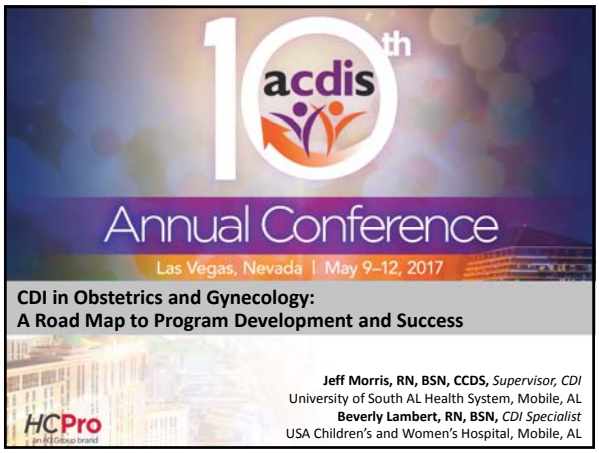

Learning Objectives

- At the completion of this educational activity, the learner will be able to:
  - Determine the need for CDI reviews of OB-GYN records at your facility and begin implementation of such program
  - Become familiar with Coding Guidelines and Coding Clinics specific to the OB-GYN patient population
  - Identify common diagnoses often overlooked or needing greater specificity
  - Compare and contrast OB-GYN MS-DRG's with OB-GYN APR-DRG's
  - Identify strategies for program success, program maintenance, and metrics to monitor

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USA Children's and Women's Hospital

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USA Children's and Women's Hospital

- 198 bed Academic Medical Center associated with the University of South Alabama located in Mobile, Alabama
- One of only a few freestanding Hospitals in the United States dedicated specifically to the health care needs of children and women
- Regional referral center for High Risk Obstetrics, GYN, GYN Oncology, General Pediatrics, Neonatal and Pediatric Critical Care

4

The Department of Obstetrics and Gynecology

- More than 2,800 babies born each year
  - Twice the amount of other hospital's in our area
- In addition to "normal" Obstetrics and Gynecology, we also offer the following services:
  - Maternal Fetal Medicine
  - Reproductive Endocrinology
  - GYN Oncology
    - Part of the Mitchell Cancer Institute which is the only center in the Gulf-Coast area to combine innovative academic cancer research with state of the art cancer treatment

5

Our Story

- The CDI program at USA Children's and Women's Hospital began in April 2012
  - One CDI hired
  - Focus of program was non-traditional
    - Provider education related to ICD-10 was top priority
    - Clinical liaison between coding staff and providers
    - Retrospective record review to determine what increased specificity would be needed in provider documentation for accurate ICD-10 code capture
    - Develop and implement provider training related to documentation specificity

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Our Story

- After ICD-10 implementation delays, CDI shifted focus to a more traditional role in addition to prior mentioned duties
  - Began concurrent reviews of DRG payers for Pediatrics and PICU
  - Began retrospective reviews (post coding/pre bill) of DRG payers for Obstetrics & Gynecology
  - Two additional CDI Specialists were hired in November 2015
    - One dedicated to OB-GYN Service Line
  - Additional CDI Specialist hired in October 2016
    - Expanded to NICU Service Line
  - Three total CDI Specialists plus system supervisor

7

Steps for Attendees to Answer/View POLLING QUESTIONS

1. Navigate to the event **Agenda** in the main menu
2. Tap the **name of the current session** to view the session details page
3. Tap **Polls**
4. Tap the **name of the poll**
5. Tap your **answer** choice and then tap **Submit**

Polling Question #1

- Does your CDI program currently have a CDI specialist reviewing OB-GYN records?
  - Yes
  - No
  - No, but we are considering
  - Not applicable

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Why We Pursued CDI in Obstetrics & Gynecology

- We knew our obstetric patient population had comorbid conditions and was sicker than the data was portraying.
- Alabama Medicaid is transitioning to an APR-DRG payment methodology.
  - Approximately 70% of our patient population
- Accurate capture of severity of illness (SOI) and risk of mortality (ROM) leads to accurate publically reported hospital and provider data. This is also a more accurate portrayal of how sick our patient population is.
- Wanted to extend the same CDI services to these providers as other service lines in our hospital

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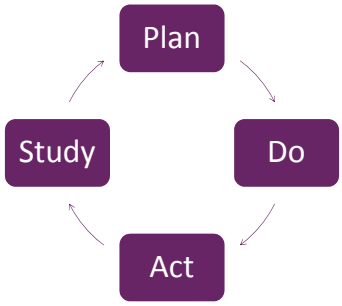
Our Road Map to Program Implementation



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Determining the Need for CDI Review of OB-GYN Records—Plan

- Baseline examination of the following data:
  - Case-mix index (CMI)
  - Severity of illness (SOI)
  - Risk of mortality (ROM)
  - Volume of coder-initiated queries
  - Types of queries that coders were initiating
  - Documentation specificity of providers

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Our Findings From Baseline Reviews

- CMI was not a reliable measure of acuity of patients or potential program success due to the majority of OB-GYN MS-DRGs being w/ CC/MCC or w/o CC/MCC with low relative weights
- Coders were only coding for CC/MCC capture, not SOI and ROM
- Coder-initiated queries were of low volume and were generally for ABLA, confirmation of pathology results, or complication clarification
- Documentation review revealed that OB-GYN provider documentation was vague and could benefit from CDI intervention

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Building Blocks for Implementation of OB-GYN Reviews—Do

- After careful review of the baseline data, we felt it was appropriate to place a CDI specialist in this service line to review our high-risk obstetrics, GYN, and GYN oncology patients
  - Short stays and "normal" deliveries would not be reviewed
- Choosing the ideal candidate
  - We felt the ideal person would be an internal candidate who had actually worked alongside our providers
  - Critical care experience was desired
- In addition to general CDI training, we sought out various training methods for this individual, which included webinars, videos, collaboration with coders, and review of pathophysiology and care of OB/GYN patients

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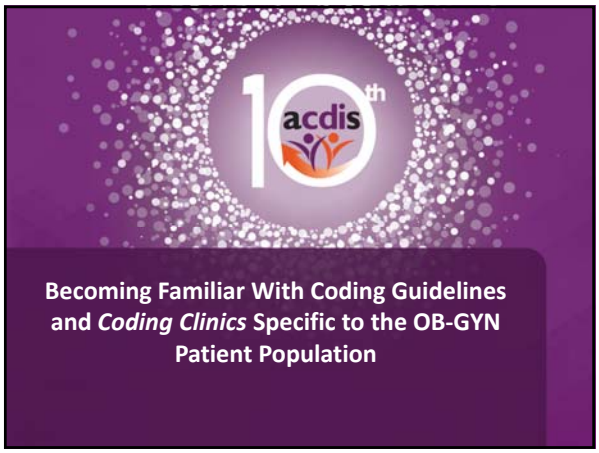

Chapter 15 Coding Guidelines

- Codes for the OB patient are only for use on the maternal record, never on the newborn record
- Codes for the OB patient are for conditions related to or aggravated by pregnancy, childbirth, and the puerperium
- Weeks of gestation are the admission date only; these do not change during the stay
- The provider's documentation of the weeks of gestation is sufficient to assign the appropriate trimester
- The addition of the seventh character is specific to the number of the fetus, if applicable

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Chapter 15 Coding Guidelines

- In most cases, the last character indicates the trimester of pregnancy
- Chapter 15 codes have sequencing priority over codes from other chapters, unless the provider specifically documents the pregnancy is incidental to the principal diagnosis (Z33.1 Pregnant state, incidental, should be used in place of Chapter 15 code)
- It is the provider's responsibility to document that the condition being treated is not affecting the pregnancy
- When a delivery occurs during the admission, use the "in childbirth" option for the principal diagnosis, if possible

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Coding Clinics Specific to the Obstetric Patient Population

- Prior to 2016, *Coding Clinic* advice on obstetrics was very sporadic
- Numerous *Coding Clinics* were issued in First Quarter 2016 that we found very helpful
- Fourth Quarter 2016 issued advice on new codes related to preexisting and gestational hypertension, including preeclampsia
- Fourth Quarter 2016 also issued advice on various obstetrics topics such as gestational diabetes, previous C-sections, and placenta previa

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Coding Clinics Specific to the Obstetric Patient Population

- *Coding Clinic,* First Quarter 2016:
  - Vaginal delivery assisted by vacuum and low forceps extraction
  - Obstetric perineal laceration repair
  - Normal delivery with third-degree laceration
  - Spontaneous vaginal delivery with fourth-degree perineal laceration
  - Periurethral laceration during delivery
  - Selection of principal diagnosis for vaginal delivery
  - Induction of labor due to gestational hypertension
  - Pregnancy complicated by gallstones and anemia
  - Pregnancy complicated by gestational diabetes and post-term status
  - Pregnancy complicated by polyhydramnios
  - Premature rupture of membranes
  - Delivery of SROM greater than 24 hours, nuchal cord and third-degree laceration

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Principal Diagnosis Selection

- Selection of the principal diagnosis is key
- For vaginal deliveries, the principal diagnosis corresponds to the main circumstances or complication of the delivery
- For cesarean sections, the principal diagnosis is either the condition that resulted in the performance of the cesarean or the reason the patient was admitted, even if it was unrelated to the condition resulting in the cesarean
- Obstetrics cases are unique in that the principal diagnosis may not be present on admission

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Common Diagnoses That Are Often Overlooked or Need Greater Specificity

- Many of the diagnoses we found that needed greater specificity or were being overlooked by coders and/or providers are common to experienced CDI specialists
- Our OB/GYN providers often describe conditions without giving a definitive diagnosis
- Through discussions with providers, we also learned that they didn't like to specify chronic conditions or to label an acute diagnosis without formally consulting their peers
- Our providers were not acknowledging diagnoses introduced by the consulting provider

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Common Medical Diagnoses That Are Often Overlooked or Need Greater Specificity

- Anemia
- AKI
- CKD
- CHF
- Complication clarification
- Diabetic complications
- Documenting complications of care
- Due to/linking terms
- Malnutrition
- Mental health diagnoses
- Obesity
- "Postop"
- Respiratory failure
- Sepsis
- Shock
- Substance abuse

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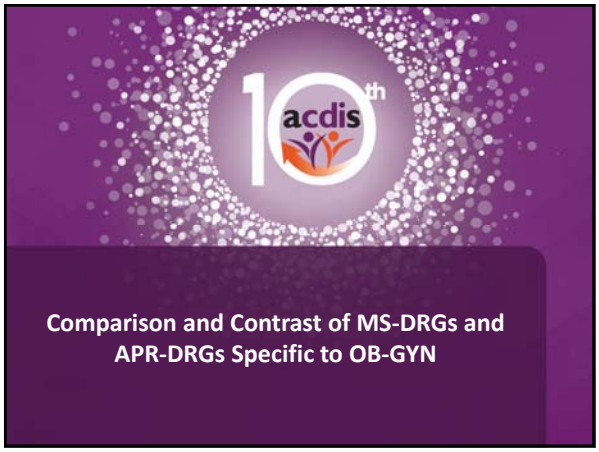
Common Obstetric and GYN Diagnoses That Are Often Overlooked or Need Greater Specificity

- Fetal anomalies
  - Affecting maternal care?
- Obstetric lacerations
  - Degree
  - Repair
- Placental abnormalities
- Pre-eclampsia
  - Degree
  - Existing hypertension?
- Status of malignancy
  - Current vs. recurrent
  - Metastatic sites

25



Comparison and Contrast of MS-DRGs and APR-DRGs Specific to OB-GYN

OB-GYN DRGs

- The MS-DRGs are w/o CC/MCC, w/ CC/MCC, w/o complicating diagnoses or w/ complicating diagnoses
  - Leaves little room for movement or improvement by CDI
  - Many of our patients already have at least one documented CC or MCC at time of review
- The APR-DRGs allow for four levels of severity of illness (SOI) and risk of mortality (ROM)
  - 1 = Minor, 2 = Moderate, 3 = Major, 4 = Extreme
  - Allows for more DRG movement or improvement by the CDI
  - Some non-CC/MCC diagnoses will actually improve SOI, ROM, or both

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Diagnoses That May Increase SOI and ROM

- Dependence on:
  - Supplementary oxygen
  - Ventilator
- Dysphagia
- Morbid obesity
- Residual effects of CVA
- Stage I and II pressure ulcers
- Statuses
  - Gastrostomy
  - Tracheostomy
  - Physical restraints
- Hypokalemia (in some instances)

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SOI and ROM Example

- 63-year-old female with PMH: Uterine fibroids and hypertension who is POD 1 s/p TAH. Patient was noted to have an area of non-blanchable redness on her coccyx as reported by RN on admission assessment. MD queried for stage 1 pressure ulcer.
- Pre query: MS-DRG 743, RW 1.0167.
  - » APR-DRG 519, S1 R1, RW 0.8872.
- Post query: MS-DRG same.
  - » APR-DRG 519, S2 R2, RW 1.060.
  - ***SOI and ROM increase of 1 point each and 0.1728 RW increase***

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Obstetrics Case Study #1

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Obstetrics Case Study #1

29-year-old female with 23 week IUP presented with new onset chest pain, SOB, 2+ edema to both extremities and SIPE per PD. PMH: Poorly controlled CHTN, morbid obesity (BMI 50). CXR on admit "suggestive of cardiomegaly and pulmonary edema." Art line placed for continuous BP monitoring. OB states "SIPE, heart failure, echo with EF 45%." Cardiology simply states echo findings of mildly decreased global L ventricular systolic function. Internal medicine states "HTN emergency/preeclampsia and new cardiomegaly/reduced EF and decreased EF consistent with acute systolic heart failure—unlikely to represent true hypertensive heart failure and most likely to fully recover over time." Patient delivered via C-section.

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Pre-Query

	Description	Affect	MCC	CC	DCI	MLM
O112	Pre-existing hypertension with pre-eclampsia, second trimester	✓			P	P
O9942	Diseases of the circulatory system complicating childbirth	✓	✓		2	1
I429	Cardiomyopathy, unspecified			✓	2	2
Z6843	Body mass index (BMI) 50-59.9 , adult			✓	2	1
E6601	Morbid (severe) obesity due to excess calories				2	1
O99214	Obesity complicating childbirth				2	1
Z370	Single live birth				1	1
O9952	Diseases of the respiratory system complicating childbirth				1	1
I517	Cardiomegaly				1	1
Z3A23	23 weeks gestation of pregnancy				1	1
O3412	Maternal care for benign tumor of corpus uteri, second trimester				1	1
D259	Leiomyoma of uterus, unspecified				1	1
O3482	Maternal care for other abnormalities of pelvic organs, second trimester				1	1
N8320	Unspecified ovarian cysts				1	1

dure Code Detail

	Description	Affect	SP
10D00Z0	Extraction of Products of Conception, Classical, Open Approach	✓	
0UB00ZZ	Excision of Right Ovary, Open Approach		

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Queries

- Heart failure
  - Type
  - Acuity
  - Agreement with internal medicine consult
- Chronic HTN with SIPE
  - Internal medicine documenting preeclampsia with hypertensive emergency

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Post-Query

O112	Pre-existing hypertension with pre-eclampsia, second trimester	✓			P	P
O9942	Diseases of the circulatory system complicating childbirth	✓	✓		2	1
I5021	Acute systolic (congestive) heart failure		✓		3	3
Z6843	Body mass index (BMI) 50-59.9 , adult			✓	2	1
I429	Cardiomyopathy, unspecified			✓	2	2
E6601	Morbid (severe) obesity due to excess calories				2	1
O99214	Obesity complicating childbirth				2	1
Z370	Single live birth				1	1
I517	Cardiomegaly				1	1
Z3A23	23 weeks gestation of pregnancy				1	1
O3412	Maternal care for benign tumor of corpus uteri, second trimester				1	1
D259	Leiomyoma of uterus, unspecified				1	1
O3482	Maternal care for other abnormalities of pelvic organs, second trimester				1	1
N8320	Unspecified ovarian cysts				1	1

Greater Specificity

dure Code Detail

	Description	Affect	SP
10D00Z0	Extraction of Products of Conception, Classical, Open Approach	✓	
03HY32Z	Insertion of Monitoring Device into Upper Artery, Percutaneous Approach		
0UB00ZZ	Excision of Right Ovary, Open Approach		

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Query Impact

- Baseline
  - MS-DRG 765, RW 1.1442
  - APR-DRG 540, S3 R1, RW 0.9296
- Final
  - MS-DRG 765, RW 1.1442
  - APR-DRG 540, S3 **R3,** RW 0.9296
- MS-DRG: No impact
- APR-DRG: ROM increased by 2 points, which more accurately reflected the acuity of this patient

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Obstetrics Case Study #2

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Obstetrics Case Study #2

19-year-old female with 36 week IUP with gestational hypertension that progressed to severe preeclampsia and delivered via NSVD. PMH: morbid obesity (BMI 46.9), RH - with anti-Lewis antibody, GBS +; history of depression and anxiety; 2/7/17 serum CR 0.44, Hgb 10.2, Hct 30.5; 2/9/17 serum CR 0.74, Hgb 7.5, Hct 22.6.

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Pre-Query

	Description	Affect	MCC	CC	Q	Dx	ROM
T O1414	Severe pre-eclampsia complicating childbirth	✓				P	P
T Z6843	Body mass index (BMI) 50-59.9 , adult			✓		3	1
T O360930	Maternal care for other rhesus isoimmunization, third trimester, not applicable or unspecified			✓		1	1
T E6601	Morbid (severe) obesity due to excess calories					2	1
T O99344	Other mental disorders complicating childbirth					2	1
T O99824	Streptococcus B carrier state complicating childbirth					1	1
T Z370	Single live birth					1	1
T Z3A37	37 weeks gestation of pregnancy					1	1
N O701	Second degree perineal laceration during delivery					1	1
T O99214	Obesity complicating childbirth					1	1
T F329	Major depressive disorder, single episode, unspecified					1	1
T F419	Anxiety disorder, unspecified					1	1

dure Code Detail

	Description	Affect	SP
10E0XZZ	Delivery of Products of Conception, External Approach	✓	
0KQM0ZZ	Repair Perineum Muscle, Open Approach		

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Queries

- Acute blood loss anemia
- Acute kidney injury

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Post-Query

	Description	Affect	MCC	CC	SOI	ROM
O1414	Severe pre-eclampsia complicating childbirth	✓			P	P
N179	Acute kidney failure, unspecified				3	2
Z6843	Body mass index (BMI) 50-59.9 , adult			✓	3	1
D62	Acute posthemorrhagic anemia			✓	2	1
E6601	Morbid (severe) obesity due to excess calories				2	1
O99344	Other mental disorders complicating childbirth				2	1
O26833	Pregnancy related renal disease, third trimester			✓	2	1
O360930	Maternal care for other rhesus isoimmunization, third trimester, not applicable or unspecified			✓	1	1
O99824	Streptococcus B carrier state complicating childbirth				1	1
Z370	Single live birth				1	1
Z3A37	37 weeks gestation of pregnancy				1	1
O701	Second degree perineal laceration during delivery				1	1
O99214	Obesity complicating childbirth				1	1
F329	Major depressive disorder, single episode, unspecified				1	1
F419	Anxiety disorder, unspecified				1	1
O9902	Anemia complicating childbirth				1	1

Query

dure Code Detail

	Description	Affect	BP
10E0XZZ	Delivery of Products of Conception, External Approach	✓	

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Query Impact

- Baseline
  - MS-DRG 775, RW 0.6094
  - APR-DRG 560, S2 R1, RW 0.3596
- Final
  - MS-DRG 775, RW 0.6094
  - APR-DRG 560, **S3** R1, RW 0.5228
- MS-DRG: No impact
- APR-DRG: SOI increase of 1 point and RW increase of 0.1632

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GYN Oncology Case Study

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GYN Oncology Case Study

60-year-old female admitted with pelvic mass, enlarged uterus with leiomyoma likely—stage IV ovarian vs. EMCA, anemia, hyperlipidemia, and CHTN. Cardiology consult on chart stated patient has CKD stage 3. Patient underwent ex-lap with partial omentectomy, R ovarian excision and resection of small bowel with side-to-side reanastamosis. Labs the next morning revealed Cr 1.80 and GFR 35. MD notified by RN that patient was having "respiratory distress, retractions, nasal flaring, and crackles with saturations 89-90 on RA. Patient was placed on 5L O2, orders for Lasix, Lovenox, and chest CT for concerns of PE. CT showed no PE but bilateral pulmonary nodules concerning for metastasis. Patient also noted to have decreasing UOP.

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GYN Oncology Case Study (cont.)

Repeat labs reveal Cr 2.5, GFR 30. BP 92/58, HR 119, 2 units PRBCs ordered, Hespan given. Patient continued to deteriorate and MD states "acute respiratory distress," given Lasix for clinical pulmonary edema. Shortly after notes stated "patient found to be in unsustainable respiratory distress, CRNA at bedside to intubate." 15 minutes later the patient lost pulse, CPR initiated. The patient was given one round of epinephrine and atropine and deemed stable for transport to our sister hospital for ICU-level care.

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Pre-Query

Diagnosis Code Detail

Code	Description	Affect	MCC	CC	SOI	ROM
C541	Malignant neoplasm of endometrium	✓			P	P
I10	Essential (primary) hypertension				1	1
R1900	Intra-abdominal and pelvic swelling, mass and lump, unspecified site				1	1
D649	Anemia, unspecified				1	1
D259	Leiomyoma of uterus, unspecified				1	1
N852	Hypertrophy of uterus				1	1
N950	Postmenopausal bleeding				1	1
E785	Hyperlipidemia, unspecified				1	1

Procedure Code Detail

Code	Description	Affect	SP
0DBS0ZZ	Excision of Greater Omentum, Open Approach		
0UB00ZX	Excision of Right Ovary, Open Approach, Diagnostic	✓	
0DT80ZZ	Resection of Small Intestine, Open Approach		
0BH17EZ	Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening		
5A1935Z	Respiratory Ventilation, Less than 24 Consecutive Hours		

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Queries

- Acute respiratory failure
- AKI
- CKD with stage (MD did not agree)
- Lung metastasis

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Post-Query

Diagnosis Code Detail

Code	Description	Affect	MCC	CC	SOI	ROM
C541	Malignant neoplasm of endometrium	✓			P	P
J9601	Acute respiratory failure with hypoxia	✓	✓		4	4
J690	Pneumonitis due to inhalation of food and vomit		✓		4	3
C7801	Secondary malignant neoplasm of right lung			✓	2	2
C7802	Secondary malignant neoplasm of left lung			✓	2	2
N179	Acute kidney failure, unspecified			✓	3	2
K9172	Accidental puncture and laceration of a digestive system organ or structure during other procedure			✓	C	C
I10	Essential (primary) hypertension				1	1
R1900	Intra-abdominal and pelvic swelling, mass and lump, unspecified site				1	1
D649	Anemia, unspecified				1	1
D259	Leiomyoma of uterus, unspecified				1	1
N852	Hypertrophy of uterus				1	1
N950	Postmenopausal bleeding				1	1
E785	Hyperlipidemia, unspecified				1	1

Query

Query

Query

Procedure Code Detail

Code	Description	Affect	SP
0DBS0ZZ	Excision of Greater Omentum, Open Approach		
0UB00ZX	Excision of Right Ovary, Open Approach, Diagnostic	✓	
0DT80ZZ	Resection of Small Intestine, Open Approach		
0BH17EZ	Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening		
5A1935Z	Respiratory Ventilation, Less than 24 Consecutive Hours		

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Query Impact

- Baseline
  - MS-DRG 741, RW 1.2358
  - APR-DRG 512, S1 R1, RW 1.1102
- Final
  - MS-DRG 739, RW 3.4992
  - APR-DRG 512, S**4** R**4,** RW 4.1935
- MS-DRG: RW increase of 2.2634
- APR-DRG: 3 point increase of SOI and ROM, RW increase of 3.0833

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Provider Engagement Strategies

- Provide evidence-based medical literature to support diagnosis specificity.
- Provide treats and goody bags—everyone loves treats!
- The CDI specialist assigned to this area is very flexible and often delivers queries to providers for face-to-face discussion:
  - Helps provider understand the question being asked and the associated rationale
  - Allows provider to ask questions
  - Allows for provider feedback on query appropriateness

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Provider Education

- Don't be afraid to get creative!
- Formal:
  - Presentations and education for incoming interns/staff
  - Presentations and education for the obstetric, GYN, GYN oncology, and medical team periodically
- Informal:
  - Tip sheets and posters—placed in high-traffic flow areas for medical staff, changed monthly
  - Pocket cards—presented to residents during initial hospital orientation in July

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Our Experiences and Struggles with Startup and Maintenance

- Challenges of a hybrid medical record
- Resident physicians are more receptive to the CDI program and concurrent process
  - Gaining attending physician buy-in
- OB-GYN providers remain hesitant to use "medical" diagnoses on their patients
  - Both chronic and acute conditions
- GYN oncology physicians are so involved in patient care and research that they appear reluctant to collaborate with the CDI program on a day-to-day basis

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Our Experiences and Struggles with Startup and Maintenance

- Currently there is no acute care area for these patients
- If acute events occur that require ICU-level care, the patients are transferred to our sister hospital, The University of South Alabama Medical Center
- Once the patients do not require ICU level of care, they are transferred back to our hospital
  - Difficulty determining PDX on readmission
  - Difficulty capturing the true SOI and ROM related to the acute illness
  - The CDI specialist often has to query on readmission to determine the true scope of care and reason for admission to our facility, since each visit stands alone

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Program Metrics—Study

- The following metrics are reviewed:
  - Review rate: 90% or greater
  - DRG reconciliation: Supervisor monitors for appropriate DRG assignment. This process is not punitive, and no agreement rate is assigned. This fosters a relationship between the CDI specialist and coder.
  - SOI and ROM quality scores for each service line.
  - Query appropriateness: Supervisor monitors issued queries for appropriateness and audits cases for any missed opportunities.
  - We do not currently track CMI (small Medicare population).
- Coder-initiated queries have significantly dropped since initiation of concurrent CDI review of OB-GYN records

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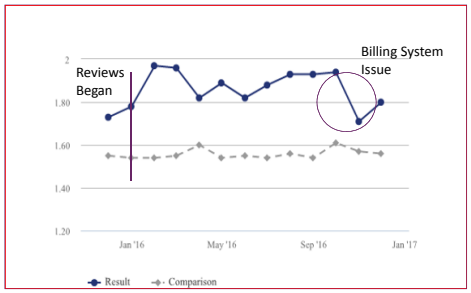
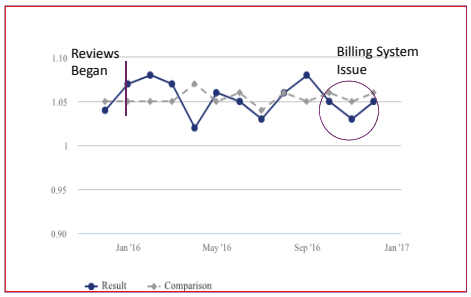
Average Severity of Illness—Obstetrics



55

Average Risk of Mortality—Obstetrics



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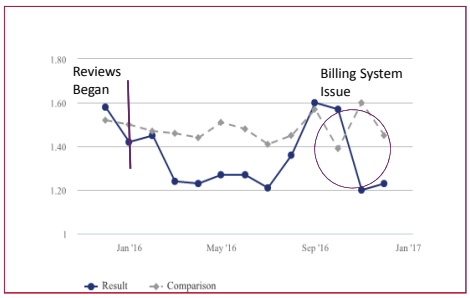
Average Severity of Illness—Gynecology



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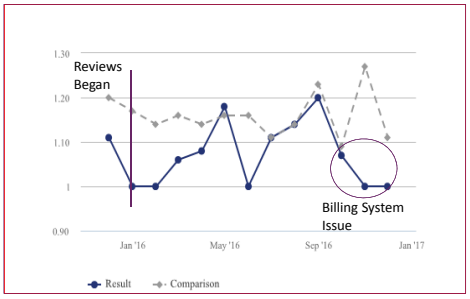
Average Risk of Mortality—Gynecology



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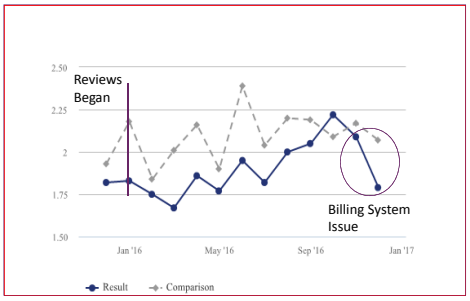
Average Severity of Illness—GYN Oncology



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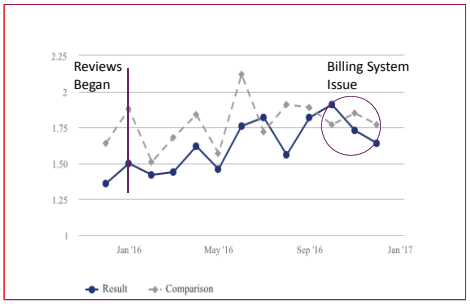
Average Risk of Mortality—GYN Oncology



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Future Plans for Growth—Act

- Rounding with providers
- Development of evidence-based clinical indicators for common medical conditions
  - Assist with provider education
  - Assist with query guidance for the staff-level CDI and coders
- Hospital leadership is evaluating the need for an acute care or intermediate care area for these patients requiring a higher level of care
- Cross-train other CDI specialists in this unique area

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Tips for a Successful Program

- Be flexible and creative
- Collaborate with bedside nurses, social workers, and dietitians as they can be a wealth of knowledge regarding issues that the provider is under-documenting
- Use meaningful metrics to show providers "what's in it for them"
- Post tip sheets and education in charting areas and lounges so that providers are more likely to see them
- Set realistic CDI goals when expanding into this new area
- Continuous evaluation is key—we learn something new every day and adapt our processes accordingly

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Thank you. Questions?

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In order to receive your continuing education certificate(s) for this program, you must complete the online evaluation. The link can be found in the continuing education section at the front of the program guide.

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