A Primer for an OB/GYN Clinical Documentation Excellence Program

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Learning Objectives

• At the completion of this educational activity, the learner will be able to:
  – Recognize opportunities for quality alignment
  – Identify focused review opportunities
  – Determine opportunities for provider engagement and education
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 facility/system have an active OB/GYN program?
  – Yes
  – No
  – No, but we’re considering adding one
Polling Question #2

- Under what umbrella is your program focused?
  - Quality cycle
  - Revenue cycle
  - HIM
Polling Question #3

• Do you have OB/GYN experience?
  – Yes
  – No
Novant Health: A System of Remarkable Care

- 15* medical centers
- 2,697 licensed beds
- 463 outpatient locations
- 1,514 medical group physicians
- 26,532 employees

*Novant Health Mint Hill Medical Center opening Fall 2018
Novant Health Clinical Documentation Excellence Program

- 30 clinical documentation specialists
- Review mortality, high risk, and Patient Safety Indicators
- Clinical improvement
- Corporate educator and second-level review team
- Service line approach with dedicated OB/GYN team
- 100% reconciliation
Novant Health OB/GYN CDE Program

• Phase I – assessment and development
  – Conducted research and information gathering on existing regional OB/GYN programs
  – Met with stakeholders and key groups, team members (coding, ambulatory CDI, quality analysts, clinical leaders in the service line)
  – Reviewed serviceline data collection by analysts
  – Strengthened relationships within the service line
Novant Health OB/GYN CDE program

• Phase II – action plan
  – Attended and participated in service line meetings to discuss role and purpose
  – Identified gaps and need for consensus building
  – Developed education for providers (first area of focus was Patient Safety Indicators)
Novant Health OB/GYN CDE program

- Phase III – implementation
  - Constructed work queue for high-risk and targeted areas
  - Incorporated routine concurrent review
    - Initiated concurrent reviews in largest facilities, expanded to include 8 total
  - Collaborated with women’s services clinical practice specialist, second-level review team members, and fellow CDS team members
  - Develop and provide education in individual clinics
  - Collaborated with IT team members to enhance delivery summary documentation
  - Develop reporting – ongoing
Quality-Focused Documentation Opportunities
Why Is It Important to Include Quality Measures?

- Reflects in many quality-related outcomes:
  - The Joint Commission perinatal core quality measures
  - Patient Safety Indicators 17, 18, 19
  - Publicly reported sites such as HealthGrades and Leapfrog
- NPIC/PQCNC data
- Clearly illustrates the patient’s condition
  - All related comorbid conditions are recorded
- Accurate designation of the patient’s severity of illness and risk of mortality
Patient Safety Indicators

• The Patient Safety Indicators (PSIs) are a set of 26 indicators (including 18 provider-level indicators) developed by the Agency for Healthcare Research and Quality (AHRQ) to provide information on safety-related adverse events occurring in hospitals following operations, procedures, and childbirth.

• PSIs related to obstetrics:
  – PSI 17 birth trauma – injury to the neonate
  – PSI 18 obstetrical trauma rate – vaginal delivery with instrumentation
  – PSI 19 obstetrical trauma rate – vaginal delivery without instrumentation
Patient Safety Indicator #17
Birth Trauma Rate – Injury to the Neonate

• Excludes:
  – Preterm infants with a birth weight less than 2,000 grams,
  – Cases with injury to brachial plexus, and
  – Cases with osteogenesis imperfecta

• Unless the provider specifically states that an observed or assessed bruise, laceration or other newborn finding is normal, expected, or insignificant it is assumed to be a birth injury and meets inclusion criteria for PSI 17
Patient Safety Indicator #18 and #19

Birth Trauma Rate – Obstetric Trauma With and Without Instrumentation

• This includes third- and fourth-degree lacerations that occur during vaginal delivery
National Perinatal Information Center (NPIC)

• Adverse Outcome Index
  – In-hospital maternal death
  – In-hospital neonatal death
    • Greater than or equal to 2,500 grams
    • Greater than or equal to 37 weeks gestation
  – Uterine rupture during labor
  – Unplanned maternal admission to ICU
  – Birth trauma
  – Unanticipated operative procedure
  – Admission to NICU of neonate
    • Greater than or equal to 2,500 grams
    • Greater than or equal to 37 weeks
    • Greater than one day of age
  – Apgar at five minutes of less than seven
  – Maternal blood transfusion
  – Third- or fourth-degree laceration
Perinatal Quality Collaborative of North Carolina (PQCNC)

• Early elective deliveries:
  – 37 weeks 0 days and less than 38 weeks 6 days gestation
• Maternal hemorrhage project
• Conservative management of pre-eclampsia
Perinatal Core Measures

• Early elective deliveries
  – Induction of labor from 37.0 weeks through 38.6 weeks gestational age

• Exclusion criteria set forth by TJC must be documented by the provider
  – Of particular interest is the impact of SROM documentation
Relationship Building
Women’s Services Administration

- Systemwide service line leadership
  - Vice president of women’s services
  - System OB/GYN service line leader
  - Presidents of individual facilities
  - Facility-based OB/GYN service line physician leaders
  - Nursing service line leaders
Multidisciplinary Service Line Opportunities

- OB/GYN committees
- Joint practice/QDT
  - Provider/nursing
- Individual clinic meetings
- Just-in-time education
Service Line Education

• Introductory presentation
• Topic-focused PowerPoint presentations at service line meetings monthly
• Tip sheets
• New resident orientation
• Service line newsletter contributions
Examples of Physician Education
Women's Services Clinical Documentation Excellence Documentation Tips

*These tips are examples of how we can better demonstrate:* The patient’s severity of illness and risk of mortality, as well as accurately demonstrating the diagnoses/procedures the patient encountered during this admission. As well as the amount of professional time and the resources that are utilized in the care of a particular patient.

### Rupture of Membranes
- PROM/PPROM
- Labor status on admission – labor started within or after 24 hours
- SROM is considered a method of rupture and cannot be captured as a diagnosis according to ICD-10 guidelines

### 3rd & 4th Degree Lacerations
- Detailed narrative in delivery summary or as a separate procedure note of the degree of laceration and repair. Describe the deepest layer of the laceration and the type of suture used to close.

Descriptions include:
- Less than 50% of the external anal sphincter thickness torn (III 3 a)
- More than 50% of the external anal sphincter thickness torn (III 3 b)
- Both external anal sphincter and internal anal sphincter torn (III 3 c)
  - Including detailed repair note

### Secondary Diagnoses
- Obesity, heart disease, preexisting HTN, renal disease, hypertensive emergency/crisis
- Clarification of type of obesity; heart disease; hypertensive disorders; Severity of preeclampsia
- Avoid vague clinical statements: Hgb 5.2, transfused; will rehydrate; unable to void
- Instead, make diagnostic statement: acute or chronic blood loss anemia; dehydration/hypovolemia; urinary retention, hypokalemia

### Hypertension
- Gestational hypertension with/without proteinurria
- Pre-eclampsia (mild, mod, severe) with or without pre-existing hypertension
- Pre-existing, includes proteinuria
- Transient

### Hypertension – Further Clarification Opportunities
- Hypertensive urgency
  - Prompt reduction of BP over hours or days using typical oral antihypertensive medications
    - No impact on SOI/ROM or DRG weight
- Hypertensive crisis
  - Prompt reduction of BP utilizing oral and IV antihypertensive medications
    - Impact: Increases SOI/ROM and DRG weight and LOS
- Hypertensive emergency
  - Immediate, urgent reduction using IV antihypertensive medications
    - Impact: Increases SOI/ROM and DRG weight and LOS

“Acute onset, severe hypertension that is accurately measured using standard techniques and is persistent for 15 minutes or more is considered a hypertensive emergency.” ACOG Committee Opinion, February 2015
3rd and 4th Degree Lacerations
Documentation Guidelines

♦ A separate procedure note describing the 3rd or 4th degree laceration is now required to meet CMS guidelines
♦ This may be included as a narrative found in the delivery summary, or a separate procedure or operative note
♦ Continuity of the laceration with repair documentation is important for coding capture (PP progress notes/discharge summary)

Third-degree lacerations
• Describe the deepest layer of the laceration and the type of suture used to close
  Descriptions include:
  ◊ – Less than 50% of the external anal sphincter thickness torn (III {three} a)
  ◊ – More than 50% of the external anal sphincter thickness torn (III {three} b)
  ◊ – Both external anal sphincter and internal anal sphincter torn (III {three} c)

Or, simply state by using:
 ◊ 3a laceration
 ◊ 3b laceration
 ◊ 3c laceration
Workflow Management

Who, what, when to review
Who and What Do You Choose to Review?

• High-risk units
  – Special maternity units
  – Women’s surgical units
  – Antepartum/gyn units
• High-risk diagnosis
• Procedure codes
• Second-level review (SLR) work queue

*Excludes labor and delivery and mother/baby
### When to Review

<table>
<thead>
<tr>
<th>Day 1</th>
<th>Second-level review WQ</th>
<th>Retrospective audits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Greatest opportunity for real-time query, documentation clarification, and just-in-time education for providers</td>
<td>• Pulled to the work queue after final coding</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Billing is not delayed</td>
<td>• Quality focused based on PSI, quality measures, or any data point that needs additional focus for clarity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Timing varies</td>
</tr>
</tbody>
</table>
Process Improvement–Focused Reviews

• Episiotomy
  – Review for nursing and physician documentation accuracy
  – Review for final coding accuracy
  – Episiotomy rate is included in Leapfrog scores

• Early elective delivery (37 weeks to 38.6 weeks)
  – Perinatal core measure
Realized Impact of Our OB/GYN CDE Program

- Establishment of baseline data
- Accurate reporting of PSI 17/18/19
- Accurate reporting of quality measures
- Increase in SOI/ROM & CMI
- Identified gaps in coding, through reconciliation, related to clinical treatment and coding exceptions
- Developed a collegial relationship with coding through the reconciliation process
Three Keys to Successful Implementation

• Select clinical documentation specialists with experience in OB/GYN
  – Speak the language
• Focus on relationship building
• Target reviews
  – High risk, quality measures
Clinical Examples
Women’s Services – Obstetrics
Clinical Example
Women’s services-obstetrics
Cesarean section delivery

Clinical scenario: 21y/o G1P0 39 weeks gestational age, presented to labor and delivery for scheduled cesarean section delivery due to breech presentation. Well pregnancy, no complications.

As documented

<table>
<thead>
<tr>
<th>Scenario</th>
<th>MS-DRG</th>
<th>MS-DRG weight</th>
<th>HCC</th>
<th>MS-DRG ALOS/GMLOS</th>
<th>SOI level / ROM level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current scenario</td>
<td>766</td>
<td>0.8371</td>
<td>No</td>
<td>3.1/2.8</td>
<td>SOI: 1 ROM: 1</td>
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<tr>
<td>w/ additional specificity</td>
<td>765</td>
<td>1.1770</td>
<td>Yes</td>
<td>4.7/3.7</td>
<td>SOI: 2 ROM: 1</td>
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<tr>
<td>Variance</td>
<td>NA</td>
<td>+0.3399</td>
<td>NA</td>
<td>+1.6/0.9</td>
<td>NA</td>
</tr>
</tbody>
</table>

PDx: Maternal care for breech presentation
SDx: 39 weeks gestation, live birth
Procedure: Extraction of POC, low transverse

With additional specificity in documentation

PDx: Maternal care for breech presentation
SDx: 39 weeks gestation, live birth, obesity complicating childbirth, morbid obesity due to excess calories, BMI 40–44.9
Procedure: Extraction of POC, low transverse
Clinical Example
Women’s services – obstetrics
Complicated vaginal delivery

Clinical scenario: 33 year old, G1P0, 35 weeks 5 days gestation. Admitted from the office for evaluation of elevated BP. Mild vague headache present on admission. Blood pressure results elevated from 140/80s to 170/90–100s. Blood pressure elevations were treated with IV labetalol x 2.

<table>
<thead>
<tr>
<th>As documented</th>
<th>PDx: Gestational hypertension in pregnancy</th>
<th>SDx: Uterine fibroids</th>
</tr>
</thead>
<tbody>
<tr>
<td>With additional specificity in documentation</td>
<td>SDx: Severe preeclampsia</td>
<td>SDx: Hypertensive emergency</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Scenario</th>
<th>MS-DRG</th>
<th>MS-DRG weight</th>
<th>Anticipated payment</th>
<th>MS-DRG GMLOS</th>
<th>SOI level / ROM level</th>
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<tbody>
<tr>
<td>Current scenario</td>
<td>782</td>
<td>0.6115</td>
<td>$4493</td>
<td>2.50</td>
<td>SOI: 2 ROM: 1</td>
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<td>w/ additional specificity</td>
<td>781</td>
<td>0.8615</td>
<td>$5947</td>
<td>2.5</td>
<td>SOI: 2 ROM: 1</td>
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<tr>
<td>Variance</td>
<td>NA</td>
<td>+0.2500</td>
<td>$1454</td>
<td>0</td>
<td>NA</td>
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</table>
Clinical Example
Women’s services – obstetrics
Complicated vaginal delivery

Clinical scenario: Due to worsening hypertension, magnesium sulfate was initiated and labor was induced. Epidural anesthesia was administered for pain control during labor and delivery. Spontaneous vaginal delivery of viable male over a 2\textsuperscript{nd} degree perineal laceration. Uneventful post-partum transition followed delivery. On day 1 PP, her headache worsened and developed a positional component. She did not develop any worsening symptoms of preeclampsia. She did have one isolated fever of 101.3 on day one PP. Anesthesia was consulted and ordered caffeine, analgesics, and hydration.

<table>
<thead>
<tr>
<th>As documented</th>
<th>PDx: Gestational hypertension in pregnancy</th>
<th>SDx: Uterine fibroids</th>
<th>SDx: Severe preeclampsia</th>
<th>SDx: Hypertensive emergency (CC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>With additional specificity in documentation</td>
<td>PDx: Severe preeclampsia affecting childbirth (changes the DRG)</td>
<td>SDx: Post-dural puncture headache (Spinal headache) (affects the DRG)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scenario</th>
<th>MS-DRG</th>
<th>MS-DRG weight</th>
<th>Anticipated payment</th>
<th>MS-DRG GMLOS</th>
<th>SOI level / ROM level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current scenario</td>
<td>775</td>
<td>0.6454</td>
<td>$4690</td>
<td>2.13</td>
<td>SOI: 2 ROM: 1</td>
</tr>
<tr>
<td>w/ additional specificity</td>
<td>774</td>
<td>0.8615</td>
<td>$5766</td>
<td>2.13</td>
<td>SOI: 2 ROM: 1</td>
</tr>
<tr>
<td>Variance</td>
<td>NA</td>
<td>0.2161</td>
<td>$1076</td>
<td>0</td>
<td>NA</td>
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</tbody>
</table>
Clinical scenario: The headache worsened and workup ensued. An initial CT scan of her head did not reveal any significant findings. She developed the complaint of “left side feels weird and (her) headache is back.” Left arm became flaccid, left leg became weak, dysarthria. Facial weakness and focal seizures also developed. NIHSS = 5. Diagnosis of CVA made. UTI diagnosed.

| As documented | PDx: Severe preeclampsia affecting childbirth  
SDx: Uterine fibroids  
SDx: Severe preeclampsia  
SDx: Hypertensive emergency (CC) |
|---------------|--------------------------------------------------------------------------------------------------------------------------|
| With additional specificity in documentation | SDx: As above, plus these additional diagnosis  
SDx: Cerebral infarction  
SDx: Hemiplegia, unspecified affecting left monodominant side  
SDx: Dysarthria  
SDx: Cerebral venous thrombosis in the puerperium  
SDx: UTI |

<table>
<thead>
<tr>
<th>Scenario</th>
<th>MS-DRG</th>
<th>MS-DRG weight</th>
<th>Anticipated payment</th>
<th>MS-DRG GMLOS</th>
<th>SOI level / ROM level</th>
</tr>
</thead>
</table>
| Current scenario | 774 | 0.8615 | $5766 | 2.13 | SOI: 2  
ROM: 1 |
| w/ additional specificity | 774 | 0.8615 | $5766 | 2.13 | SOI: 3  
ROM: 3 |
| Variance | NA | 0 | 0 | 0 | NA |
Clinical EXAMPLE  
Women’s services – Obstetrics  
Complicated vaginal delivery

• **Outcome:**
  • The thrombosis that resulted in the CVA was thought to be attributable to the hypercoagulable state of pregnancy.
  • She was discharged on Lovenox at home and anti-epileptic medication.
  • Mom was discharged home with her baby on day 13. She was fortunate that all of her symptoms had resolved by discharge.

• **Discussion**
  – **Opportunities of OB CDI**
    • SOI/ROM increase drives the case-mix index
    • Seizure activity has possible HCC impact
    • More accurate reflection of the consumption of resources and expertise of care
    • Indirect revenue is impacted by accurate diagnosis, documentation, and coding in a pay-for-performance environment
Quality Impact
Women’s Services – Obstetrics
Quality Impact Documentation Example

**Physician delivery note**

“Pt C&P x 2 1/2 hours, maternal exhaustion setting in, MLE cut, 3C 3rd degree 4 cm in length with complete disruption of external and internal anal sphincter noted.”

**Postpartum progress note**

**A/P:**
Postpartum—Day 1
3rd degree laceration w/repair
Doing well. No complaints. Continue routine postpartum care.

**Nursing documentation pulled into delivery summary**

<table>
<thead>
<tr>
<th>Episiotomy</th>
<th>Median Degree</th>
<th>3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lacerations</td>
<td>Perineal</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Periurethral</td>
<td>Repaired</td>
</tr>
<tr>
<td></td>
<td>Labial</td>
<td>Repaired</td>
</tr>
<tr>
<td></td>
<td>Sulcus</td>
<td>Repaired</td>
</tr>
<tr>
<td></td>
<td>Vaginal</td>
<td>Repaired</td>
</tr>
<tr>
<td></td>
<td>Cervical</td>
<td>Repaired</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C-Section Details:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority:</td>
</tr>
<tr>
<td>Indications:</td>
</tr>
<tr>
<td>Incision type:</td>
</tr>
</tbody>
</table>

| Total estimated blood loss (mL): 350 |

Active Hospital Problems

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date Noted</th>
<th>POA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Third degree laceration of perineum during delivery, postpartum</td>
<td>12/20/2017</td>
<td>No</td>
</tr>
<tr>
<td>Normal labor and delivery</td>
<td>12/18/2017</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
References


Thank you! Questions?

Feel free to contact us with further questions!

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cm.walters@novanthealth.org

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.