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Inpatient Behavioral Health

Jorde Spitler Bio

Jorde is the Clinical Documentation Integrity Program Manager at Dayton Children's Hospital. He has led the CDI program (100% remote) since its inception in 2017, achieving a remarkable 100% query response rate. Jorde has extensive experience in reviewing multiple specialties, including NICU, PICU, Heme/Onc, and IPMH. He recently graduated with his Master's in Health Administration from WGU.

He is known for his data-driven approach and has a wealth of experience in customizing dashboards and reports from the EMR. Additionally, Jorde is well-versed in handling insurance denials and actively involved in writing appeals. He is passionate about educating providers and coding staff on the significance of comprehensive clinical documentation. Since 2021, Jorde has been a valuable member of the ACDIS Leadership Council. Jorde also functions as a lead pediatric CDI consultant for PRG.

Dayton Children's Hospital 2022 Annual Report

Inpatient Visits

- 182 inpatient beds
- 24 inpatient BH beds
  - 7,977 admissions
  - 4,870 observations
  - 47,268 patient days
  - 3.58 average stay
  - 123.3 average daily census

Top 5 inpatient diagnoses

- **SI / Self-harm**
- Bronchiolitis
- Respiratory Failure
- **Depression**
- Dehydration

Outpatient Visits

- 493,763 total visits
  - 149,890 specialty care visits
  - 11,518 surgeries
  - 101,084 ER visits
  - 3,389 transports
  - 43,320 UC visits
  - 29,052 Kids express visits

CDI Team

- CDI Manager
- CDI Team Lead
- 3 Clinical Documentation Specialist

Dayton Children's Hospital 2024 Annual Report

Inpatient Visits

- 182 (205) inpatient beds
- 24 (48) inpatient BH beds
  - 8,061 admissions
  - 5,243 observations
  - 37,051 patient days
  - 4.60 average stay
  - 119.7 average daily census

Top 5 inpatient diagnoses

- Bronchiolitis and other URI
- **Anxiety and personality disorders**
- Pneumonia
- **ADHD**
- Neonatal conditions

Outpatient Visits

- 694,004 total visits
  - 210,279 specialty care visits
  - 13,732 surgeries
  - 99,948 ER visits
  - 3,352 transports
  - 50,787 UC visits
  - 38,034 Kids express visits

Mental Health

- 16,166 Psychology visits
- 15,585 Psychiatry visits
- 2,003 Inpatient admits
- 447 Day treatment patients
- 5,916 Mental health risk assessments
- 5,727 Mental health resources connection referrals

Objectives

- **Inpatient Behavioral Health data**
  - Benchmark NIH, UK, CDC, PHIS
  - Baseline
- **Research, education, & collaboration**
  - Official coding guidelines/clinics
  - Division chief of psychiatry
  - Psychiatrists
  - Coders
  - Tip sheets
- **Documentation/Workflow opportunities**
- **Case Scenarios**
  - Major Depressive Disorder
  - ADHD/ODD
  - PTSD
  - Secondary Impacts
- **Results**
  - Queries
  - CMI
  - DRG Trend
  - Financial Impact
- **Next Steps**
- **Open Discussion**

Inpatient Behavioral Health Data

- Benchmark
- Dayton Children's Baseline

Benchmark NIH

TABLE 3

Most Common Primary and Comorbid Pediatric Mental Health Inpatient Diagnoses in Hospitals Nationally and in Free-standing Children's Hospitals for 3- to 20-Year-Olds in 2009

	Primary Mental Health Diagnosis[a]		Any Mental Health Diagnosis[b]	
Ranking	National Inpatient Hospitals (N = 228 808)[c]	Children's Hospitals, Inpatient (N = 12 542)	National Inpatient Hospitals (N = 523 105)[c]	Children's Hospitals, Inpatient (N = 66 660)
1	Depression*: 100 988 (44.1)	Depression*: 5290 (42.2)	Depression: 187 902 (35.9)	Developmental disorder: 21 796 (32.7)
2	Bipolar disorder*: 41 345 (18.1)	Externalizing disorder: 1351 (10.8)	Substance abuse: 177 680 (34.0)	Depression: 15 936 (23.9)
3	Psychosis*: 27 589 (12.1)	Bipolar disorder*: 1325 (10.6)	ADHD: 101 658 (19.4)	ADHD: 15 247 (22.9)
4	Externalizing disorder: 14 087 (6.2)	Anxiety: 971 (7.7)	Anxiety: 90 140 (17.2)	Autism: 7120 (10.7)
5	Reaction disorder: 11 856 (5.2)	Psychosis*: 823 (6.6)	Bipolar disorder: 79 352 (15.2)	Externalizing disorder: 6509 (9.8)
6	Anxiety: 9288 (4.1)	Eating disorder: 684 (5.5)	Externalizing disorder: 63 368 (12.1)	Substance abuse: 5918 (8.9)
7	Substance abuse: 8501 (3.7)	Miscellaneous: 535 (4.3)	Developmental disorder: 61 662 (11.8)	Anxiety: 5326 (8.0)
8	ADHD: 6920 (3.0)	ADHD: 343 (2.7)	Psychosis: 51 158 (9.8)	Psychosis: 4545 (6.8)
9	Eating disorder: 2398 (1.1)	Substance abuse: 308 (2.5)	Reaction disorder: 28 030 (5.4)	Bipolar disorder: 4539 (6.8)
10	Autism: 2353 (1.0)	Autism: 271 (2.2)	Personality disorder: 26 666 (5.1)	Reaction disorder: 3012 (4.5)

Data are presented as n (%). Conditions shown with an asterisk (*) indicate the most common and costly primary diagnostic groups in the nationally representative KID. "Developmental disorder" includes learning and communication disorders and intellectual disabilities; "Externalizing disorder" includes oppositional defiant disorder, intermittent explosive disorder, impulse control disorder, and conduct disturbance; "Miscellaneous" includes psychogenic pain, postconcussive syndrome, sleep disorders, and tension headaches.

[a]Mental health diagnoses are designated as primary based on physician discharge documentation. Comparison of national KID and free-standing children's hospitals (PHIS) data sets using Wilcoxon rank sum testing, P = .002.

[b]"Any" mental health diagnosis refers to primary or nonprimary (ie, comorbid) mental health diagnoses. Comparison of national KID and PHIS free-standing children's hospitals datasets using Wilcoxon rank sum testing, P = .001.

[c]Unweighted observations used for estimation sample of hospitalizations with a primary mental health diagnosis in national visits: 159 629 visits; hospitalizations with primary or comorbid mental health diagnosis nationally: 375 325.

Common and Costly Hospitalizations for Pediatric Mental Health Disorders—PMC. (n.d.). Retrieved January 31, 2024, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3966505/

Benchmark UK – International Journal of Mental Health Systems

From: Admissions to acute adolescent psychiatric units: a prospective study of clinical severity and outcome

		Test of differences between the four units		
	Proportion	X^2	d.f.	P[b]
Sex (female)	70%	3.6	3	0.306
Living arrangements:		28.8	21	0.120
With one parent	38%			
With both parents	31%			
With one parent and one stepparent	10%			
Institution	10%			
Alone or with others	6%			
Foster care	4%			
Child Protection Service involved at intake	24%	6.1	3	0.108
Suicidal problems at intake:		10.7	12	0.556
Suicide attempt before intake	10%			
Specific suicidal plans	10%			
Suicidal ideation without any associated plans	38%			
Passive wish to die	12%			
No suicidal problems	26%			
Missing	4%			
Influenced (probably/definitely) by substances at intake	10%	1.7	3	0.635
Main disorder[a] (grouped):				
No disorder from Axis One	16%			
Affective	28%			
Externalizing	26%			
Neurotic	18%			
Psychosis	11%			
Eating	2%			
Developmental disorder:	14%			

[a] Main disorder from Axis One in the ICD-10 Multiaxial Classification [43].
[b] We did not correct the *P* values for multiple comparisons.

- *psychotic disorders* (F20-F29)
- *affective disorders* (F30-F39)
- *neurotic and stress-related disorders* (F40-F48, F93, F94)
- *eating disorders* (F50)
- *externalizing disorders* (substance use F10-F19, personality F60-F69, hyperkinetic F90, conduct F91-F92, and "tics" F95).
- No Disorder Axis One diagnosis.
- *developmental disorder* (F70-F79, F80-F89).

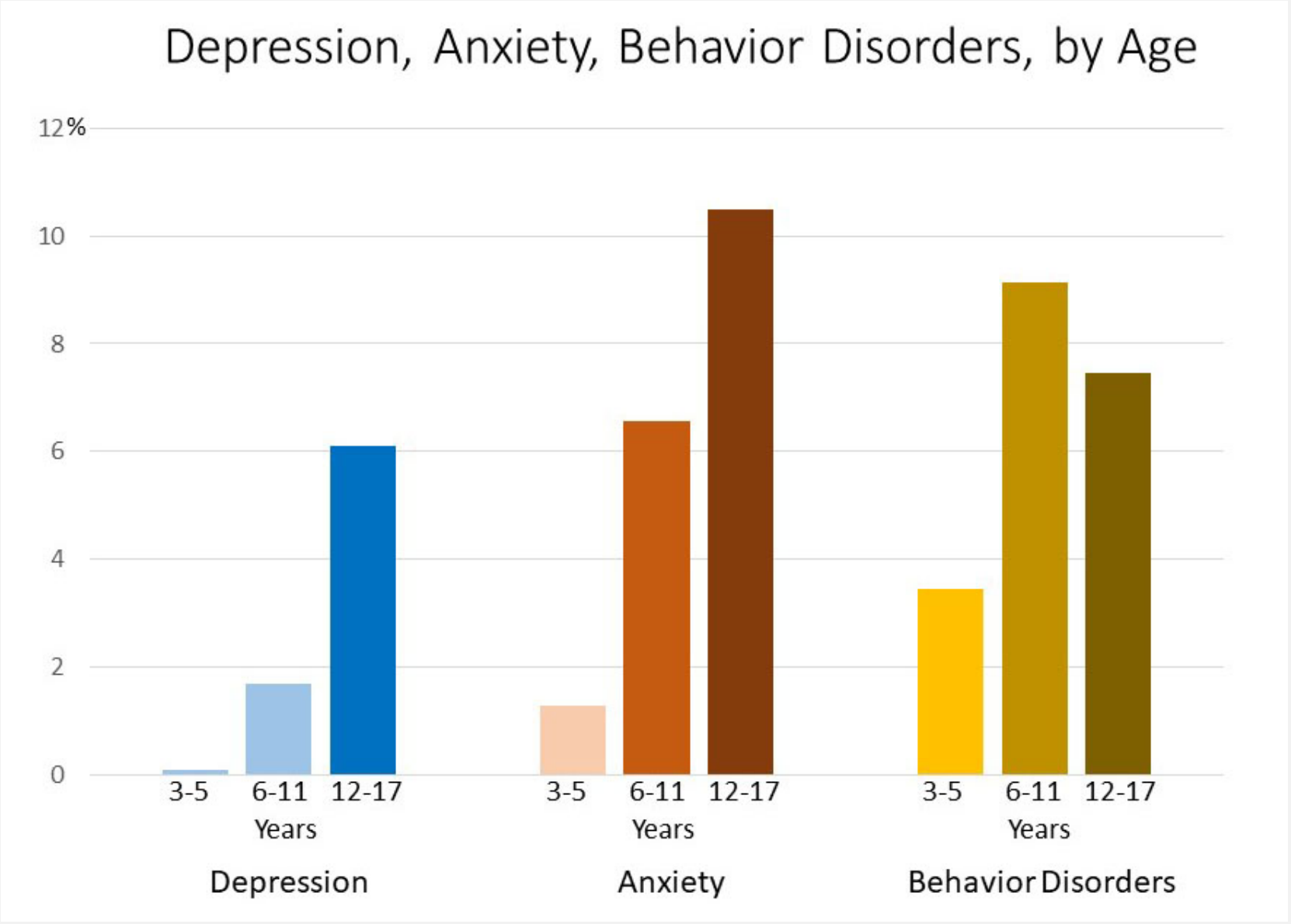
REFERENCE:
Hanssen-Bauer, K., Heyerdahl, S., Hatling, T., Jensen, G., Olstad, P. M., Stangeland, T., & Tinderholt, T. (2011). Admissions to acute adolescent psychiatric units: A prospective study of clinical severity and outcome. *International Journal of Mental Health Systems*, *5*(1), 1. https://doi.org/10.1186/1752-4458-5-1

https://ijmhs.biomedcentral.com/articles/10.1186/1752-4458-5-1#ref-CR43

Benchmark CDC

Estimates for children ever having a diagnosis of…

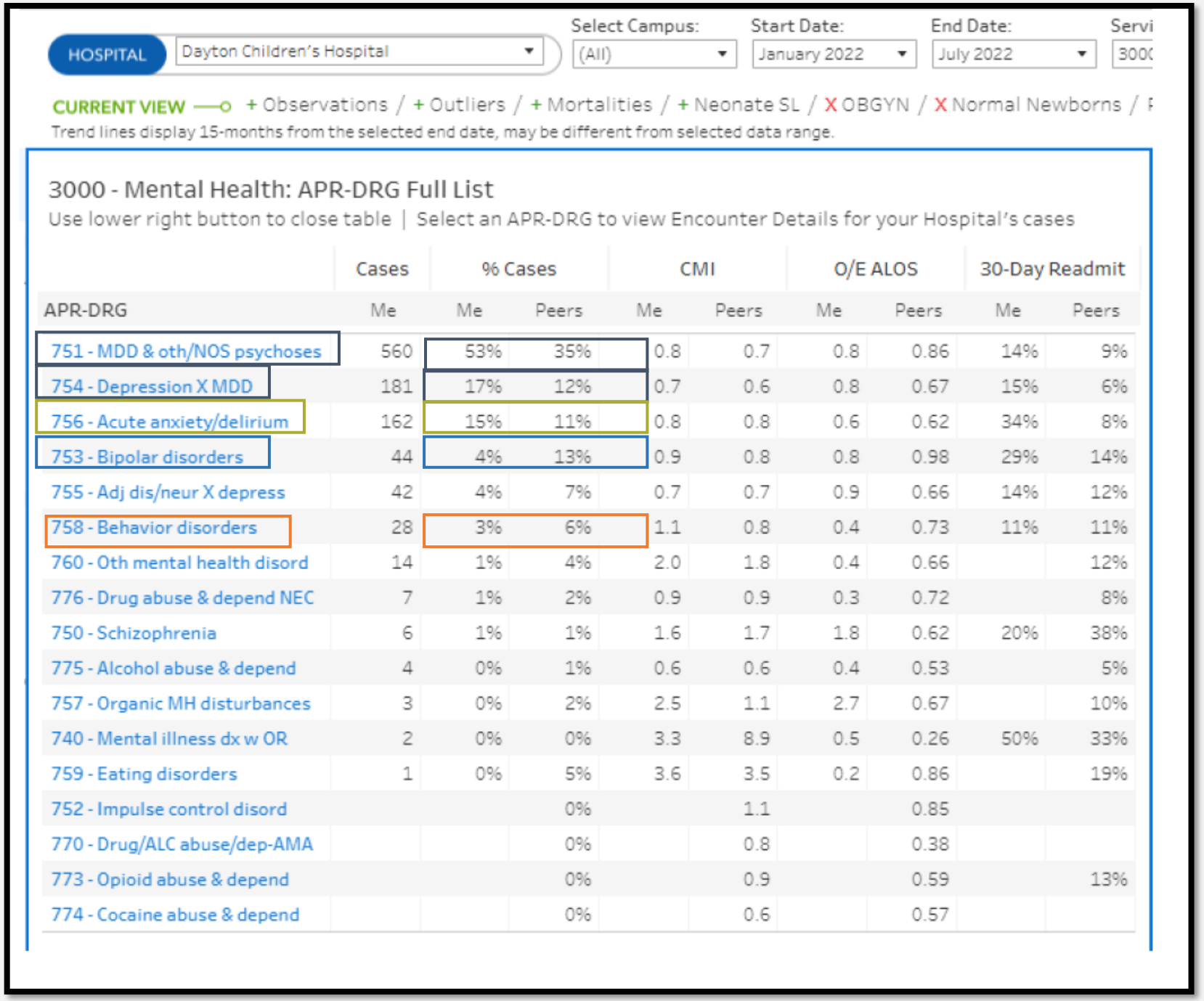
- ADHD 9.8% (6 million)
- Anxiety 9.4% (5.8 million)
- Behavior problems 8.9% (5.5 million)
- Depression 4.4% (2.7 million)



REFERENCE:
CDC. (2022, June 3). *Data and Statistics on Children's Mental Health | CDC*. Centers for Disease Control and Prevention. https://www.cdc.gov/childrensmentalhealth/data.html

Benchmark PHIS

- Comparison of PHIS data reflected that Dayton Children's had a higher amount of Depression APR-DRGs than our peers and a lower amount of Bipolar and Behavior disorder APR-DRGs



HOSPITAL: Dayton Children's Hospital | Select Campus: (All) | Start Date: January 2022 | End Date: July 2022 | Servi 3000

CURRENT VIEW + Observations / + Outliers / + Mortalities / + Neonate SL / X OBGYN / X Normal Newborns / F

Trend lines display 15-months from the selected end date, may be different from selected data range.

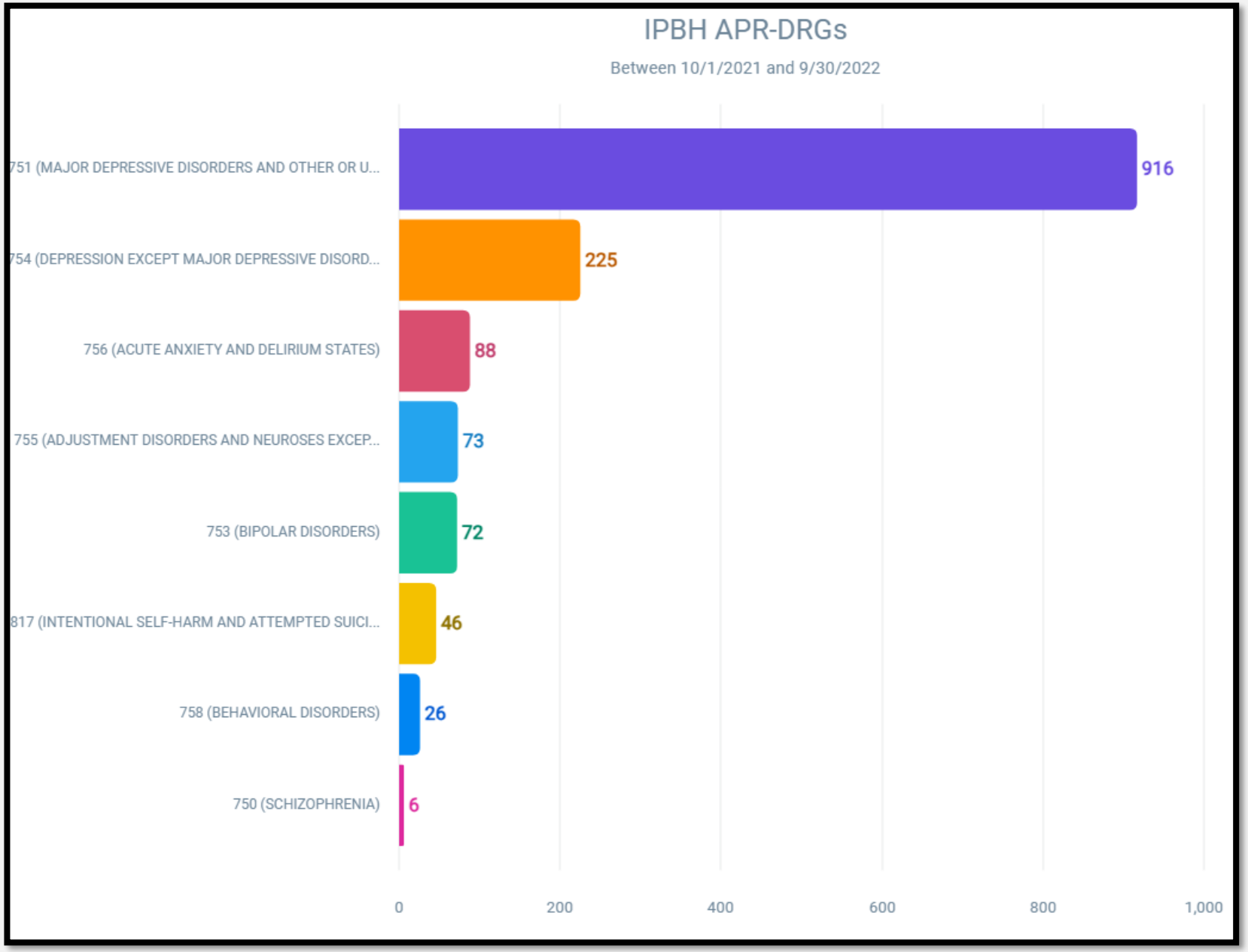
3000 - Mental Health: APR-DRG Full List

Use lower right button to close table | Select an APR-DRG to view Encounter Details for your Hospital's cases

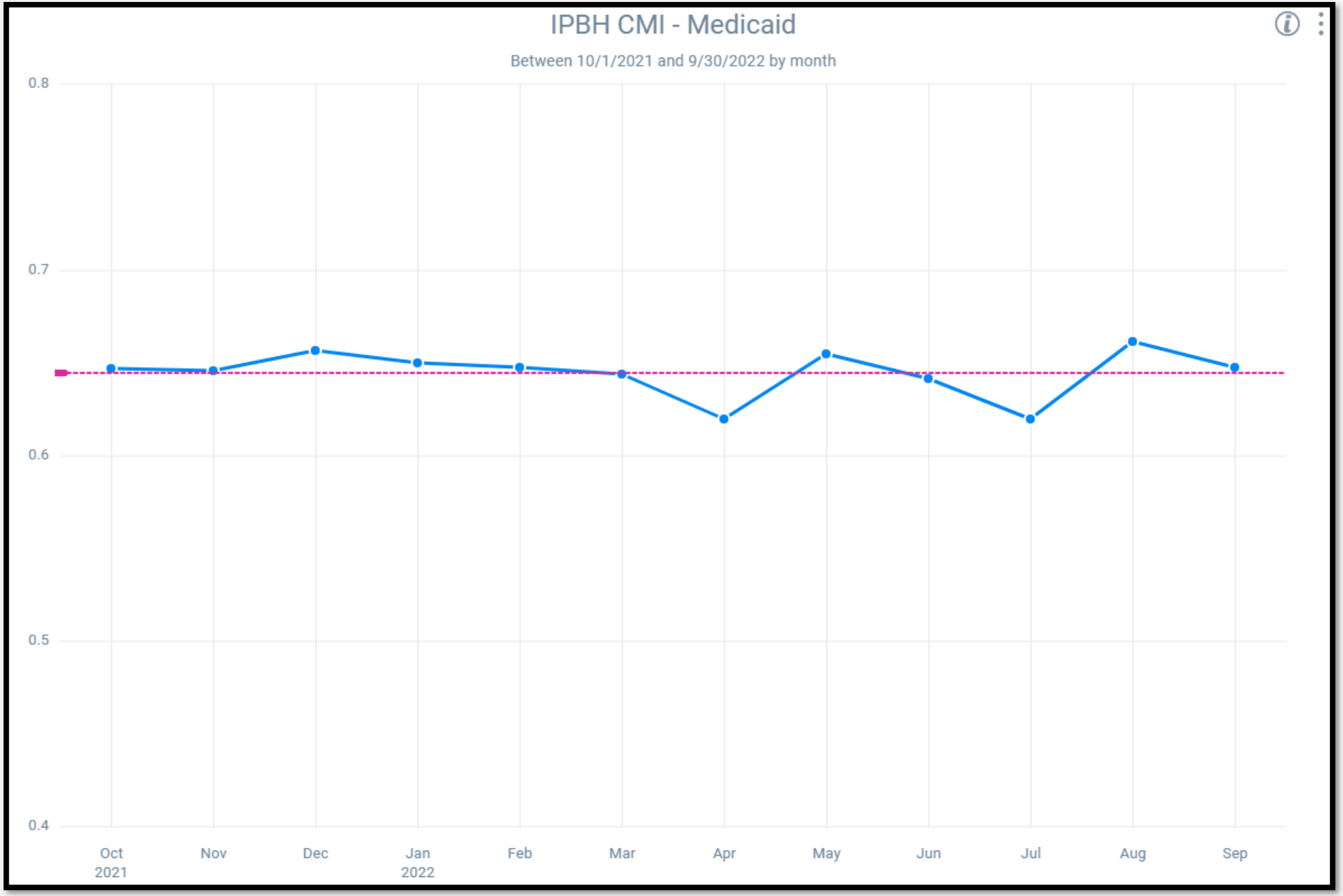
	Cases	% Cases		CMI		O/E ALOS		30-Day Readmit	
APR-DRG	Me	Me	Peers	Me	Peers	Me	Peers	Me	Peers
751 - MDD & oth/NOS psychoses	560	53%	35%	0.8	0.7	0.8	0.86	14%	9%
754 - Depression X MDD	181	17%	12%	0.7	0.6	0.8	0.67	15%	6%
756 - Acute anxiety/delirium	162	15%	11%	0.8	0.8	0.6	0.62	34%	8%
753 - Bipolar disorders	44	4%	13%	0.9	0.8	0.8	0.98	29%	14%
755 - Adj dis/neur X depress	42	4%	7%	0.7	0.7	0.9	0.66	14%	12%
758 - Behavior disorders	28	3%	6%	1.1	0.8	0.4	0.73	11%	11%
760 - Oth mental health disord	14	1%	4%	2.0	1.8	0.4	0.66		12%
776 - Drug abuse & depend NEC	7	1%	2%	0.9	0.9	0.3	0.72		8%
750 - Schizophrenia	6	1%	1%	1.6	1.7	1.8	0.62	20%	38%
775 - Alcohol abuse & depend	4	0%	1%	0.6	0.6	0.4	0.53		5%
757 - Organic MH disturbances	3	0%	2%	2.5	1.1	2.7	0.67		10%
740 - Mental illness dx w OR	2	0%	0%	3.3	8.9	0.5	0.26	50%	33%
759 - Eating disorders	1	0%	5%	3.6	3.5	0.2	0.86		19%
752 - Impulse control disord			0%		1.1		0.85		
770 - Drug/ALC abuse/dep-AMA			0%		0.8		0.38		
773 - Opioid abuse & depend			0%		0.9		0.59		13%
774 - Cocaine abuse & depend			0%		0.6		0.57		

Baseline Data

- **Depression – 78%**
- Anxiety – 6%
- Adjustment Disorder –5%
- Bipolar Disorders – 4.9%
- Attempted Suicide – 3.1%
- Behavioral Disorders – 1.8%
- Schizophrenia – 0.4%



Baseline Data



Research, Education, & Collaboration

- APR-DRG research / Taskforce Creation
- Official Coding Guidelines and Coding Clinics
- SI/HI/aggressive behavior associated with…
- Documentation and workflow opportunities
- Case Scenarios

APR-DRG Research / Taskforce Creation

- **CDI/Coding Teams reviewed APR-DRG data and compared it to the benchmark data**
  - A large percentage of Depression APR-DRGs 751/754
  - Analyzed baseline DRGs and SOI difference
  - Identified what diagnoses place you in each mental health APR-DRGs (examples next slide)
- **Task Force Group**
  - IPBH Division Chief – Dr. Katherine Winner
  - CDI Leadership - Greg Dillard - Executive Director of Finance
  - Coding Leadership – Leslie Ross - HIM/Coding Director
- **Development of education geared towards “think in ink” when documenting the reason for admission and specifying all mental health conditions to the fullest.**
  - Rule out versus likely/suspected
  - Linking SI/HI/aggressive behavior to a mental health condition
  - Identified opportunity through discussion with Psychiatrist

IPBH APR-DRG Example Slides

CY2022 DRG-751 Major depressive disorders and other unspecified psychoses: 609 D/C

PRINCIPAL DIAGNOSES

- F23: Brief psychotic disorder
- F28 Other psychotic disorder not due to a substance or known physiological condition
- F29 Unspecified psychosis not due to a substance or known physiological condition
- F320/F321 MDD, single episode, mild-moderate
- F322/F323 MDD, single episode, severe with &without psychotic features
- F324/F325 MDD, single episode, in partial remission – full remission
- F330/F331 MDD, recurrent, mild – moderate
- F332/F333 MDD, recurrent severe with & without psychotic features
- F3340/F3341/F3342, MDD, recurrent in remission – partial remission – full remission
- F339 MDD, recurrent

- **DRG 751, SOI 1 = 240 patients**
  - RW = 0.552
  - AMLOS = 4.3 days
- **DRG 751, SOI 2 = 345 patients**
  - RW = 0.664
  - AMLOS = 5.3 days
- DRG 751, SOI 3 = 23 patients
  - RW = 0.962
  - AMLOS = 7.2 days
- DRG 751, SO1 4 = 1 patient
  - RW = 1.704
  - AMLOS 12.7 days

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9

CY2022 DRG-754 Depression except MDD: 192 D/C

PRINCIPAL DIAGNOSES

- F329 MDD, single episode, unspecified
- F32A Depression unspecified
- F341 Dysthymic disorder
- F4321 Adjustment disorder with depressed mood

- **DRG 754, SOI 1 = 93 patients**
  - RW = 0.528
  - AMLOS = 3.7 days
- **DRG 754, SOI 2 = 96 patients**
  - RW = 0.698
  - AMLOS = 4.6 days
- DRG 754, SOI 3 = 3 patients
  - RW = 0.900
  - AMLOS = 5.0 days
- DRG 754, SO1 4 = 0 patients
  - RW = 0.9
  - AMLOS 9.667 days

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10

CY2022 DRG-753 Bipolar disorders: 53 D/C

PRINCIPAL DIAGNOSES

- F3010 – F309 Manic episodes (see notes for list)
- F310 – F 319 Bipolar disorders (see notes for list
- F3281 Premenstrual dysphoric disorder
- F3289 Other specified depressive episodes
- F340 Cyclothymic disorder
- F3481 Disruptive mood dysregulation disorder
- F3489 Other specified persistent mood disorders
- F349 Persistent mood [affective] disorder

- **DRG 753, SOI 1 = 12 patients**
  - RW = 0.584
  - AMLOS = 4.6 days
- **DRG 753, SOI 2 = 41 patients**
  - RW = 0.685
  - AMLOS = 5.5 days
- DRG 753, SOI 3 = 0 patients
  - RW = 0.911
  - AMLOS = 7.14 days
- DRG 753, SO1 4 = 0 patients
  - RW = 1.8315
  - AMLOS 13.29 days

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12

CY2022 DRG-755 Adjustment disorders and neuroses except depressive diagnoses: 53 D/C

PRINCIPAL DIAGNOSES

- F4000 Agoraphobia
  - F4001, F4002 w/ panic and w/o panic disorder
- F4010 Social phobia
  - F4011 generalized
- F428-429 OCD
- F4310-F4312 PTSD
- F4320-F4329 Adjustment disorder
- F4381 Prolonged grief disorder
- F4389 Other reactions to severe stress
- F450 Somatization disorder
- F481 Depersonalization-derealization syndrome
- F930 Separation anxiety disorder of childhood
- R4587 Impulsiveness

- **DRG 755, SOI 1 = 21 patients**
  - RW = 0.483
  - AMLOS = 3.1 days
- **DRG 755, SOI 2 = 24 patients**
  - RW = 0.748
  - AMLOS = 4.5 days
- DRG 755, SOI 3 = 5 patients
  - RW = 1.044
  - AMLOS = 6.9 days
- DRG 755, SO1 4 = 0 patients
  - RW = 1.044
  - AMLOS 6.9 days

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13

CY2022 DRG-758 Behavioral Disorders: 24 D/C

PRINCIPAL DIAGNOSES

- F631 Pyromania
- F6381 Intermittent explosive disorder
- F6389 Other impulse disorders
- F639 Impulse disorder, unspecified
- F900 ADHD, inattentive type
  - F901 ADHD, hyperactive type
  - F902 ADHD, combined type
  - F908 ADHD, other type
  - F909 ADHD, unspecified
- F910 Conduct disorder confined to family context
  - F911 Conduct disorder, childhood onset type
  - F912 Conduct disorder, adolescent onset type
- F913 Oppositional defiant disorder
- F918 Other conduct disorders
- F919 Conduct disorder, unspecified
- F939 Childhood emotional disorder, unspecified
- F948 Other childhood disorders of social functioning
- F989 Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence

- DRG 758, SOI 1 = 1 patient
  - RW = 1.232
  - AMLOS = 5.3 days
- **DRG 758, SOI 2 = 21 patients**
  - RW = 1.325
  - AMLOS = 6.1 days
- DRG 758, SOI 3 = 2 patients
  - RW = 1.593
  - AMLOS = 7.0 days
- DRG 758, SO1 4 = 0 patients
  - RW = 1.593
  - AMLOS = 7.0 days

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14

Official Coding Guidelines and Coding clinic

The circumstances of inpatient admission always govern the selection of principal diagnosis. The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."

- Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.

When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicate otherwise.

- H. Uncertain Diagnosis

If the diagnosis documented at the time of discharge is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis. Note: This guideline is applicable only to inpatient admissions to short-term, acute, long-term care and psychiatric hospitals.

- Counseling/obstetrics V codes 10/1/2005

ICD-9-CM Coding Clinic, Fourth Quarter 2005 Page: 96 Effective with discharges: October 1, 2005

-A new code, V62.84, Suicidal ideation, has been created for patients who have not attempted suicide, and who may not be considered a suicide risk, but who have indicated thoughts about suicide. **This code is a secondary code only.** It may be used with another mental health code when appropriate.

Behavioral Health CDI Tipsheet

Dayton Children's Hospital

Clinical Documentation Integrity Tip Sheet

Inpatient Behavioral Health

SPECIFICITY OF DOCUMENTATION MATTERS!!!

1-Daily notes need to be clear & consistent as to the condition(s) warranting the admission.

- IF SI/HI warranted admission, document the likely/known mental health condition(s) associated.
- IF SI and another condition (i.e., behavioral issues) warranted admission, state it.
- IF abuse and/or neglect are reported to CSB and are an etiology of presentation, document it.
  *suspected abuse/neglect needs documented day of discharge OR coding will not report it.

2-CMS Guidelines for Inpatient setting

- Uncertain conditions: If the diagnosis documented in the discharge summary is qualified as "probable," "suspected," "likely," "questionable," "possible," or "still to be ruled out," "compatible with," "consistent with," or other similar terms indicating uncertainty, the condition will be coded as if it existed or was established.
- Two or more interrelated conditions, each potentially meeting the definition for principal diagnosis.
  When there are two or more interrelated conditions (such as diseases in the same ICD-10-CM chapter or manifestations characteristically associated with a certain disease) potentially meeting the definition of principal diagnosis, either condition may be sequenced first, unless the circumstances of the admission, the therapy provided, the Tabular List, or the Alphabetic Index indicates otherwise.

3-R/O conditions on H&P need to be consistently noted in daily notes, upon Discharge the status needs to be specified for our coder.

- R/O status of condition(s) upon discharge needs to state: "rule**D** in, still possible-unable to rule out, or rule**D** out."
  Documentation examples:
  - H&P: hospitalized for SI associated with MDD, R/O conduct disorder.
  - Daily notes: hospitalized for SI associated with MDD, R/O conduct disorder
  - Discharge summary: hospitalized for SI associated with MDD and likely conduct disorder, unable to rule out.

Documentation below is telling the coder that each of these condition(s) are chiefly responsible for warranting the admission. Please be sure to only document those that did!!!

- Hospitalized for active episodes of GAD, ODD, and depression.
- Admitted with SI/HI related to MDD, PTSD, and emotional abuse.
- Hospitalized for SI/HI associated with GAD, likely ODD, and depression.

"The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation the application of all coding guidelines is a difficult, if not impossible, task."

SI, HI, aggressive behavior associated with…

- Many different diagnoses
  - Major Depressive Disorder
  - Generalized Anxiety Disorder
  - Post Traumatic Stress Disorder
    - Chronic (≥ 3 mos.) vs Acute (≤ 3 mos.)
  - Oppositional Defiant Disorder
  - Disruptive Mood Dysregulation Disorder
  - Attention Deficit Hyperactivity Disorder
  - Conduct Disorder
  - Adjustment Disorder
  - Schizophrenia
  - Bipolar Disorder

- Optimal principal diagnosis
  - What diagnosis is the principal contributor to the reason for admission

REFERENCE:
Traumadissociation.com (Feb 1, 2024). Posttraumatic stress disorder. Retrieved Feb 1, 2024 from http://traumadissociation.com/ptsd.html. Read more: http://traumadissociation.com/ptsd.html

Documentation/Workflow Opportunities

- **# 1 Principal diagnosis**
  - Key into the crisis statement at admit
  - Key into the notes from PEC/CEC (meeting / phone call with parent) a couple days into the admission where further discussion of why the patient was admitted to the hospital.
    - patients are not always forthcoming at presentation, but as their story unfolds during the admission it becomes more clear

- **# 2 Secondary diagnoses**
  - MDD (moderate-severe)
  - mandated reports
    - physical abuse
    - emotional abuse codes to psychological abuse
    - neglect
  - bullying: The provider must document a clarifying statement as to the status during an encounter/affecting patient admission. Codes to psychological abuse
    - Bullying – What is bullying and how is it coded? (hiacode.com)
  - malnutrition
  - eating disorder
  - lacerations
  - violent behavior
  - noncompliance with meds
  - welfare custody (z6221)
  - mild intellectual disability
  - disruptive behavior confined to the family context/ CD confined to family context
  - auditory hallucinations
    - Excluded: schizophrenia, delusional disorders, mood disorders with psychotic symptoms

Case Scenario 1

Admission: 7 days
Total Hospital Cost: $28,101.75

Query

Please review for CDI.

(4/12) H&P states 14-year-old admitted for SI.

Can you specify the mental condition(s) associated with the SI?
- MDD, severe single episode
- ADHD, combined type
- ODD
- other, please specify

Clinical Indicators/Treatment:
(4/12) H&P- "Review of symptoms

-ADHD- endorses hyperactivity, impulsivity, difficulty sitting still, talkativeness, difficulty regulating emotions, inattention, distractibility, forgetfulness, loses things easily, difficulty listening, difficulty following directions.

-ODD- per collateral from sister Loses temper, Argues w/adults, Actively defies, Deliberately annc Blames others, Easily annoyed, Angry & resentful, Spiteful or vindictive

-Depression-patient states that he has a history of being depressed for 10 years. He states mood have improved slightly from last hospitalization. He endorsed improving mood with less depressio less anhedonia, enjoying more activities decreased sleep"

-"does endorse improvements in symptoms of depression from last hospitalization. Continues to h significant distractibility and impulsivity.

-MDD single episode severe.. Continue Prozac 20 mg daily.... would benefit from continuing indiv therapy to help process previous stressors and develop healthy coping techniques.

-ADHD combined type…consider treating patient ADHD symptoms after discussion with family

-ODD Patient would benefit from continuing individual therapy to help process previous stressors and develop healthy coping techniques. "

Use of terms such as suspected, likely, concern for, unable to rule out are acceptable and can be coded in the inpatient setting, when documented at the tir of discharge

- **Query response: "**I am still trying to clarify. He has SI after getting in trouble at home for having tobacco products. A lot of time their Si is not directly linked to a specific diagnosis. Most time it is an association or contributing factor, but the SI is due to a specific event. He is not insightful and is unable to give the direct causation. I will continue to try but I'm guessing its more impulsive act which could be caused by ADHD, MDD, ODD and his low IQ. I know this is wishy washy but welcome to child psychiatry."
- **Follow up response**: "Unfortunately, unable to clarify which diagnosis brought patient and to the hospital. He was not very forthcoming nor was family able to clarify. Leaving the diagnoses, the way I have stated them. Thank you"

APR DRG 756 Acute anxiety and delirium states	**APR DRG 751** Major depressive disorders and other or unspecified psychoses	**APR DRG 758** Behavioral disorders
PDx: Suicidal Ideation	**PDx: MDD, severe**	**PDx: ODD /ADHD**
LOS 4 days	LOS 4 days	LOS 6 days
SOI/ROM 3/1	SOI/ROM 1/1	SOI/ROM 2/1
RW .7165	RW .5519	RW 1.3246
Secondary diagnoses: - MDD, severe - ODD - ADHD	**Secondary diagnoses:** -suicidal ideations -ODD -ADHD	**Secondary diagnoses:** -suicidal ideations -MDD, severe

Case Scenario 2

Admission: 4 days
Total Hospital Cost:$24,072.18

Query

Please review for CDI.

Documentation within the EMR (12/7, 12/8) includes bullying.

- (12/7) crisis note "Reports that she has been having suicidal thoughts multiple times a day…this has been triggered by bullying at school that has gotten worse recently. She reports that last Thursday, she was suspended for walking out of class and cussing out a peer who was bullying her and other classmates"
- (12/8) H&P Bullying: Reports intermittent verbal bullying from peers at school. Feels school has not done anything to address this.

Can you clarify the likely/known status of bullying?

- bullying by peers at school triggering SI ruled in
- bullying by peers at school triggering SI ruled out
- unable to determine

Clinical Indicators:

(12/9) CEC meeting note -Discussed with family reasons for hospitalization

-Grandmother reports patients mood has been down and she has been somewhat apathetic but has been triggered by peers making fun of her parents. Grandmother reports patient will become extremely angry, sometimes to the point of hitting a peer, but this anger will come home if Grandmother asks patient about her grades or tries to discipline.

Use of terms such as suspected, likely, concern for, unable to rule out are acceptable and can be coded in the inpatient setting, when documented at the time of discharge.

- **Query response:** Bullying associated with SI

APR DRG 751 Major depressive disorders and other unspecified psychosis	**APR DRG 815** Other injury, poisoning and toxic effect diagnoses
PDx: MDD, severe	**PDx: Bullying**
LOS 5.25 days	LOS 4.21 days
SOI/ROM 2/1	SOI/ROM 3/1
RW .6644	RW 1.2083
Secondary diagnoses - suicidal ideations - PTSD, chronic	**Secondary diagnoses** -suicidal ideation -MDD, severe

Case Scenario 3

Admission: 5 days
Total Hospital Cost:$29,648.61

Query

Please review for CDI.

(8/28) RDN note states "Eating disorder pattern related to major depressive disorder as evidenced by pt report of binging/ restricting/ purging behaviors."

Could you clarify if you concur with the RDNs assessment of eating disorder?

- present
- not present
- unable to determine

Clinical Indicators/Treatment:

(8/28) RDN note

- "Reviewed chart due to failed nutrition screen…Reduced or increased appetite or food intake, and Eating habits such as bingeing, purging, restricting foods, and/or other behaviors that may be indicators of an eating disorder. Pt reports restricting intake x 3 days prior to admission.

- Patient reports having an eating disorder- restrictive type with food. Depending on his mood and stomach pain, he may skip a few meals for a 2-3 day period. Notes that he feels a tad overweight despite his PCP stating he is trending well. Notes that he would like to grow taller, RDN discussed how food is important for adequate growth. No other questions or concerns were expressed during visit.

-Please restrict bathroom access within 1 hour after meals and snacks

Use of terms such as suspected, likely, concern for, unable to rule out are acceptable and can be coded in the inpatient setting, when documented at the time of discharge.

- **Query response:** unspecified eating disorder likely-unable to rule out

APR DRG 751
Major depressive disorders and other or unspecified psychoses

PDx: MDD, severe	**Sdx added: Eating disorder**
LOS 5.25 days	LOS 7.15 days
SOI/ROM 2/1	SOI/ROM 3/1
RW 0.6644	RW 0.9616
Secondary diagnoses: -suicidal ideations -noncompliance with meds -GAD -mild malnutrition	

Case Scenario 4

Admission: 5 days
Total Hospital Cost:$ 29,565.97

Behavioral Health Counselor

Crisis Statement: Today at school was states that he went to the school nurse to share that he was feeling suicidal…reported plans to run into traffic and get hit by a car… also stated he would try to choke on a chicken bone to kill himself as an alternative plan...

- Pt stated that school today was "trash" and he watched a peer he doesn't like get "socked" and state he enjoyed that…He stated that maybe if he went home he would talk to grandma about his feelings maybe he would kill himself…Pt stated "admit me or not, either way is fine" and he continued to endo ambivalence about if he would follow through on killing himself at home tonight.

Patient stated Goal:
"To know how to release anger better & work through my suicidal thoughts."

EMR Psychiatrist notes

- **(H&P)** Hospitalization was caused by active episodes of: ADHD, ODD, suicidal ideation--at this time the patient is denying any depression/anxiety-Will continue to evaluate.

-TX: Behavioral/Psychotherapeutic. Stabilize symptoms on the secure behavioral unit with individual, group, and milieu therapeutic interventions. Coping skills will be developed and practiced.

- **(1/26)** Discussed with family reasons for hospitalization

-Patient reports that he his here due to having suicidal ideation with a plan. He states that he thinks he had these thoughts due to being concerned that something bad was going to happen that day at school. He reported that there are a lot of kids that act out there and he worries about a fire or a shooting.

-Grandmother states that he has anger outbursts once and a while. She feels that he continues to struggle with thinking through his problems or actions. Discussed that this provider sees this and continues to encourage her to get some testing done on him. Discussed that his answers are so concrete and he seems surprised when he thinks about things with help (like to avoid homicide he threatened suicide).

- **(1/28)** continues with inpatient hospitalization secondary to suicidal ideation due to symptoms of ADHD and ODD.

- **(1/29)** DS admitted to the inpatient psychiatry unit at Dayton Children's Hospital for acute stabilization of suicidal ideation due to symptoms of ADHD and ODD.

APR DRG 758 Behavioral Disorders	
PDx: ODD/ADHD	
LOS	5.28 days
SOI/ROM	1/1
RW	1.2318
Secondary diagnoses: - suicidal ideation - insomnia - depression, unspecified	

Case Scenario 5

Admission: 5 days
Total Hospital Cost:$32,132.61

Please review for CDI.

Could you specify a likely/known condition reflective of below?

- noncompliance of medicine due to insurance concerns
- other please specify

Clinical indicators:

11/25 Discharge summary

-Medications - Patient reports that she has not been taking her medication for the past couple of weeks due to running out of medication. Per chart review, this may have been due to insurance concerns

Use of terms such as suspected, likely, concern for, unable to rule out are acceptable and can be coded in the inpatient setting, when documented on the discharge summary.

- **Query response:** noncompliance with medication due to insurance difficulties

APR DRG 756 **Acute anxiety and stress syndromes**	**APR DRG 756** **Acute anxiety and stress syndromes**
PDx: PTSD	**PDx: PTSD**
LOS 4.02 days	LOS 4.58 days
SOI/ROM 2/1	SOI/ROM 3/1
RW 0.8590	RW 0.9738
Secondary diagnoses: - Suicidal ideation - MDD, severe episode - Bullying - GAD - Hypoalbuminemia	**Secondary diagnoses:** - Suicidal ideation - MDD, severe episode - Bullying - GAD - hypoalbuminemia - noncompliance with med for other reason

Results-KPIs

- Query Metrics
- Case Mix Index – IPBH
- IPBH APR-DRG Trends
- Financial Impact
- Next Steps

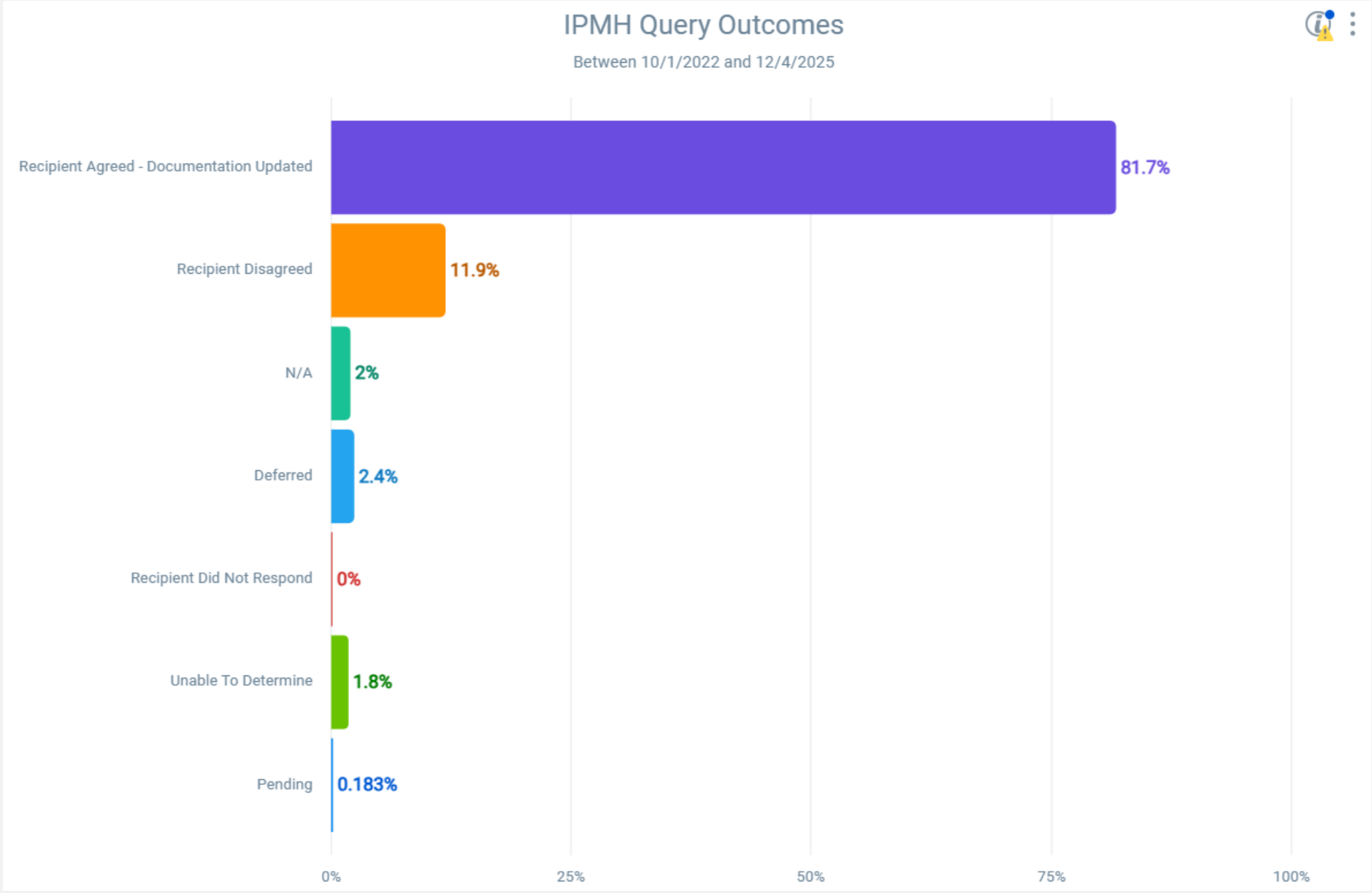
Results- Query Outcomes/Query Types

Query Outcome

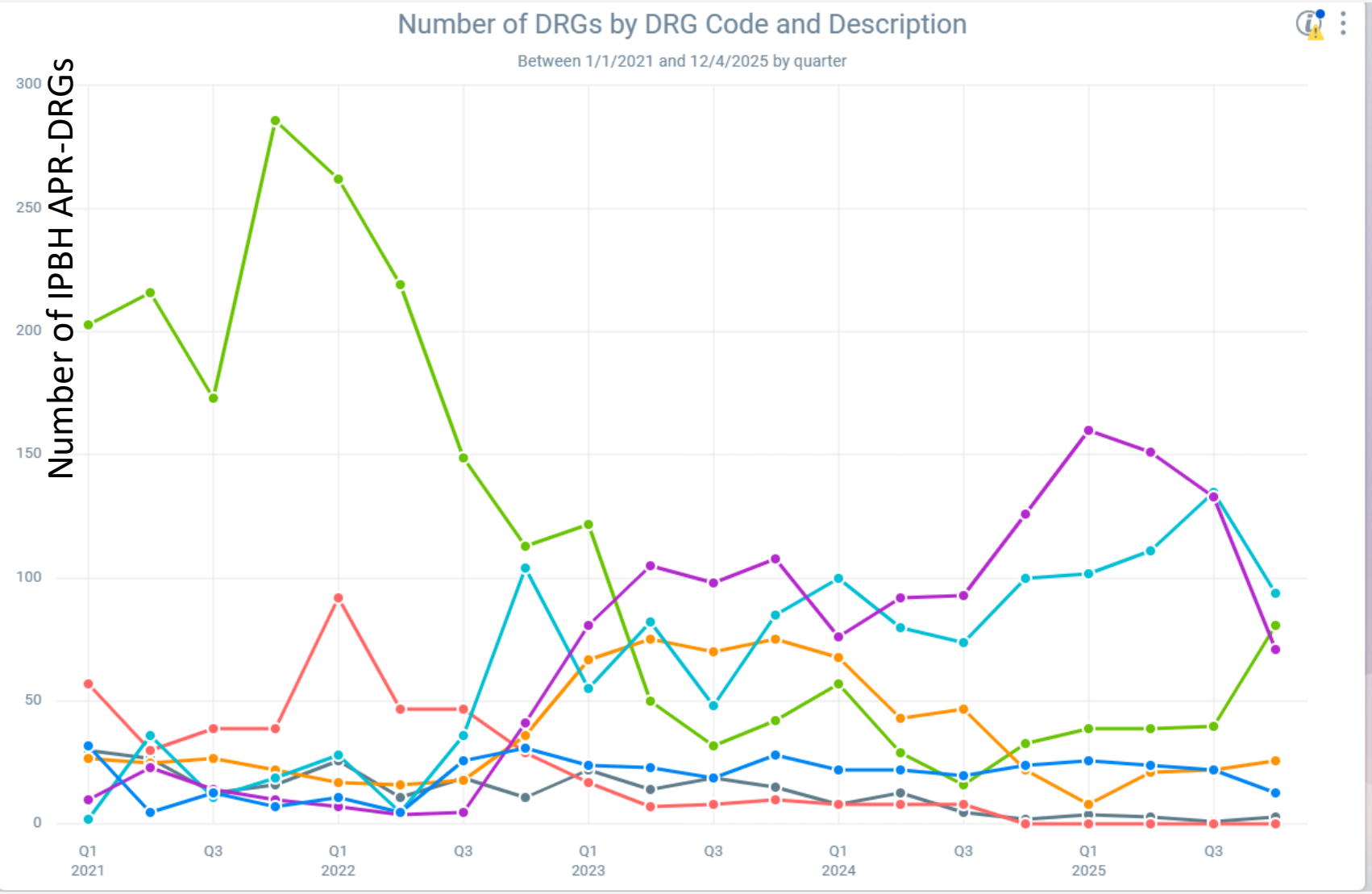
- Agree Rate – 82%
- Response Rate – 100%

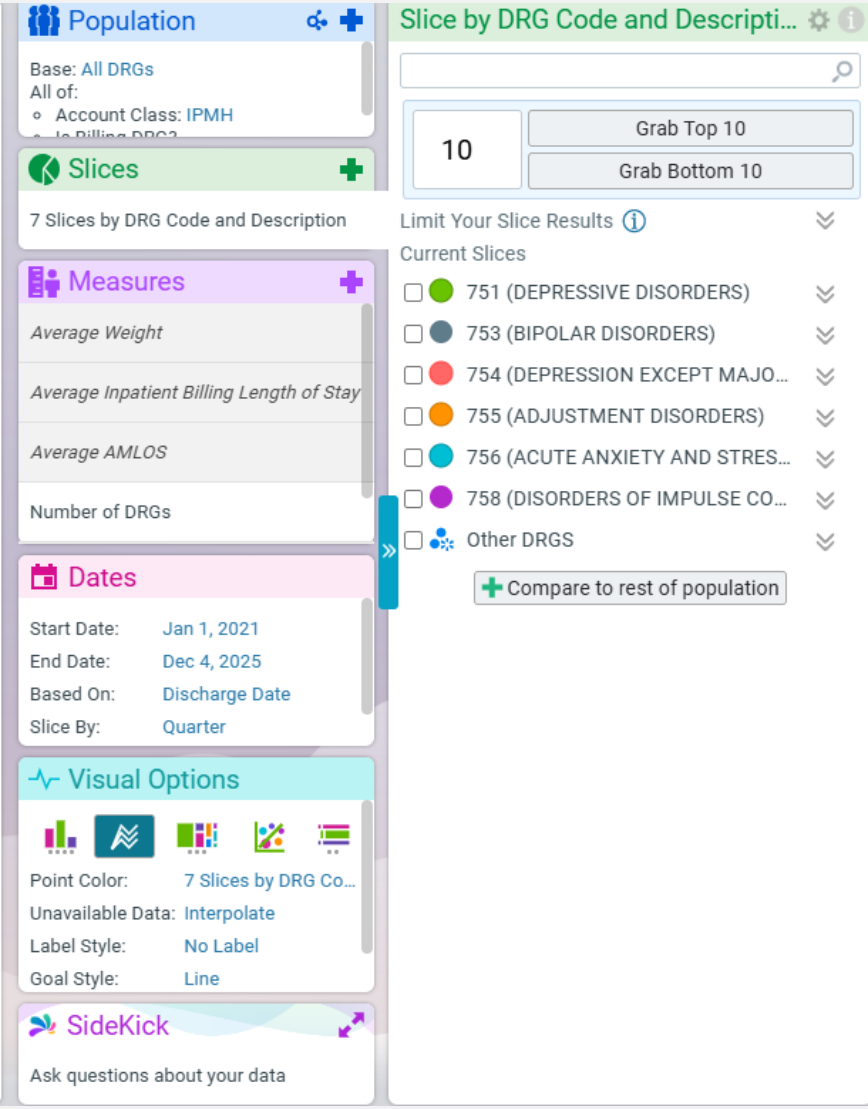
Top 5 query types

- Mental Health
- Neglect, abuse, bullying
- Malnutrition confirmation
- Confirmed/ruled out
- Encephalopathy



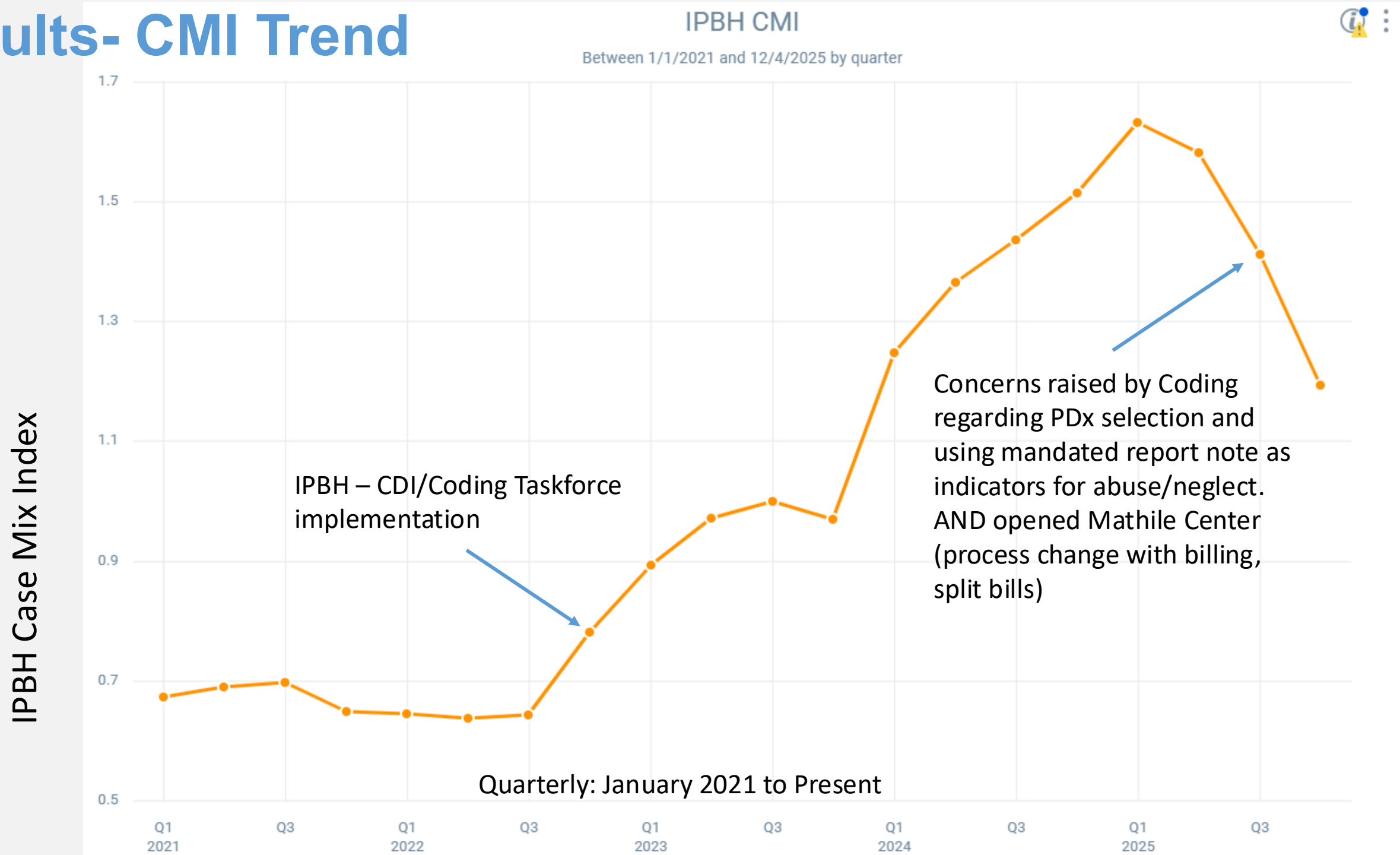
Results- APR-DRG Trend





Quarterly: January 2021 to Present

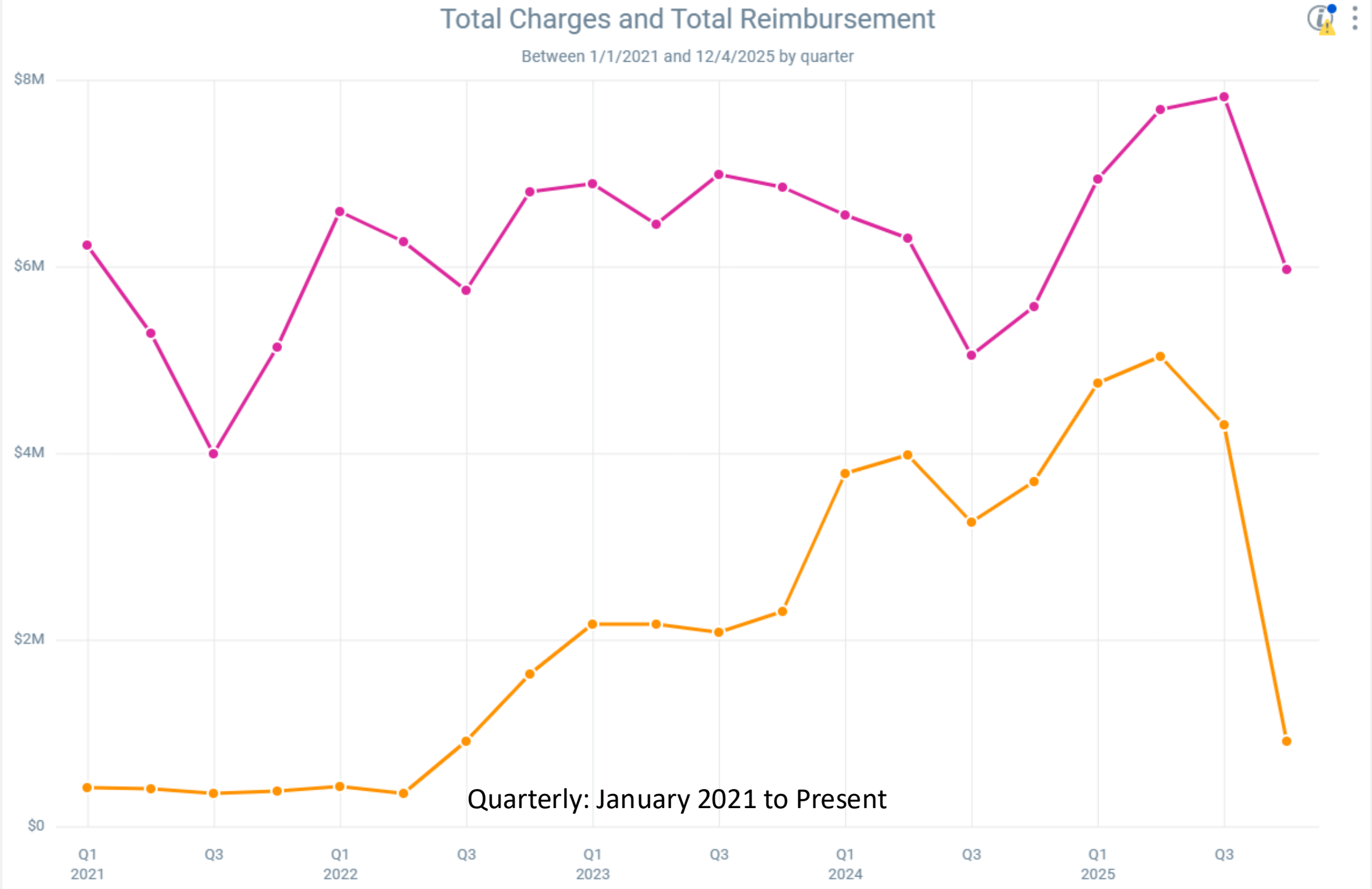
Results- CMI Trend



Medicaid Only

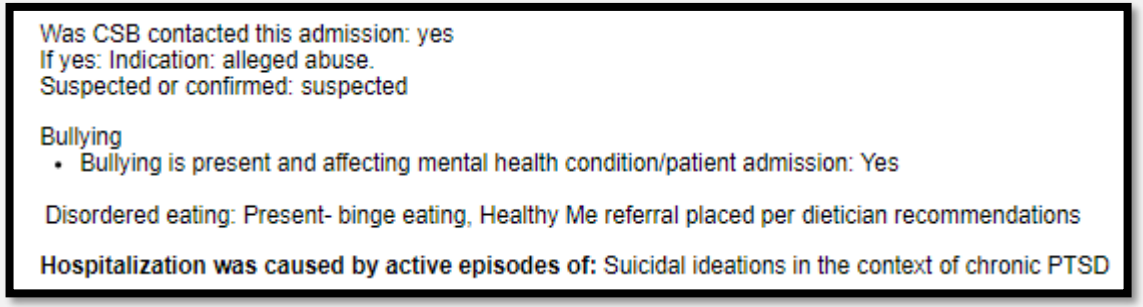
Charges per admission &

Reimbursement



Next Steps

- **Mathile Center**
  - Opening up to 48 beds soon
- **Templated discharge summary**



Was CSB contacted this admission: yes
If yes: Indication: alleged abuse.
Suspected or confirmed: suspected

Bullying
- Bullying is present and affecting mental health condition/patient admission: Yes

Disordered eating: Present- binge eating, Healthy Me referral placed per dietician recommendations

Hospitalization was caused by active episodes of: Suicidal ideations in the context of chronic PTSD

- **Track & trending**
  - continual auditing
- **Maintenance**
  - onboarding new psychiatrists
  - Quarterly meetings with Chief

questions and open discussion