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NEW VBAC GUIDELINES:

What they mean to you and your patients

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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: INMAGINE

Working to increase healthy births

Richard N. Waldman, MD, President

CHILDBIRTH is a joyous, safe experience for most mothers in the US, and ob-gyns play the leading role in delivering their care. Yet the US lags behind other industrialized nations in healthy births, and we know very little about why. The growing rate of maternal deaths in this country is a significant and deeply troubling problem. The US maternal mortality ratio has doubled in the past 20 years, reversing years of progress. Increasing cesarean deliveries, obesity, increasing maternal age, and changing population demographics each contribute to the trend.

In 2008 the cesarean delivery rate reached another record high—32.3% of all births. There is a community not far from my home in which 45% of the newborns are delivered via an abdominal incision. Let me be very honest. This increase in cesarean delivery rate grieves me because it seems as if we are changing the culture of birth. While it is certainly true that a physician has a contract with an individual patient, our specialty has a covenant with our society.

The College's new guidelines for VBAC are expected to help address the rising cesarean rate, making trial of labor after cesarean an option for more women. Our Committee on Practice Bulletins-Obstetrics worked tirelessly to review data and evidence, including the 2010 findings of the NIH Consensus Development Conference on Vaginal Birth after Cesarean, to develop our new Practice Bulletin, *Vaginal Birth After Previous Cesarean Delivery*, described on page six.

Ob-gyns must keep moving ahead to tackle all factors contributing to the maternal mortality rate. While the recently enacted health care reform law will expand access to prenatal care, research is critically needed to understand how our nation can drive down maternal and infant mortality and prematurity rates. Effective research based on comprehensive data is the key to developing, testing, and implementing evidence-based actions. Other countries have developed robust approaches to maternal mortality and the US should follow their lead.

ACOG's "Making Obstetrics and Maternity Safer" (MOMS) initiative is a comprehensive, multi-pronged approach to this challenge. The goals of MOMS include understanding and reducing premature births, improving data collection on maternal and infant health, and focusing on obesity research and prevention. *ACOG Today* will include more on MOMS next month.

We are committed to leading this improvement as part of our imperative to make motherhood as safe as possible. The US Congress and government have important roles to play by helping fund major research to understand and ensure safe births and healthy babies.

I know each of you is committed to making every birth healthy and safe in your practices, and I commend you for the diligent work you do every day.

Thank you.

Submit papers, posters, and DVDs for the 2011 ACM in Washington, DC, April 30–May 4

The Committee on Scientific Program invites you to submit an abstract for an oral paper or poster presentation and/or DVD for the film festival on topics of interest to practicing ob-gyns. Visit www.acog.org/acm. The online submission deadline for oral papers or posters is September 24, and the deadline for film festival abstracts is October 15.

Apply today for a 2011–2012 committee appointment

Ralph W. Hale, MD, Executive Vice President

ALL COLLEGE AND CONGRESS committee members are appointed for one-year terms beginning the day after the new president is inaugurated at the spring Annual Clinical Meeting. A committee member may be reappointed for a total of three terms, and can serve for an additional two years if the member becomes committee chair. The Executive Boards of The Congress and The College create, abolish, and define functions of their respective committees.

The process for appointment to a committee for the following year begins in the summer after the ACM. Application forms for committee service are placed on the ACOG website, www.acog.org, and must be completed and received at the national office in Washington, DC, by early September. For 2010, the deadline date is September 10.

Following receipt of the applications, staff review the requests and compile a list, by committee, from which the selections will be made by the president elect. There are several principles that affect the appointments because many committees have special requirements. To serve on an obstetric committee, for example, you must be actively providing obstetric care. Another principle states that, in general, no more than two members from the same district may serve on a committee. For a 2011–2012 appointment, no committee member can have a relationship with the pharmaceutical or device industry except in relation to clinical investigations or studies conducted in accordance with government regulations.

In an average year, we receive more than 400 applications. With annual openings limited to about 60 or 70, we regret that many very qualified individuals cannot be appointed to a committee. Repeated applications improve your chances of being appointed, but the most important factor is your involvement in district and section activities. District chair recommendations are very influential and prior exposure to Congress and College activities is helpful in distinguishing you from another applicant.

Committee members are responsible for making critical decisions that affect our specialty and how we practice. We encourage Fellows and Junior Fellows to consider applying for a committee position to help The College and Congress develop the best positions we can.

Ralph W. Hale MD

SHUTTERSTOCK

FREE PREGNANCY GUIDE

Tips for having a healthy pregnancy, including a message from ACOG President Richard N. Waldman, MD

Available in limited supply. Call 202-484-3321 or email communications@acog.org.

inside

Treasurers' conference

Current and incoming district treasurers and new section treasurers are invited to the 13th Annual ACOG Treasurers Conference, January 15–16, 2011, in Orlando, FL. Other officers and administrators responsible for the financial management of their districts or sections are also invited. There is no registration fee. The two-day educational meeting trains officers and administrators in the financial management of their districts or sections, and updates them on new ACOG policies and changes in tax laws. Presenters will include ACOG finance division staff, national and district officers, and outside investment managers. Contact Steve Cathcart at 800-281-1551 or scathcart@acog.org for information. The registration deadline is December 17.

ARE YOU REGISTERED?

ANNUAL DISTRICT MEETINGS 2010

SAVANNAH, GA: DISTRICT IV
October 1–3

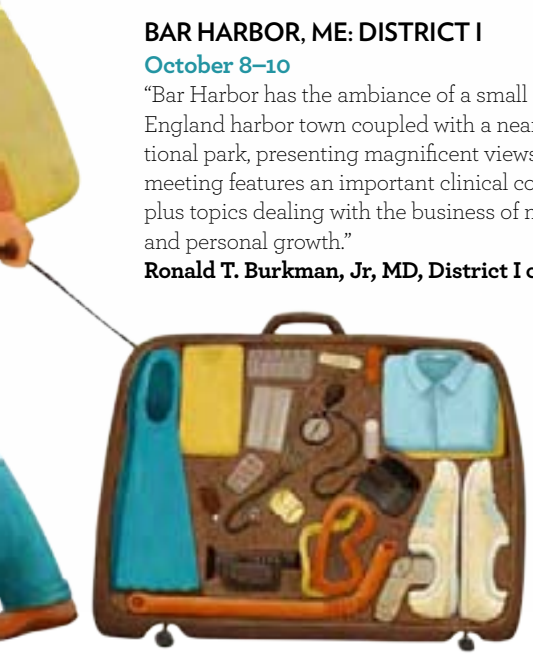
"Enjoy our fun-filled Stump the Professors competition between residents and Fellows, outstanding speakers on current topics, and a taste of some southern charm on the harbor lawn. Party at the Saturday night gala, and bring the family to Oktoberfest on the River on historic River Street."

Alfred H. Moffett, Jr, MD, District IV chair

BAR HARBOR, ME: DISTRICT I
October 8–10

"Bar Harbor has the ambiance of a small New England harbor town coupled with a nearby national park, presenting magnificent views. The meeting features an important clinical course plus topics dealing with the business of medicine and personal growth."

Ronald T. Burkman, Jr, MD, District I chair



KEY BISCAYNE, FL: DISTRICTS III AND VI
October 8–10

"The excellent scientific program includes an update on the evaluation and treatment of cervical diseases, plus outstanding College postgraduate training. The multi-district format allows members of both districts to meet new Fellows and Junior Fellows and enjoy old acquaintances."

Owen C. Montgomery, MD, District III chair

MAUI, HI: DISTRICTS VII, VIII, IX, AND XI
October 14–16

"This year's program, 'Reawakening the Excitement of Ob-Gyn,' includes impressive faculty and is augmented by excellent lectures, the Lonnie Burnett Film Festival, and a fascinating patient safety presentation by a physician pilot. Plus, enjoy the 'Whales and Reefs' marine science program and the recently remodeled Grand Wailea Resort."

J. Joshua Kopelman, MD, District VIII chair

SAN ANTONIO, TX: ARMED FORCES DISTRICT
October 17–20

"Come for the phenomenal setting, outstanding educational program, superb paper presentations, inter-service Jeopardy, and Riverwalk Olympics. Enjoy the excellent camaraderie among our Junior Fellows, young physicians, and Fellows, and experience the best fajitas on the planet."

Christopher M. Zahn, MD, Armed Forces District chair

CANCUN, MEXICO: DISTRICT V
October 20–23

"We will gather in beautiful Cancun amidst lively and leisurely attractions, wonderful shopping, and dining opportunities. In addition to the first class scientific program, attendees can visit nearby Mayan sites or simply relax on The Ritz-Carlton's white-sand beachfront."

Robert P. Lorenz, MD, District V chair

NEW YORK CITY: DISTRICT II
October 29–31

"New York's premier women's health care event of the year offers attendees the opportunity to roll up their sleeves and practice laparoscopic techniques. Have a total hands-on experience using the most current technology available to the gynecologic surgeon, including robotics. Take in a Broadway show, and historic landmarks."

Scott D. Hayworth, MD, District II chair

INFORMATION:
Learn about each meeting and how to register at www.acog.org/goto/districtMeetings

CORRECTION: John W. Calkins, MD, is the District VII member of the Committee on Nominations, not J. Martin Tucker, MD. Dr. Tucker was incorrectly listed as the District VII member in the July issue of *ACOG Today*. Visit www.acog.org and click on "National Officers Nominations Process" under "Membership" for information on ACOG's national elections.

SHUTTERSTOCK

NEW MESSAGE FOR JUNIOR FELLOWS

get involved, stay involved

CYNTHIA A. BRINCAT, MD, PHD, chair of the Junior Fellow Congress Advisory Council (JFCAC), has made her priorities clear—sustaining Junior Fellows in ob-gyn by increasing Junior Fellow involvement in ACOG and keeping Junior Fellow leaders active in ACOG once they leave the JFCAC. Elected at the ACM in May, Dr. Brincat is past Junior Fellow chair of District V and a fellow in female pelvic medicine and reconstructive surgery at the University of Michigan Medical Center.

Under Dr. Brincat's leadership, the JFCAC is publicizing a database of Junior Fellows who have expressed an interest in being involved in ACOG and in section-level legislative efforts. The database will include those who have run for committee appointments or leadership positions, but haven't yet found a traditional role in ACOG. "The JFCAC is well positioned to get these individuals involved in service projects, legislative activities, medical student outreach, and other similar ACOG initiatives," Dr. Brincat said.

"ACOG offers Junior Fellows great opportunities to be leaders," Dr. Brincat said. "But once formal involvement ends, there seems to be a chasm between those at the Junior Fellow level and others who are active in ACOG governance," she said. She plans to involve former JFCAC members in planning courses, communicating with outside organizations, and identifying new future ACOG leaders.

The JFCAC is also developing a "Dealing with Adverse Events" project that will include a discussion of the effect of adverse events on physicians, the institutional environment in which these events take place, and the best ways to deal with them.

Learn more about Junior Fellows at www.acog.org. Click on "Junior Fellows" under "Membership."

VOTE

Vote online in the Junior Fellow district elections, August 1–31.

Log on to eballot.votenet.com/acog.

Guaranteed renewability

Are you ready for more patients?

UNDER NEW HEALTH CARE REFORMS, health insurance providers will be obligated to continue a patient's coverage, as long as premiums are paid on the policy. This guarantee in renewability is excellent news for women, as it means fewer will be denied the coverage they need.

Guaranteed renewability, which will take effect January 1, 2014, is also expected to generate an increase in the number of patients seeking care. Although this change is several years away, said Mark S. DeFrancesco, MD, MBA, ACOG secretary and chief medical officer at Women's Health Connecticut in Avon, CT, the time to start preparing for it is now.

"This could have a very positive effect on the practices of our Fellows," he said. "Quite simply, if more women are covered, more women will seek care. We should be thinking about increasing our capacity to see more patients and providing them with the same high quality care."

But what is the best way to prepare for this possible patient load increase? Historically, it would have meant adding staff. However, both Dr. DeFrancesco and Scott D. Hayworth, MD, District II chair and president and chief executive officer of the Mount Kisco Medical Group in Mount Kisco, NY, are convinced that although evaluating staffing needs is important, transitioning practices to an electronic health records (EHR) system is the best way to begin preparing for the future today—plus, there are financial incentives to set one up now.

Electronic health records are key

"The only way to handle a large amount of patient data, including histories, medical records, prescriptions, lab reports, reminders for follow-ups, and so on, is electronically," said Dr. DeFrancesco. "Not having that capability will limit your growth in the short term and will possibly preclude you from even participating in the health care 'system' that is evolving."

Dr. Hayworth agrees. "Fellows will need electronic medical records in order for their practices to remain viable," he said. "They should also take advantage of the federal money provided for EHRs to install them in their practices."

There are several programs under which a physicians' practice or medical center can qualify for federal stimulus funds—and the sooner a practice adopts this technology, the more money it will be eligible to receive. Eligible physicians who treat Medicare patients can qualify for up to $44,000 over a five-year period (2011 to 2015) or up to $63,750 for treating Medicaid patients.

In addition to establishing an electronic environment, it's also important for ob-gyns to take a step back and evaluate their practices from a broad perspective. "Fellows should take inventory of their current resources, particularly the number and types of providers in their practices, as well as the physical space in which they see patients," Dr. DeFrancesco said. "They should consider new ways to work more efficiently. Can they expand their practice's hours, for instance, and have multiple shifts of providers in the office at different times? Can they cross cover with other providers so they can provide care as more of a team?"

Consider hiring mid-level staff

Dr. Hayworth suggested that ob-gyn practices consider hiring mid-level staff. "More patients being covered will be good for physicians if they have the capacity to see them," he said. "Since reimbursements overall are expected to drop, ob-gyns should consider hiring more affordable mid-level health care professionals such as physician assistants and nurse practitioners to round out their staffs."

Despite the positive changes anticipated for women's health, including guaranteed renewability, health care reform is expected to bring both opportunity and challenge—and Fellows should continually monitor news and information on reform. "I think it is wonderful for patients not to have to worry about renewability," Dr. Hayworth said. "However, I have concerns about the new law. It did nothing about liability and our Fellows may be unable to keep their practices viable because of the rising costs and risks of liability."

"Change can be hard to embrace," Dr. DeFrancesco added. "Yet we all know the current system cannot continue its upward cost spiral. At the same time we do not want to ration health care and depersonalize it by 'rationing' it to the extreme. We need to be out in front on this, proactively adapting to the changes that are coming. A wise man once told me, 'Predicting the rain is important, but building the ark is essential.'"

ACOG welcomes the extension of medical care to much greater numbers of women who otherwise would not have health coverage and would not seek care.

SHUTTERSTOCK, ISTOCK

New VBAC guidelines

What they mean to you and your patients

THE RATE OF CESAREAN DELIVERY in the US has increased dramatically over the past four decades—from 5% in 1970 to 32.3% in 2008—and a contributing factor behind this increase is a decline in the number of vaginal births after cesareans (VBACs).

This decrease in VBACs is due to a number of factors, such as decisions by patients not to have VBACs, the restrictions that some hospitals and insurers have placed on trial of labor after cesarean (TOLAC), and the medical liability environment in general. VBACs have been in steady decline since 1996 and fell to only 8.5% in 2006. Yet, it's estimated that 60–80 percent of appropriate candidates who attempt VBAC will be successful.

Earlier this year, the National Institutes of Health convened a Consensus Development Conference to evaluate, discuss, and raise awareness about this complex topic. After the conference, the conference panel offered a statement, "Vaginal Birth After Cesarean: New Insights." They acknowledged there are many "clinical uncertainties" when it comes to VBACs, yet given the available evidence, they believe trial of labor is a reasonable option for many pregnant women with one prior low transverse uterine incision.

During his inaugural address at the Annual Clinical Meeting (ACM) in May, ACOG President Richard N. Waldman, MD, said a new sense of urgency must be placed on reducing the rate of cesarean deliveries and asked Fellows to "recommit to do everything in our power to reduce the cesarean rate."

ACOG guidelines state VBACs are "safe and appropriate" for most women

In August 2010, the College issued a new Practice Bulletin, *Vaginal Birth After Previous Cesarean Delivery*, that states that attempting a VBAC is a safe and appropriate choice for most women who have had a prior cesarean delivery, including for some women who have had two previous cesareans.

Consistent with past recommendations, most women with one previous cesarean delivery with a low-transverse incision are candidates for and should be counseled about VBAC and offered a TOLAC. In addition, "The College guidelines state that women with two previous low-transverse cesarean incisions and women carrying

ISTOCK, INMAGINE

twins may be considered appropriate candidates for a TOLAC, and TOLAC is not contraindicated for some women with an unknown type of uterine scar," said Jeffrey L. Ecker, MD, of Massachusetts General Hospital in Boston and immediate past vice chair of the Committee on Practice Bulletins-Obstetrics.

Physicians and patients should discuss all benefits and risks

"These VBAC guidelines emphasize the need for thorough counseling of benefits and risks, shared patient-doctor decision making, and the importance of patient autonomy," said Dr. Waldman.

In making plans for delivery, ob-gyns and patients should consider a woman's chance of a successful VBAC as well as the risk of complications from a trial of labor, all viewed in the context of her future reproductive plans. Physicians and patients should discuss specific benefits and risks including:

"The College guidelines state that women with two previous low-transverse cesarean incisions and women carrying twins may be considered appropriate candidates for a TOLAC ..."

OVERALL BENEFITS: A VBAC avoids major abdominal surgery, lowers a woman's risk of hemorrhage and infection, and shortens postpartum recovery. It may also help women avoid the possible future risks related to having multiple cesareans, such as hysterectomy, bowel and bladder injury, transfusion, infection, and abnormal placenta conditions (placenta previa and placenta accreta).

OVERALL RISKS: Both repeat cesarean and a TOLAC carry risks including maternal hemorrhage, infection, operative injury, blood clots, hysterectomy, and death. Most maternal injury that occurs during a TOLAC happens when a repeat cesarean becomes necessary after the TOLAC fails. A successful VBAC has fewer complications than an elective repeat cesarean while a failed TOLAC has more complications than an elective repeat cesarean.

UTERINE RUPTURE RISK: The risk of uterine rupture during a TOLAC is low—between 0.7% and 0.9%—but if it occurs, it is an emergency situation. A uterine rupture can cause serious injury to a mother and her baby. The College maintains that a TOLAC is most safely undertaken where staff can immediately provide an emergency cesarean, but recognizes that such resources may not be universally available.

Promoting the safest environment, planning for emergencies

"Given the onerous medical liability climate for ob-gyns, interpretation of ACOG's earlier guidelines led many hospitals to discontinue VBACs altogether," said Dr. Waldman. "Our primary goal is to promote the safest environment for labor and delivery, not to restrict women's access to VBAC."

Women and their physicians may still make a plan for a TOLAC in situations where there may not be "immediately available" staff to handle emergencies, but it requires a thorough discussion of the local health care system, the available resources, and the potential for incremental risk.

"It is absolutely critical that a woman and her physician discuss VBAC early in the prenatal care period so that logistical plans can be made well in advance," said William A. Grobman, MD, from Northwestern University in Chicago. Hospitals that lack "immediately available" staff should develop a clear process for gathering them and all hospitals should have a plan in place for managing emergency uterine ruptures, however rarely they may occur.

The guidelines emphasize that restrictive VBAC policies should not be used to force a woman to undergo a repeat cesarean delivery against her will if, for example, a woman in labor presents for care and declines a repeat cesarean delivery at a center that does not support TOLAC. On the other hand, if, during prenatal care, a physician is uncomfortable with a patient's desire to undergo VBAC, it is appropriate to refer her to another physician or center.

Moving forward

"The current cesarean rate is undeniably high and absolutely concerns us as ob-gyns," Dr. Waldman said. "Moving forward, we need to work collaboratively with our patients, our colleagues, hospitals, and insurers to swing the pendulum back to fewer cesareans and a more reasonable VBAC rate."

Information:

- Practice Bulletin #115, *Vaginal Birth after Previous Cesarean Delivery*, August 2010 issue of *Obstetrics & Gynecology*
- National Institutes of Health Consensus Development Conference Statement, "Vaginal Birth After Cesarean: New Insights," March 8–10, 2010

http://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf

ACOG LEADERS PARTICIPATE FREQUENTLY IN MEDIA INTERVIEWS and are featured on radio, in print, and on television. On July 26, ACOG President Richard N. Waldman, MD, explained ACOG's new VBAC guidelines on National Public Radio during an interview on the Brian Lehrer Show. "It's important for a woman to discuss the issues with her ob-gyn early in the prenatal process so she can make an informed decision," he said.

Cervical cancer screening in adolescents

CERVICAL CANCER SCREENING should begin at 21 years of age, but cases do exist where Pap testing should begin earlier, according to *Cervical Cancer in Adolescents: Screening, Evaluation, and Management*, a new College Committee Opinion published in the August issue of *Obstetrics & Gynecology*. The Committee Opinion addresses these situations and continues to advise against testing for the human papillomavirus (HPV) in all adolescents.

A healthy adolescent immune system will typically resolve an HPV infection, the primary cause of cervical cancer, within two years. A compromised, weakened adolescent immune system has more difficulty fending off viral infections and may not be able to resolve HPV at all. Therefore, The College recommends that adolescents with HIV be screened for cervical cancer twice in the first year after diagnosis and annually thereafter.

It also recommends that adolescents with compromised immune systems, such as those who have received an organ transplant or those on long-term steroids, undergo screening after the onset of sexual activity. They should be screened six months apart in the first year and receive annual screenings moving forward.

Because some adolescents under the age of 21 may have received Pap tests before The College released its updated screening guidelines in December 2009, the Committee Opinion includes recommendations on how ob-gyns should proceed with screening for these patients. It recommends that any adolescent who has had one or more Pap tests with normal results should not be rescreened until age 21. The same recommendation is made for adolescents who have had a previous abnormal Pap test followed by two subsequent normal Pap test results.

For adolescents who present low- to high-grade cervical dysplasia, the Committee Opinion offers detailed recommendations. Generally, these conditions can be managed through periodic observation. When screening results show regression of the abnormal cells, rescreening can be delayed until age 21. However, if cervical intraepithelial neoplasia 3 is found, treatment is recommended.

"This Committee Opinion is important because ob-gyns who do not follow The College's recommendations can overtreat patients," Anna-Barbara Moscicki, MD, American Society for Colposcopy and Cervical Pathology liaison to the Committee on Adolescent Health Care, said. "The guidelines offered should decrease the number of young women inappropriately referred to colposcopy and/or treated, and will allow ob-gyns to focus more on STD screenings and reproductive health care for adolescents."

Information:

- ACOG Practice Bulletin #109, *Cervical Cytology Screening*, www.acog.org/publications/educational_bulletins/pb109.cfm
- "Guidelines for Prevention and Treatment of Opportunistic Infections in HIV-Infected Adults and Adolescents," www.cdc.gov/mmwr/preview/mmwrhtml/rr5804a1.htm
- American Society for Colposcopy and Cervical Pathology Consensus Guidelines, www.asccp.org/consensus.shtml

FDA warns providers not to use unapproved IUDs

FEDERAL HEALTH officials warned medical practitioners in July not to use unapproved intrauterine devices (IUDs). However, both The College and the Food and Drug Administration (FDA) emphasize that FDA-approved IUDs are safe, effective methods of birth control that can be used with confidence.

"We need to reassure our patients," said Hal C. Lawrence III, MD, vice president of Practice Activities for ACOG. "IUDs can prevent pregnancy for years at a time, and if more women used them, the unintended pregnancy rate in this country would be a lot lower. IUDs are one of the most effective methods of reversible contraception."

In a July 22 letter, the FDA reminded health professionals that using unapproved IUDs raises concerns about effectiveness and safety, as well as the potential for fraud and counterfeiting.

"Federal law requires that IUD/IUSs (intrauterine systems) be FDA-approved prior to marketing. This law is designed to protect patients," said Theresa Toigo, FDA's liaison with health professionals. FDA is investigating reported uses of non-approved IUDs. Links to the FDA communications and information regarding the regulatory status of imported IUDs is available on The College's "Practice Management and Managed Care" webpage on www.acog.org. Click on "Importing IUDs."

Information:

Clinical, coding, and other resources for long-acting reversible contraception, including IUDs, can be found at www.acog.org/goto/larc.

VEER, VECTORSTOCK

IN TIMES OF DISASTER

Lisbet Hanson, MD, holding a six-year-old boy with severe head trauma caused by the earthquake

PHYSICIANS HAVE MUCH NEEDED SKILLS in disaster relief, and ob-gyns are particularly valuable because the vulnerability of a woman's health increases exponentially in the wake of a disaster. Though many physicians may want to volunteer, they often do not know what to expect or where to begin.

A crucial first step for would-be volunteers is to connect with a reputable organization that has a track record in the affected country, according to Julie Taft, reproductive health advisor for International Medical Corps.

"Coordination is vital to relief efforts," Taft said. "Organizations that are already familiar with the country can ensure there is an appropriate allocation of resources for volunteers and can quickly prioritize the needs of the country."

In a situation like this year's Haiti earthquake, volunteers who jumped on planes and showed up to help often only added to the chaos.

Hector Tarraza, MD, caring for women and children injured in the 2010 Haiti earthquake

"Many people who came on their own had difficulty finding simple resources like food and shelter," said Taft. "If you can't take care of yourself, it's hard to take care of other people."

On the ground

ACOG Fellow Hector Tarraza, MD, was very familiar with Haiti when he traveled there just 12 days after the earthquake with a team of volunteers. Dr. Tarraza is medical director of Global Health Ministry (GHM), a non-profit organization that has been sending volunteers to Haiti since 1998 to promote women's health.

The organization had been building a maternity unit for the St. Francis De Sales Hospital in Port-au-Prince, and after the earthquake, it was the only part of the hospital left standing. GHM's first team of volunteers operated on patients in the maternity unit who were then sent outside to recover in tents. Dr. Tarraza's team of volunteers was the second to arrive.

"Our purpose was to work with staff from the hospital and set up primary care clinics," said Dr. Tarraza. "With so much need for the acutely injured, everything else can fall by the wayside. And there were a lot of pregnant women with no place to go."

Rebuilding what was lost

ACOG Fellow Lisbet Hanson, MD, has been volunteering in Haiti on and off for seven years. She was working at a hospital 45 miles outside of Port-au-Prince with an outreach program for the International Society of Ultrasound in Obstetrics and Gynecology when the earthquake hit. Dr. Hanson started her trip providing training and education in the use of ultrasound to Haitians and ended it providing emergency care to earthquake victims.

"Haiti already had chronic problems in women's health care," said Dr. Hanson. "Now, with hospitals, schools, and so many workers gone, the country needs people who are interested in working through the Ministry of Health to develop a new infrastructure and train nurses and physicians to take better care of patients."

According to Taft, a relief organization's entry point is usually a disaster, but the organization immediately begins to lay groundwork to rebuild the country's health infrastructure and resources. While it's often a disaster that raises the most attention, the ongoing provision of health services and the training of the country's health care providers is critical to mitigate damage in future disasters.

Getting involved

Ob-gyns can register with International Medical Corps (imcworldwide.org), Doctors without Borders (doctorswithoutborders.org), and others. The ACOG website has information on the International Activities web page. Go to www.acog.org, and click on "Women's Issues" and then "International Activities." You can register with the American Medical Association at ama-assn.org/go/haiti-volunteer if you are specifically interested in Haiti.

To gain experience in disaster relief, start locally. Many local organizations and Red Cross chapters hold disaster training courses throughout the year. To find your Red Cross chapter visit www.redcross.org and click on "Preparing and Getting Trained."

DO YOU KNOW AN EXTRAORDINARY OB-GYN? TELL US ABOUT HIM OR HER IN AN EMAIL TO LHUMPHREY@ACOG.ORG. WE WILL TRY TO FEATURE HIM OR HER IN A FUTURE ISSUE.

AS PART OF THE NEW HEALTH REFORM LEGISLATION, "medical homes" are being introduced as a potential way to improve patient care and manage costs. Via the medical home model, state Medicaid agencies are now authorized to require certain Medicaid patients, including those who have two or more chronic conditions, to join a medical home. Medicare will also be part of this system, and both Medicaid and Medicare medical home practices will receive compensation for the services they provide. Ob-gyn practices can establish medical homes if they choose, but most medical homes are expected to be family practice, internal medicine, or pediatric care providers.

Can an ob-gyn practice support a medical home model?

The medical home concept was first introduced in 1967 in the pediatric sector as a way to better manage care for patients with chronic conditions who require care from multiple sources. Through a medical home, these patients align with a single provider who coordinates all their care.

The goal is for the patient to get the comprehensive, preventive care he or she needs. In turn, the patient has fewer acute or costly emergency room visits and stays healthier, and overall health care costs are lower. At the same time, on a broad level, funds are freed up, so medical homes providing these services can be compensated.

Two years ago, ACOG decided to look more closely at the medical home model and formed a working group to see if it might be of value for ob-gyns. Through this analysis, says J. Craig Strafford, MD, committee member and director of Clinical Research and staff physician at Holzer Medical Center in Gallipolis, OH, the group determined that a medical home model could be of value as a care resource for women ages 15–55.

Health plans to provide free preventive care

ACOG-SUPPORTED FEDERAL REGULATIONS, issued July 14, require new private health plans to provide free preventive health services to enrollees. ACOG worked closely with Congress to win inclusion of this important part of the Affordable Care Act.

The new regulations, issued jointly by the US Departments of Health and Human Services, Labor, and the Treasury, will enable women to get the recommended screenings and immunizations to keep them healthy without worrying about copayments and deductibles. Health plans will now be required to cover preventive care provided to women under both the US Preventive Services Task Force recommendations and new guidelines being developed by an independent group of experts, including doctors, nurses, and scientists, expected to be issued by August 1, 2011.

Preventive services guaranteed in these regulations will help women have a healthy pregnancy and help safeguard them from obesity, heart disease, and breast and cervical cancers.

ACOG recognizes, too, that important work lies ahead. "Recently I met with the White House and encouraged the Administration to ensure that family planning and contraception, well-women visits, and prenatal counseling are included in the comprehensive guidelines it is developing for women's preventive services," said Richard N. Waldman, MD, ACOG president. "These guidelines should incorporate scientifically and medically sound recommendations from ACOG and should be updated as new science emerges."

Breastfeeding mothers get a break

One provision in the new health care reform law requires employers to provide unpaid break time and private space for nursing mothers to pump breast milk at work until their children turn one. Companies of less than 50 employees are not required to comply if they show "undue hardship."

"During this time in a woman's life, she requires ongoing medical services such as Pap smears, vaccinations, and mammograms," Dr. Strafford said. "So the ob-gyn model is different from the medical homes outside of ob-gyn care in that women are viewed as having a continuing 'condition' versus a disease that requires ongoing treatment."

Is now the right time?

In a paper-based environment, the majority of costs to maintain a medical home would lie in compensating staff to do the scheduling and follow-up with patients. But, for practices that have the right electronic health record (EHR) system in place, it could be an opportunity.

"Properly designed EHR systems have patient reminders built into them that can do much of this work in a fraction of the time it would take a staff person to do it," Dr. Strafford said. "An EHR is not an official requirement for a medical home, but in reality you need it to run one.

"At this time, I would advise keeping current on the changing health care reform landscape and seeing how the medical home continues to develop," Dr. Strafford said.

Information

The committee has developed a medical home toolkit, available on the ACOG website. This resource can help practices assess their interest in becoming a medical home, determine how significant the changes will be to their current practice, and make the required changes. Visit www.acog.org/departments/dept_notice.cfm?recno=19&bulletin=5203 to learn more and download the toolkit.

Visit the Agency for Healthcare Research and Quality's new patient centered medical home resource center at http://pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483.

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No link between moderate caffeine consumption and miscarriage

PREGNANT WOMEN CAN EASE THEIR MINDS about drinking a cup of coffee or having a soft drink—moderate caffeine consumption doesn't appear to cause miscarriage or preterm birth, according to The College. However, The College says it remains unclear whether high levels of caffeine consumption have any link to miscarriage, according to its Committee Opinion published in the August *Obstetrics & Gynecology*.

"For years, women have been getting mixed messages about whether or not they should have any caffeine during pregnancy," said William H. Barth, Jr, MD, chair of the Committee on Obstetric Practice. "After a review of the scientific evidence to date, daily moderate caffeine consumption doesn't appear to have any major impact in causing miscarriage or preterm birth."

Moderate caffeine consumption is considered less than 200 mg of caffeine per day. In practical terms, this equates to about 12 ounces of coffee. Caffeinated tea and most soft drinks have much less caffeine (less than 50 mg), as do the average chocolate candy bars (less than 35 mg). The committee also reviewed the scientific evidence related to caffeine's effect on fetal growth, and found no clear evidence showing that caffeine increases the risk of restricting fetal growth. When asked what this means for pregnant women, Dr. Barth said, "Given the evidence, we should reassure our pregnant patients and let them know that it's OK to have a cup of coffee."

Committee Opinion #462, *Moderate Caffeine Consumption During Pregnancy,* is published in the August 2010 issue of *Obstetrics & Gynecology*.

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Practice Updates

Committee Opinions

- 463 *Cervical Cancer in Adolescents: Screening, Evaluation, and Management*
- 462 *Moderate Caffeine Consumption During Pregnancy*
- 461 *Tracking and Reminder Systems*

Practice Bulletin

- 115 *Vaginal Birth after Previous Cesarean Section*

These documents appear in the August issue of the Green Journal, and are online under Publications at www.acog.org

ACOG COURSES AND CODING WORKSHOPS

- AUGUST 27-29, Coding Workshop, Charlotte, NC
- SEPTEMBER 21, ACOG Webcast: Physician Recovery from Medical Error
- SEPTEMBER 24-26, Coding Workshop, Nashville, TN
- OCTOBER 7-9, Quality and Safety for Leaders in Women's Health Care, Atlanta, GA
- OCTOBER 8-10, Reawakening the Excitement of Obstetrics and Gynecology, In conjunction with the District I Annual Meeting, Bar Harbor, ME
- OCTOBER 8-10, Update on Cervical Diseases, In conjunction with District III and District VI Annual Meeting, Key Biscayne, FL
- OCTOBER 12, ACOG Webcast: Diagnosis Coding for Obstetric Care Complications
- OCTOBER 14-16, Reawakening the Excitement of Obstetrics and Gynecology, In conjunction with the Districts VII, VIII, IX, and XI Annual Meeting, Maui, HI
- OCTOBER 15-17, Coding Workshop, San Antonio, TX
- NOVEMBER 9, ACOG Webcast: Cord Blood Gases: From Delivery Room to Courtroom
- NOVEMBER 19-21, Coding Workshop, Chicago, IL
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