Poll: These ObGyn "practice enhancers" shone brightly in 2010

With the year drawing to a close, we asked a cross section of your peers to reveal what especially boosted their efficacy, efficiency, and bottom line in 2010—so that you might benefit from what they discovered

Robert L. Barbieri, MD, OBG Management Editor in Chief, and members of the Virtual Board of Editors

Developed by Janelle Yates, Senior Editor

OBG Management is blessed to have readers who are world-class clinical experts in obstetrics, gynecology, and women's health. Thanks to your education, training, and experience, you are the women's health experts of America, a unique resource.

Dr. Barbieri is Kate Macy Ladd Professor of Obstetrics, Gynecology, and Reproductive Biology at Harvard Medical School and Chairman of Obstetrics and Gynecology at Brigham and Women's Hospital in Boston.

None of the contributors to this article report financial relationships relevant to their statements.

We decided to tap into this resource by inviting members of our Virtual Board of Editors to offer a clinical pearl that has helped increase their efficacy or efficiency over the past year. The pearls contained in this article are well worth your time to read. (And we welcome your contributions, as well. Simply email them to obg@qhc.com, and we will publish a compilation in the future.)

PAUL ZWOLAK FOR OBG MANAGEMENT

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As for my contribution, I have found the levonorgestrel-releasing intrauterine system (Mirena) to be invaluable in the provision of contraception and treatment of menorrhagia and pelvic pain, often averting the need for a surgical procedure. If it were more widely utilized—even in the face of a major price increase—it could reduce both the number of unintended pregnancies and hysterectomy procedures. As we become comfortable with the technique and clinical efficacy of this system, I expect utilization to increase significantly.

And now, we present eight other practice-enhancing pearls....

—Robert L. Barbieri, MD

1. Don't underestimate the value of a phone call ($20,000, in one case)

Stanley F. Franklin, MD

Three-dimensional ultrasonography (US) is nice; fancy cystometrics are helpful; and electronic health records (EHR) may or may not reduce paperwork—but all of these technologies are expensive. In this era of plummeting reimbursement, the common telephone can help you pay the overhead.

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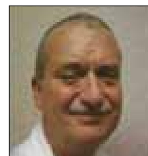
—Stanley Franklin, MD

Here's an example: Mrs. Smith, a new patient, visited my office for a consultation about her difficulty in getting pregnant. It seems that my competitor in a nearby town had failed to telephone Mrs. Smith about her lab results, despite repeated attempts to obtain them on her part. His loss, my gain. I called her back multiple times to report lab values and coordinate the ovulation induction that ensued. She conceived, became an obstetric patient, and had a vaginal delivery. Laparoscopy followed several years later for pelvic pain. A second round of ovulation induction produced another pregnancy. She was pleased and always is pleasantly surprised when she gets a personal call from me. I consider it time well spent. And I estimate that, over the years I have managed this patient, she has brought at least $20,000 into my coffers.

A phone call is cheap, effective, and shows you care. Use your phone! You're paying the monthly bill anyway! Make it work for you. It's an asset, not a liability!

Dr. Franklin practices ObGyn in Lewisville, Tex.

E. William McGrath Jr, MD

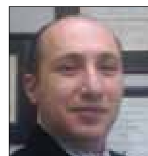


Every summer, I hire a high school student to call every patient who has not been seen in the office over the past 13 to 36 months. I provide the student, who works for the minimum wage, with a script outlining different scenarios. The script includes inquiries about the patient's current address and whether she wishes to be considered a patient of the practice. Most important, this script instructs the student to offer each patient an appointment.

Rather than waste time instructing the student how to schedule an appointment and enter the patient's data, I have the employee simply transfer the call to an office scheduler when the patient wishes to make an appointment. This strategy has proved quite successful at generating office visits at minimal cost.

Dr. McGrath is Chief of Obstetrics and Gynecology at Baptist Medical Center Nassau in Fernandina Beach, Fla.

Peyman Zandieh, MD



The one thing that has definitely made my life a little simpler is the transition from beepers and pagers to cell phones. Before this transition, I would get paged to a message. Then I would have to get to a phone and dial the number in the message. If I was in the car, this supposedly simple process was not so simple. And if the number was busy, that was another headache. Then I would have to start all over.

Now the message comes into my smartphone as a text message with the callback number right there in the message. I click on it and, right then and there, I am connected to my patient!

For private practitioners out there who deal with emergency calls and patients in labor, the new technology is a life and time saver!

Dr. Zandieh practices ObGyn in Bethpage, NY.

2. Electronic health records are better for both physician and patient

Daniel M. Avery Jr, MD

Adoption of an EHR has made the biggest difference in my practice over the past year. The EHR is an electronic version of the patient record that includes documentation of the history and physical exam, progress notes, diagnoses, medications, laboratory and radiographic studies, US imaging, and immunizations. It has proved to be integral to the efficient and effective delivery of health care to my patients. Although my institution implemented the EHR in 2002, I have come to appreciate it more every year. Here are a few of the reasons:

Improved legibility Penmanship is not a virtue of most physicians. The EHR presents the patient's record in a clear, readable format and reduces errors in care.

Portability The EHR can be viewed in the hospital, emergency room, or at home when the physician is on call.

Accessibility Multiple departments treating a patient may see one another's work-up, records, and ancillary studies.

Easier and less expensive storage With the EHR, physical storage of records is minimal. There is also a reduction in staff to care for those records.

Security and liability The EHR provides more secure records and limits access. Once it is signed, the medical record in the EHR cannot be altered.

Improved coding High-quality, more legible medical records improve the accuracy of coding and the submission of more accurate claims.

Confidentiality The EHR is more confidential than paper records by virtue of its limited and controlled access.

Improved patient care is the most important part of medicine today. By virtue of its ease of use, great security, accessibility and portability, the EHR contributes to better care.

Dr. Avery is Professor and Chair of Obstetrics and Gynecology at the University of Alabama School of Medicine in Tuscaloosa, Ala.

Some things don't help!

"The EHR interferes with my assessment of the patient"

Carolyn V. Brown, MD, MPH

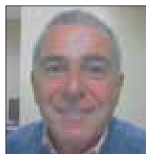
One of the most important changes in my practice has been implementation of the electronic health record (EHR). Supposedly, that is a good thing, but I have found that utility of the EHR depends on who designs it. Before the EHR, I relied largely on the patient's history to reveal clues to her condition. Now, when I go into an examination room, I have to spend precious minutes blowing through a screen of questions that a high school graduate has plugged into the computer. I no longer can spend my time observing the patient's body language or listening to her stories to detect the "second agenda" that patients inevitably bring with them on their visits. Remember: I only have 7 minutes to spend with each patient!

What in the name of evidence-based medicine are we doing? (I think I am trainable, but this waste of time is beyond the pale!)

Dr. Brown practices ObGyn in Douglas, Alaska.

"Too much paperwork!"

Anthony T. Bozza, MD



This year I have seen an increase in paperwork—precertifications, email, e-billing, and faxes. The electronic era was supposed to herald a decrease in this traffic and make it easier for us to focus on direct patient care, but I have seen an increase in both paperwork and the demands of patients! That means longer hours for less reimbursement. Although my patients always come first, they seem to want more and more of my time—not only face-to-face time but also telephone and e-mail responses. I try to do the best I can by being there for them, but I hope the paperwork demands begin to ease!

Dr. Bozza practices ObGyn in Lake Success, NY.

3. A few preoperative measures can avert complications, ease discomfort

E. William McGrath Jr, MD

When I perform a suction D&C or D&E, I administer 20 U of intravenous oxytocin preoperatively and intraoperatively to reduce the risk of uterine perforation. The firmer uterine wall lowers this risk in even the most difficult cases.

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And when I schedule a hysteroscopic tubal occlusion (i.e., sterilization), I pretreat the patient with a progestin-only minipill 1 month in advance. The birth control pill renders the endometrium completely atrophic, making the tubal ostia easy to identify.

Dr. McGrath is Chief of ObGyn at Baptist Medical Center Nassau in Fernandina Beach, Fla.

Robert del Rosario, MD

I have been performing endometrial ablations in my office for about 2 years. Over that interval, I have "tweaked" my preoperative local injection and medication regimen, based on feedback from patients, conversations with other physicians and our instrument representative, and clinical experience. Although patients tolerated the procedure, I still found myself trying to talk an occasional patient through her discomfort.

Two events led to remarkable improvement in patient comfort during ablations:

- One patient refused our then-standard preop diazepam because it made her feel "too weird." After a brief discussion, we opted to use lorazepam instead, with the understanding that I had not given the drug before as part of my protocol.
- My instrument rep mentioned that he had seen some physicians inject normal saline paracervically in cases involving intraoperative breakthrough pain. I decided to try injecting it in addition to paracervical mepivicaine preoperatively.

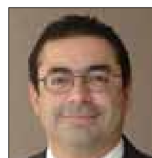
These two refinements to my traditional protocol, I feel, have dramatically reduced, and, in many cases, eliminated, intraoperative discomfort for my patients.

Dr. del Rosario practices ObGyn in Camp Hill, Pa.

> "In my 34-year career, high-resolution two-dimensional ultrasonography has been the most significant breakthrough"
>
> —John Armstrong, MD, MS

4. Evolving technology boosts value-added care

Soheil Hanjani, MD



Without a doubt, the biggest practice changer for me has been increasing use of the Essure device (Conceptus) for office hysteroscopic tubal occlusion. I place about four or five of these devices each month, after giving the patient the full range of contraceptive options. Those seeking permanent contraception appreciate this 5-minute, very-low-risk procedure, which offers minimal discomfort and a return to normal activity in 1 day.

Dr. Hanjani practices ObGyn in Brockton, Mass.

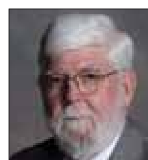
Delos Clow, MD

About 2 years ago, I began using a device called INSORB absorbable skin stapler (Incisive Surgical). This device places subcuticular staples for skin closure. Since I began using INSORB, I have noticed several benefits:

- The cosmetic result is as good as—and usually better than—that seen with skin staples.
- Seromas are less likely because this form of closure allows spontaneous wound drainage during the first 24 hours.
- Staple removal is not required, so patients are happier!

Dr. Clow practices ObGyn in Chillicothe, Mo.

Ponce D. Bullard, MD



Over the past year, I have increased my insertion rate for the Implanon contraceptive device (Schering-Plough). In my practice, Implanon has almost completely replaced the intrauterine device (IUD), thanks to issues of cost and a lack of interest in a 10-year method of contraception.

Dr. Bullard practices ObGyn in West Columbia, SC.

John Armstrong, MD, MS

In my 34-year career, high-resolution two-dimensional US has been the most significant breakthrough. Transvaginal US (office-based) for pelvic screening and diagnosis, and breast US for screening and diagnosis, have dramatically increased the accuracy of what we do on a daily basis. The technology is extremely accurate, painless, and cost-effective. I just hope that it becomes more widely available soon

despite the bureaucratic nonsense we face at every turn.

Dr. Armstrong practices gynecology and women's health in Napa, Calif.

5. Offer this simple remedy for refractory bacterial vaginosis

Mark A. Firestone, MD

Patients who experienced repeated bouts of bacterial vaginosis (BV) used to be an especially frustrating population for me. I would prescribe a myriad of antibiotics, both oral and vaginal. The patients would experience a short interval of relief, then return to my office 1 month later with the same complaints. Even prolonged courses of antibiotic therapy were of limited benefit and a great cost to them. Patients were encouraged to alter their sex habits, use yogurt formulations, and were instructed on how to properly wash themselves. These patients called my office often, demanding to be treated over the phone to avoid the expense of an office visit. As they became more frustrated, they began to doubt my abilities and sometimes sought medical care elsewhere.

One day, I discovered a probiotic blend containing 8 billion colony-forming units of various lactobacilli. I instructed my patients who were bothered by recurrent BV to use this product at least twice daily. Although the probiotic is usually taken orally, I had several patients who used it vaginally. The results have been astounding!

Now, I rarely see a patient who has recurrent BV complaints. Patients also report that they experience less abdominal bloating and improved bowel function after using the product.

This approach seems to me to be much more effective and safer than serial antibiotics. What a pleasure not to receive so many telephone calls with complaints of recurrent vaginal discharge and odor!

Dr. Firestone practices Gynecology in Aventura, Fla.

"In the long run, if we are truly committed to improving safety, then economics will have to become a secondary consideration"

—William H. Deschner, MD

6. A change in practice can boost your quality of life

William H. Deschner, MD

About 18 months ago, I made a decision to leave private practice (after 33 years!) and take a position as an OB hospitalist. The move turned out to be a good one. I now enjoy freedom from the daily worries of running a business and securing reimbursement. The tradeoff? I no longer have my own patients or perform gynecologic surgery. Although I miss these aspects of practice, the change has been worthwhile. With the OB hospitalist model, patient safety is enhanced, as are the lifestyle of the attending physician and job satisfaction for the hospitalist.

I am glad to be involved in this model of care from the early days of its evolution. Although many questions remain unanswered—not the least of which is whether the model can achieve long-term economic viability—I believe the improvement in safety justifies its existence. In the long run, if we are truly committed to improving safety, then economics will have to become a secondary consideration.

Dr. Deschner practices as an OB hospitalist in Seattle, Wash.

7. Pap recommendations simplify care of young patients

Takeko Takeshige, DO

In February 2010, the New York State Medicaid program fully endorsed ACOG's new recommendations on Pap testing, which call for no screening at all among adolescents and longer intervals between screenings among the rest of the population. Since then, we have modified our policy for cervical cytology to comply with the ACOG recommendations.

We are stringent about compliance. For low-risk patients, we perform no screening

until 21 years of age. We then screen every other year in patients 21 to 29 years old and every 3 years in patients 30 years and older, provided there have been three consecutive negative Pap tests.

Not only does the new protocol reduce the financial burden of screening uninsured patients, it also alleviates anxiety among physicians as well as patients. We now know that, when a Pap test is found to be abnormal in the younger age group, watchful waiting is usually appropriate because human papillomavirus (HPV) regresses in a majority of patients.

For the same reason, we are less likely than before to perform an invasive procedure in a young woman who has an abnormal result. By abstaining from invasive interventions such as curettage, we preserve the integrity of her endocervical mucus and protect her reproductive capacity until such time as she is ready to conceive.

Dr. Takeshige practices ObGyn at Lincoln Hospital in Bronx, NY.

> **"We are less likely than before to perform an invasive procedure in a young woman who has an abnormal result"**
>
> **—Takeko Takeshige, DO**

8. Documentation a problem? Redesign the form!

Raksha Joshi, MD

Monmouth Family Health Center, an outpatient facility, is a teaching institution for residents from the Monmouth Medical Center ObGyn program. Because the annual well-woman examination is an integral part of the care we provide, comprehensive documentation of it is vital. The exam covers all aspects of the patient's gynecologic and obstetric history, including menses, contraception, Pap testing, sexually transmitted infection, sexual practices and partners, allergies, medications, and a review of systems. Also crucial is the patient's medical, surgical, and family history.

In most cases at our center, although the examination was thorough, documentation was markedly deficient, especially among junior residents, despite regular review and feedback. To overcome this deficiency, I redesigned the documentation sheet so that all essential elements of the history and physical examination are printed on the form and documentation is achieved by circling the applicable element. For example, in regard to the uterus, the form lists the following:

Parity: Nulliparous / Parous
Size: 6 / 8 / 10 / 12 / >12 wks
Position: Axial / Anteverted / Retroverted / Anteflexed / Retroflexed
Consistency: Firm / Soft
Contour: Regular / Irregular
Mobility: Yes / No
Tenderness: Yes / No
Anterior fornix:
Mass: Yes / No
Tenderness: Yes / No
Thickening: Yes / No
Fullness: Yes / No
Left fornix:
Mass: Yes / No
Tenderness: Yes / No
Thickening: Yes / No
Fullness: Yes / No
Right fornix:
Mass: Yes / No
Tenderness: Yes / No
Thickening: Yes / No
Fullness: Yes / No
Posterior fornix (cul de sac):
Mass: Yes / No
Tenderness: Yes / No
Thickening: Yes / No
Fullness: Yes / No

After implementation of this form, documentation and completeness improved markedly.

Other advantages of the form: It can be completed quickly, and it is legible!

We also use the form to teach essential elements of the comprehensive examination to new residents and students.

Dr. Joshi is Chief Medical Officer and Medical Director of Monmouth Family Health Center in Long Branch, NJ.