depend on many factors, including the number of sexual partners, community prevalence, the behavior of a woman's sexual partner, and access to screening and treatment services.

The document addresses the various types of STDs and the risks of acquiring each one of them through different types of noncoital sexual behavior.

Ask specific, direct questions

Each patient will define “sex” in a variety of ways, so the Committee Opinion stresses that it's important that practitioners ask direct questions regarding sexual activity, including questions about oral and anal sex; mutual masturbation; and sexual partners, specifically asking whether the patient has had sex with men, women, or both. Lesbians and bisexual women should be screened based on the same risk factors as other women.

“To individualize counseling, the clinician must consider the woman's infection risk from partner factors (number of sexual partners and her partners' sexual behaviors, particularly sexual partnerships) and the community prevalence of STDs,” the Committee Opinion



states. “Because most women who engage in noncoital sexual activity also are engaging in penile-vaginal intercourse, the clinician needs to consider whether noncoital behaviors add any additional risks to those already posed by sexual intercourse. When a young person engages in only oral or anal sex, the likelihood of encountering a partner infected with an STD should be considered. Correct and consistent condom use should be encouraged, especially for anal sex and vaginal sex. Practitioners should also consider the patient's history of STDs and patterns of barrier method use with each partner. In brief, practitioners need to consider the totality of the patient's STD risk.” ♀



Perinatal HIV testing guidelines updated

ACOG HAS UPDATED ITS PERINATAL HIV testing recommendations and will soon be reaching out to Fellows and Junior Fellows in specific states to inform them about their individual state's HIV testing laws.

The ACOG Committee Opinion *Perinatal and Perinatal Human Immunodeficiency Virus Testing: Expanded Recommendations* was published in the September issue of *Obstetrics & Gynecology*.

This fall ACOG will mail packets of perinatal HIV resources to Fellows and Junior Fellows in 10 states whose laws allow opt-out HIV testing. The packets will include a chart of ACOG's perinatal HIV recommendations comparing them with that specific state's laws. Members will also receive a copy of their state law and updated versions of ACOG's HIV and pregnancy tearpad and physician script.

The packet is being distributed as part of an ACOG cooperative agreement with the Centers for Disease Control and Prevention. ♀

info

- rcarlson@acog.org
- On the ACOG website, under “Women's Issues,” click on “HIV”

WWW.MENTALHEALTHSCREENING.ORG

Screening patients for depression

Ob-gyns are encouraged to screen patients for mental health disorders next month as part of National Depression Screening Day on October 10. Fellows can raise awareness about depression and postpartum depression among their patients throughout the month.

info

- Screening kits are available on the National Depression Screening Day website, www.mentalhealthscreening.org, but there is a fee for the kits

Do your hospital's practices support breastfeeding?

WHETHER IT'S GIVING free formula samples to new moms, supplementing healthy breast-fed newborns with water, or separating mothers and newborns after birth, hospitals and birth centers across the US have practices that are not fully supportive of breastfeeding, according to a new study.

A Centers for Disease Control and Prevention survey of 2,690 US birth facilities found a substantial prevalence of maternity practices that are not evidence-based and are known to interfere with breastfeeding, according to the report published in the June 13 issue of *Morbidity and Mortality Weekly Report*.

"Although the results aren't surprising to breastfeeding advocates, this study is important because it's the first national study from a federal organization that looks at the maternity care practices and their impact on breastfeeding," said Fellow Sharon B. Mass, MD, an editor of *Breastfeeding Handbook for Physicians*, published by ACOG and the American Academy of Pediatrics.

ACOG recommends exclusive breastfeeding until an infant is six months old, while promoting that a longer period of breastfeeding is beneficial. A national health survey released in April reported that the percentage

of US infants who were ever breastfed had reached 77%, surpassing the national Healthy People 2010 goal of 75%. However, there was no significant change in the rate of breastfeeding at six months, which remains at about 41%, lower than the 50% goal, according to federal statistics.

In the CDC survey, the facilities were scored in seven categories. The lowest score was for the "breastfeeding support after discharge" category. In this subscale, 70% of facilities gave new moms discharge bags that contained infant formula samples, a practice that studies have shown reduces breastfeeding rates. In the "newborn feeding" category, 24% of facilities reported giving supplements, such as formula, water, or sugar water, as a general practice with more than half of all healthy, full-term breastfeeding newborns, which is unnecessary and detrimental to breastfeeding.

While the study focused on hospital practices, individual ob-gyns can encourage breastfeeding among their patients, as well as effect change in hospitals. ACOG encourages ob-gyns to ask if their hospital participated in the study and to compare the hospital's scores with the national scores to help focus improvement efforts. CDC has sent each hospital its individual benchmark report.



CONNECT WITH OTHER BREASTFEEDING ADVOCATES

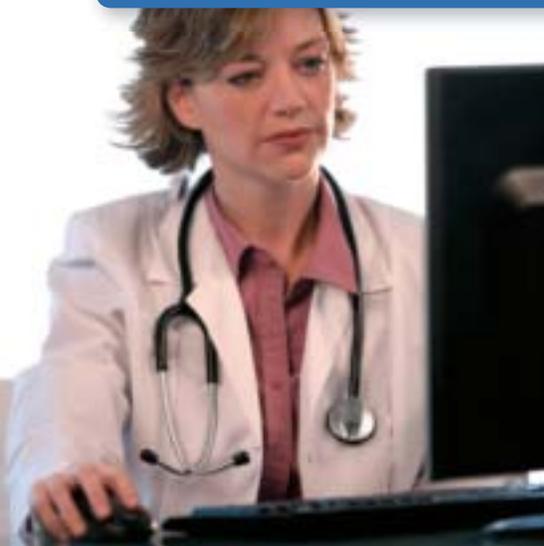
Fellow Sharon B. Mass, MD, is working to reinvigorate ACOG's special interest group on breastfeeding and encourages interested ACOG members to contact her at sbmass@pol.net.

Ob-gyns can promote supportive practices such as making sure a baby is breastfed in the first hour after birth and is fed only breast milk in the hospital and ensuring that routine infant procedures are performed while mother and newborn remain skin to skin, Dr. Mass said. ♀

info

- Breastfeeding report in *MMWR*: www.cdc.gov/mmwr/preview/mmwrhtml/mm5723a1.htm
- *Breastfeeding Handbook for Physicians and Patient Education Pamphlet Breastfeeding Your Baby*: <http://sales.acog.org>; 800-762-2264
- Committee Opinion *Breastfeeding: Maternal and Infant Aspects* (#361, February 2007) www.acog.org/publications/committee_opinions/co361.cfm

'DEAR DOCTOR' PATIENT SAFETY ALERTS NOW AVAILABLE BY EMAIL



ACOG MEMBERS ARE ENCOURAGED to sign up for the new Health Care Notification Network, which sends drug alert notifications to physicians by email, replacing the antiquated and slower paper-based alerts.

These "dear doctor letters" deliver important patient safety alerts that are product-related and mandated by the US Food and Drug Administration. Enrollment is free for all licensed US physicians.

Physicians can add up to three other email addresses to their account, allowing them to

designate staff members to receive the alerts. Physicians who do not sign up for the email alerts will continue to receive the paper alerts, typically a few weeks after the emailed alerts.

HCNN is being promoted by most major medical liability carriers because of its ability to reduce notification delays and, thus, reduce medical liability. ♀

info

- To enroll, on the ACOG website, www.acog.org, see the Health Care Notification Network link under "Announcements" or visit www.hcnn.net

2008 CALENDAR

PLEASE CONTACT THE INDIVIDUAL ORGANIZATIONS FOR ADDITIONAL INFORMATION.

SEPTEMBER

4-6
American Urogynecologic Society 29th Annual Scientific Meeting

Chicago
www.augs.org
 202-367-1167

5-7
ACOG District I Annual Meeting

Brewster, MA
 202-863-2531

5-7
ACOG District IV Annual Meeting

Orlando, FL
 202-863-2441

9
ACOG WEBCAST: E/M Coding and Medical Necessity

1-2:30 pm ET
 800-673-8444, ext 2498

11-13
American Gynecological and Obstetrical Society

Carlsbad, CA
www.agosonline.org
 202-863-2648

17-20
Royal College of Obstetricians and Gynaecologists 7th International Scientific Meeting

In conjunction with ACOG and the Society of Obstetricians and Gynaecologists of Canada
 Montreal, QC
www.rcog2008.com

17-20
Association of Reproductive Health Professionals Annual Meeting

Washington, DC
www.arhp.org
 202-466-3825

17-20
Society of Laparoscopic Surgeons 17th Annual Meeting & Endo Expo

Chicago
www.laparoscopy.org
 305-665-9959

17-21
American Academy of Family Physicians Scientific Assembly

San Diego
www.aafp.org
 800-274-8043

21-25
Annual World Congress for the International Society for the Study of Hypertension in Pregnancy

Washington, DC
www.isshp2008-washington.org
 202-877-8141

24-27
North American Menopause Society 19th Annual Meeting

Orlando, FL
www.menopause.org
 440-442-7657

26-28
ACOG District VII, VIII, and XI Annual Meeting

Los Cabos, Mexico
 202-863-2542

OCTOBER

11-14
American Academy of Pediatrics National Conference & Exhibition

Boston
www.aap.org
 847-434-4000

12-15
ACOG Armed Forces District Annual Meeting

Norfolk, VA
 202-863-2571

12-16
American College of Surgeons 94th Annual Clinical Congress

San Francisco
www.facs.org/clincon2008
 312-202-5000

14
ACOG WEBCAST: Physician Employment Contracts

1-2:30 pm ET
 800-673-8444, ext 2498

15-19
Pacific Coast Obstetrical and Gynecological Society

Victoria, BC
www.pcogs.org
 650-723-8156

17-19
ACOG District V Annual Meeting

Cincinnati
 202-863-2574

22-25
Central Association of Obstetricians and Gynecologists

New Orleans
www.caog.org
 701-838-8323

23-26
Academy of Breastfeeding Medicine 13th Annual International Meeting

Dearborn, MI
www.bfmed.org

24-26
ACOG District II Annual Meeting

New York City
 518-436-3461

28-Nov 1
The 37th Global Congress of Minimally Invasive Gynecology—American Association of Gynecologic Laparoscopists Annual Meeting

Las Vegas
www.aagl.org
 714-503-6200

31-Nov 5
Association of American Medical Colleges Annual Meeting

San Antonio
www.aamc.org
 202-828-0553

NOVEMBER

8-11
American Medical Association Interim Meeting

Orlando, FL
www.ama-assn.org

8-12
American Society for Reproductive Medicine 64th Annual Meeting

San Francisco
www.asrm.org
 205-978-5000, ext 114

13-15
Council of Medical Specialty Societies Annual Meeting

Chicago
www.cmss.org
 847-295-3456

18
ACOG WEBCAST: Evaluation and Management of Diabetes in Pregnancy

1-2:30 pm ET
 800-673-8444, ext 2498

DECEMBER

9
ACOG WEBCAST: Preview of New Codes for 2009

1-2:30 pm ET
 800-673-8444, ext 2498

ACOG COURSES

- For Postgraduate Courses, call 800-673-8444, ext 2540/2541, weekdays 9 am-4:45 pm ET or visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings"
- For Coding Workshops, visit www.acog.org and click on "Postgraduate Courses and CPT Coding Workshops" under "Meetings." Telephone registration is not accepted for Coding Workshops.

Registration must be received one week before the course. On-site registration subject to availability.

SEPTEMBER

12-14
ICD-9-CM and CPT Coding Workshop

Chicago

18-20
Update on Cervical Diseases

Charleston, SC

26-28
ICD-9-CM and CPT Coding Workshop

Dallas

NOVEMBER

6-8
Practical Obstetric and Gynecologic Ultrasonography: Spotlight on Chronic Pelvic Pain

Naples, FL

14-16
ICD-9-CM and CPT Coding Workshop

Atlanta

20-22
New Surgical Approaches to Incontinence and Prolapse

Chicago

DECEMBER

4-6
The Art of Clinical Obstetrics

New York City

5-7
ICD-9-CM and CPT Coding Workshop

Las Vegas

ACOG treasurers invited to conference

CURRENT AND INCOMING DISTRICT treasurers and new section treasurers are invited to ACOG's 11th Annual Treasurers Conference, Jan 17–18, 2009, in Orlando, FL. Other officers and administrators responsible for their district's or section's financial management are also invited. There is no registration fee for attending.

The conference is a two-day educational meeting designed to train officers and administrators in the financial management of their district or section and update them on new ACOG policies and changes in tax laws.

Presenters will include ACOG finance staff, national and district officers, and outside investment managers. ♀



info

→ Conference registration is free, but participants must register by December 19. Contact Steve Cathcart: 800-281-1551; scathcart@acog.org



Call for 2009 ACM participation

THE ACOG COMMITTEE ON SCIENTIFIC program is inviting submissions of abstracts of paper or poster presentations on any topic related to ob-gyn for the 2009 Annual Clinical Meeting, to be held May 2–6 in Chicago. All abstracts must be submitted online.

The committee also welcomes online submission of abstracts of films for the 2009 Film Festival on topics of interest to practicing ob-gyns. For submission details and the online application, visit www.acog.org/acm.

Deadlines for online submission

- ▶ Paper/poster abstracts: September 12
- ▶ Film Festival abstracts: November 5 ♀



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on ACOG's revised pamphlets.



Endometriosis (AP013)

- ▶ Explanation of endometriosis and possible causes
- ▶ Symptoms and diagnosis
- ▶ Treatments and their side effects



Cancer of the Uterus (AP097)

- ▶ Risk factors for uterine cancer
- ▶ Symptoms
- ▶ How it is diagnosed and treated



NOW AVAILABLE IN SPANISH

Nutrition During Pregnancy (SP001)

- ▶ Daily food choices for a healthy pregnancy
- ▶ Table listing basic nutrients, why they are needed, and good sources for each
- ▶ Healthy weight gain during pregnancy, including a body mass index table

info

- To preview these pamphlets: www.acog.org/goto/patients
- To order pamphlets: <http://sales.acog.org>; 800-762-2264 (use source code DM68 1006)
- To request a free sample: resources@acog.org