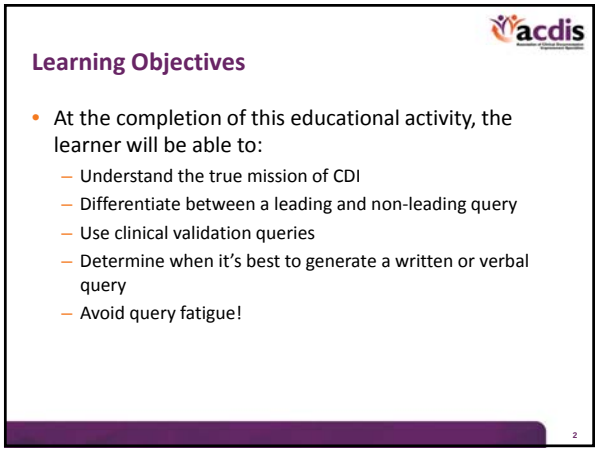

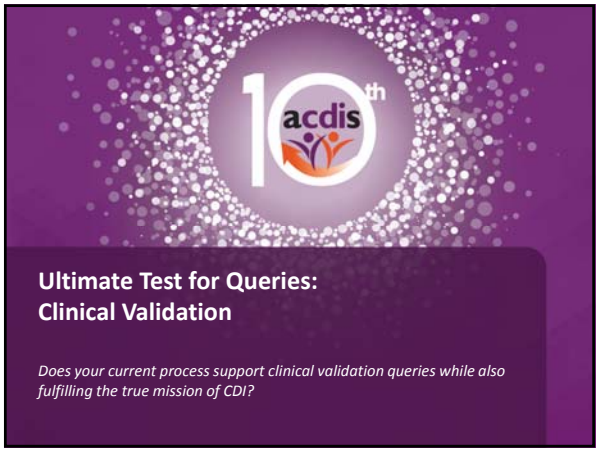

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The True Mission of CDI

Is your program primarily directed toward …

- Accurate coding?
- Better reimbursement?
- Higher severity of illness?
- Better risk-adjusted scores?

  or

- Capturing the **#CLINICAL TRUTH?**

The end justifies all of these means …

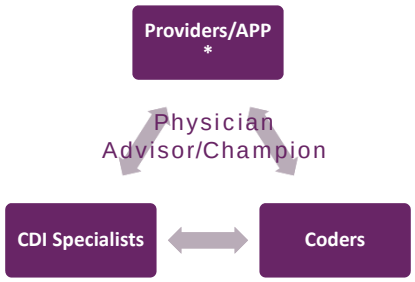
4

Align Your CDI Program's TRUE Mission With the #CLINICAL TRUTH

- CDI key performance indicators
  - Productivity measures
  - Outcome measures
  - Not on $ gains alone, but on $ saved …
    - From audit denials, fraud cases
  - Big picture
    - CMI
    - APR CMI
    - Losses from DRG denials and RAC audits

5

True CDI Success Is Founded on the #CLINICAL TRUTH



*Advanced Practice Providers

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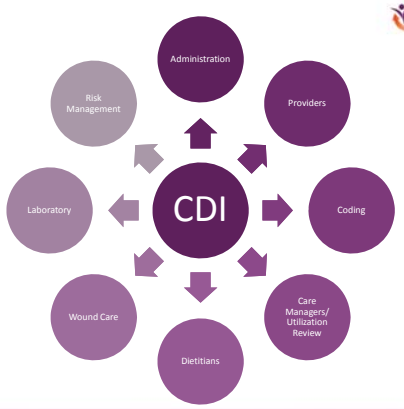

7

So What Are Clinical Validation Queries?

- Provider queries that address documented diagnoses lacking appropriate clinical support
  - Need conditions to be ruled out

    OR
  - Provide additional clinical information to support a documented diagnosis

8

Why Are Clinical Validation Queries Important?

- Unfortunately, CDI teams can no longer afford to ignore implementation of clinical validation queries as part of their common practice in the face of growing third-party DENIALS!

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How Can We Successfully Implement a Clinical Validation Query Process?

- Use your physician advisor to help navigate the development of clinical validation query policies
- Involve the physician advisor in getting the message out to the medical staff

10

Don't Misunderstand …

- Queries should not be used to question a provider's clinical judgment, but rather to clarify documentation. In situations where the clinical information or clinical picture do not appear to support the documentation of a condition or procedure, hospital policies should provide guidance on a process for addressing the issue. (AHIMA, 2008)

11

Avoid Denials by Validating the #CLINICAL TRUTH

Top Clinical Conditions at Risk for Denial
Sepsis/acute pyelonephritis
AKI/ATN
Acute respiratory failure
Encephalopathy
Severe malnutrition

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Tips for Handling Risky Documentation

- Educate providers about the risks involved with documentation never being ruled out after study.
  - Review denial cases with providers
- Determine when a written query to discuss such risky cases will be effective and when a verbal discussion might be best.
- Involve the CDI physician champion to support the CDSs with difficult clinical discussions and use those conversations as a means for educational opportunities!

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Neutral Queries Built on No Bias

You may know the answer you want, but it may not necessarily be true!

Vital Components of a Neutral Query

- Clinical presentation
  - Signs and symptoms
  - HPI/progress notes/consults
- Diagnostic workup/lab values
  - CBC
  - ABGs
  - Diagnostic and interventional procedure reports
- Multiple-choice options
  - Either/or
  - Yes/no

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Leading vs. Non-Leading Queries

- Vital components of neutral query (previous slide)
- What is your intention?
  - If you are pushing for a specific answer, you are already biased. Keep an open mind!
  - Presentations, lab values, and diagnostic criteria are not infallible. You need to exclude other conditions that may explain the issue!
  - Go back to your program's true mission …
  - Your query will bear out your true intentions.
  - Is it clinically valid?

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How to Win Friends and Influence Providers With Valid Queries!

- Provide adequate clinical information in the query to help physicians give an answer without digging for additional information
  - Echo results to determine CHF type
  - Baseline creatinine/GFR info for the patient with CKD staging table to reference

  (often, provider queries do not consistently include this type of information)
- Do all you can to cater to the providers in order to build relationships – it generally pays off!

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How to Win Friends and Influence Providers With Valid Queries!

- Don't be guilty of query fatigue!
  - Little bumps in creatinine corrected with IV hydration within a few hours are not considered AKI
  - Slight drops in Na+ easily corrected with normal saline within a few hours do not need a query for hyponatremia
  - Don't take a BMI that is auto-calculated and exhaust providers for a diagnosis that may lack the true support needed to be a secondary diagnosis

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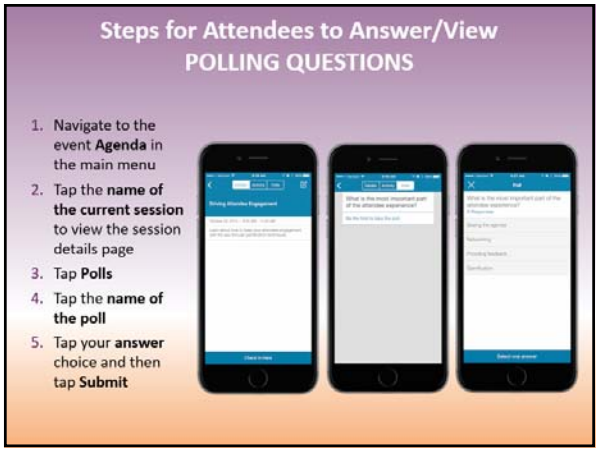

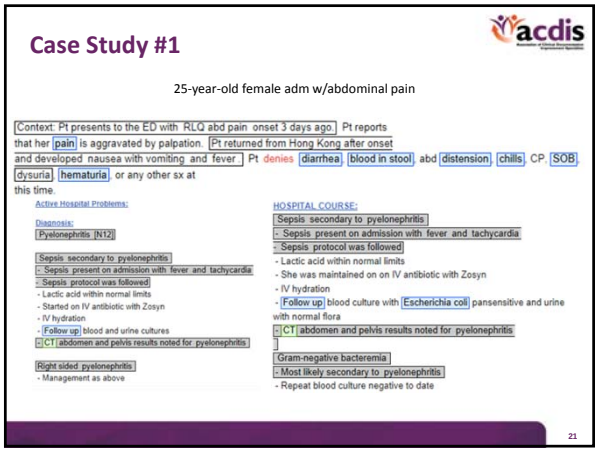

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Polling Question #1

- What is the principal diagnosis?
  - Acute pyelonephritis
  - Gram-negative bacteremia due to acute pyelonephritis
  - Sepsis secondary to acute pyelonephritis

acdis

Clinical and Laboratory Findings in Patients with Acute Pyelonephritis

CATEGORY	FINDINGS
History	Lower urinary tract symptoms (e.g., frequency, urgency, dysuria)
	Upper urinary tract symptoms (e.g., flank pain)
	Constitutional symptoms (e.g., fever, chills, malaise)
	Gastrointestinal symptoms (e.g., nausea, vomiting, anorexia, abdominal pain)
Physical examination	Fever (temperature > 100.4°F [38.0°C]), tachycardia, hypotension
	Costovertebral angle tenderness
	Possible abdominal or suprapubic tenderness
Laboratory tests	Urinalysis showing positive leukocyte esterase test, microscopic pyuria or hematuria, or white blood cell casts
	Peripheral blood smear showing leukocytosis, with or without left shift
	Positive blood culture in 15 to 30 percent of cases
	Urine culture growing ≥ 10^5 colony-forming units per mL of urine

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acdis

Drugs & Diseases > Nephrology

Acute Pyelonephritis Workup

Updated: Sep 08, 2016 | Author: Tibor Fulop, MD, FASN, FACP; Chief Editor: Vecihi Batuman, MD, FASN more...

Share Feedback

- Overview
- Presentation
- DDx
- Workup
  - Approach Considerations

Urine and Blood Cultures

Urine culture is indicated in any patient with pyelonephritis, whether treated in an inpatient or an outpatient setting, because of the possibility of antibiotic resistance. Reliable results require proper specimen collection.

Blood cultures are indicated in any patient who is being admitted or who has already been admitted. Approximately 12-20% of patients have cultures that are positive for infection. Bacteremia has not been associated with a poor outcome unless sepsis or another significant comorbidity is present.

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Case Study #2

- 84-year-old admitted with mental status changes off baseline of dementia. DX: UTI, B/P 114/45, HR = 77.
- WBC – WNL, LA = 1.3, BUN/Cr initially 54/2.13 and at D/C the BUN/Cr 38/1.75 noted as BL of CKD 3.
- Within 24 hours, mental status changes were improving with IVFs and IV antibiotics.
- Discharged on HD 2.

In the elderly, AMS is often triggered with dehydration in the setting of infection. With rapid improvement, this is likely UTI with dehydration, CKD 3. A query to rule out sepsis would have been appropriate.

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Sepsis

- Differentiate sepsis from uncomplicated infection!
- Make sure that the patient's condition cannot be explained by other etiologies.
- On admission, it may be hard to tell. But in a day or two, it becomes clearer! (Be sure to get the condition ruled out if not clinically supported after study.)
- If present, documentation should show supporting evidence for the diagnosis.

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Common Sepsis Issues

- Reliance on "criteria of SIRS" to define sepsis when either VS abnormalities not related to infection or patient not sick
- Placing in "sepsis bundle" is not a diagnosis of sepsis
- Simple infections with fever and elevated white count called "sepsis" and patient sent home
- Sepsis sometimes ruled out but gets copy/pasted

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Case Study #3

AKI versus Severe Dehydration on CKD 4

On admit BUN/Cr = 21/2.28
1/10 BUN/Cr = 22/2.09
1/11 BUN/Cr = 28/2.67
1/12 BUN/Cr = 29/3.02
1/13 BUN/Cr = 32/2.88

MD makes mention of baseline ranging from 1.7–1.9 in one note. Another note mentions baseline 2.0. Documentation reflects patient was admitted with severe dehydration versus progression of CKD. Not sure the AKI can be supported in the setting of already existing CKD 4. Need sustained elevations 1.5 times baseline.

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Case Study #4

- 62-year-old presents to ED with non-productive cough
- Hx of lung CA, cocaine abuse, COPD, CHF, and HTN
- ROS: + for chills/fever, cough, no shortness of breath
- PE: T 36.9, HR 132, RR 16, BP 123/96, MAP 104, SpO2 97%
- CXR possible infiltrates
- Influenza A positive
- MD notes: "admitted with respiratory failure"
  - Principal problem: Pneumonia
    - Respiratory failure
      - +Influenza A
      - +RLL infiltrate vs. scarring

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Polling Question #2

- What is the principal diagnosis?
  - Acute respiratory failure
  - Pneumonia due to influenza A
  - Sepsis due to pneumonia

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Case Study #5

- HOSPITAL COURSE:
  - 84-year-old female was admitted with confusion and dysarthria and found to have a multidrug-resistant urinary tract infection. This caused sepsis with symptoms that included leukocytosis with left shift, tachycardia, and mental status changes. Patient was placed on IVF and antibiotics (Cipro, Zosyn). Fever, leukocytosis, and mental status changes resolved by day 3 and discharged on 5th hospital day.
  - MRI BRAIN FINDINGS: Mild white matter hyperintensities are noted on FLAIR and T2-weighted images. No acute infarct is seen on diffusion-weighted images.

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Polling Question #3

- What is the principal diagnosis?
  - Hypovolemia causing altered mental status
  - Sepsis with no organ dysfunction/failure
  - Severe sepsis with metabolic encephalopathy

Sepsis-Associated Encephalopathy

Brain imaging findings may also be remarkable in patients with SAE.[42,60,61] Sharshar et al. performed brain MRI evaluations in nine critically ill septic patients.[42] Five of these patients had white matter lesions (leukoencephalopathy) that were characterized by hyperintensity on fluid-attenuated inversion recovery (FLAIR) images and predominated around enlarged perivascular spaces, which are likely related to damage to the BBB. The severity of these lesions was correlated to neurologic prognosis, as evaluated by the Glasgow Outcome Scale.

Posterior reversible encephalopathy (PRE) may also be linked to sepsis and infection.[62] In a study of 106 patients with PRE, 23.6% had infection or sepsis/septic shock. The clinical symptoms included altered mental status, seizures and visual disturbances. PRE was not an early finding, as it occurred up to 30 days after infection.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3180153/

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Case Study #6

Nutritional assessment

Subjective:

- He stated he has been losing weight, and that his usual weight is 247#; currently 223#.

Pertinent Laboratory Indices 9/29 glucose 222,Prealbumin 20.4,albumin 3.0 (mild protein depletion)

Nutrition Diagnosis:
Sub-optimal oral intake
Related to: decreased appetite
As Evidenced by: Intake of <75% of most meals, reported weight loss of 10% of UBW.

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Polling Question #4

- What is the diagnosis?
  - Obesity
  - Hypoproteinemia
  - Mild malnutrition

Malnutrition in Obesity

- Personal history
  - Fast food/high-calorie but poor-nutrition diet
  - > 10% weight loss in the past 6 months
- Patients who are edematous may be malnourished with no documented weight loss
- Clinical studies have shown poorer outcomes in hospitalized patients with malnutrition in obesity

http://www.acphospitalist.org/archives/2015/02/nutrition.htm

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Malnutrition: Identify, Stratify

- Malnutrition increases mortality statistics for surgeries, infections, malignancies, and tolerance of treatment for malignancies – virtually every disease for which patients are admitted
- Documentation shows "cachectic," "lost 30 pounds in a month," "skeletal," etc.
- Criteria for stratifying mild, moderate, and severe malnutrition exist

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Collaboration: CDSs/RDs

The RD did not use an actual diagnosis:

- Moderate malnutrition, or
- Severe malnutrition

CDSs need to collaborate with RDs to make certain the patient's nutritional status is well documented to assist providers. CDSs have a responsibility to use available information to query providers for further specificity when lacking.

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Make Your Collaborative Efforts With RD Iron-Clad!

- Assess the status of current internal process with RD for capturing malnutrition
- Include RDs in case studies to show the impact of NOT capturing a malnutrition diagnosis
- Make sure CDSs are addressing RD assessments that do NOT include an actual malnutrition diagnosis
- Work hard to develop a sustained collaborative effort between providers, RDs, and CDSs

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Conclusion

Preserving the Clinical Story

- Paint the picture of the patient's true severity of illness
  - What necessitated the patient's admission/surgery?
  - What comorbid conditions does the patient bring to the hospital?
  - Why did a condition develop during the hospital course?
- Drill down to the etiology of the patient's condition ("due to")
- Use descriptive words
  - Acute, chronic, acute on chronic (or exacerbation)
  - Condition ruled in, ruled out, improved, resolved
  - Events after surgery are due to the nature of:
    - Disease
    - Procedure
    - Complication—explain why it happened

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Thank you. Questions?

k.estes@yahoo.com
dr_cesar_limjoco@icloud.com

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