JULY 2018

SOGH

Society of OB/GYN Hospitalists

The Society of Ob/Gyn Hospitalists is dedicated to improving outcomes for hospitalized women and supporting those who share this mission.

Dayna Smith, M.D. and Jane Van Dis, MD
Co-Editors

NEWSLETTER

www.societyofobgynhospitalists.org

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PRESIDENT'S MESSAGE

Tanner Colegrove, MD
SOGH President

Dear Colleagues,

The SOGH Annual Clinical Meeting is fast-approaching. If you haven't yet, please register soon to secure spots in the workshops. Spaces are filling quickly and this is a meeting you won't want to miss!

In addition to the fantastic clinical offerings, we will also be conducting our annual business meeting in Cleveland during which the 2018 officer and board member elections will take place. An official call for applications will be coming soon – please stay tuned.

With these important elections on the horizon, I wanted to take this opportunity to talk about member engagement and the value and rewards of volunteerism. Let me start by expressing my sincere thanks to all who have served the organization throughout the past year. Whether you contributed as a board member, committee member, volunteer faculty at the ACM, author of a chapter in the core competencies, or in any one of a variety of other roles, I am so grateful for and honored by your ongoing support and dedication. Your efforts are vital to advancing the mission of SOGH. Please know your time and talents are greatly appreciated.

In our strategic plan Vision 2020, we set a goal to engage at least 10% of members in volunteer service opportunities by 2020. I am pleased to announce that we are well on our way to that goal with over 60 members currently involved and therefore think that we should aim even higher to a goal of 20%. Why? The obvious answer is because as a non-profit organization, volunteers are a vital resource, critical to successfully carrying out the work of the organization. A less obvious, but no less important answer, is that volunteers are essential to the organization's sustainability. It is through volunteering that future leaders are recognized, mentored and cultivated. Finally, while your volunteer efforts clearly benefit SOGH, volunteering itself can greatly benefit you. As my presidency winds to a close and I reflect on my own experience over the past 6 years, I can attest to the immense personal satisfaction and professional growth that comes from engaging actively in SOGH. Through my leadership roles in the organization, I've honed communication, team management, and many other skills that I call upon daily in my clinical and administrative roles as a hospitalist, and contributing to the hospitalist movement on a larger scale through SOGH-related activities has given me a renewed purpose. I encourage you all to get involved – the organization needs your talents. And who knows, you just might encounter, as I have, an unexpected and truly enriching experience that changes the direction of your career.

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PRESIDENT'S MESSAGE

For information on volunteer opportunities, check out the "About Us" tab on the SOGH website, email me at SOGHpresident@societyofobgynhospitalists.org, or contact our administrative team at SOGHadmin@societyofobgynhospitalists. org. For those joining us in Cleveland, we will once again hold the volunteer match where you can learn more about opportunities and sign up for SOGH committees.

Hope to see you in Cleveland!

Warm regards

Tanner Colegrove, MD
SOGH President

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ANNUAL CLINICAL MEETING

Vanessa Torbenson, MD

Kim Puterbaugh, MD

SOGH ANNUAL CLINICAL MEETING 2018

The Hilton Cleveland Downtown & Global Center | Cleveland, Ohio
September 27-30, 2018

Greetings from the ACM committee!

We are busily preparing an educational and fun-filled meeting in Cleveland. We have a line-up of expert speakers, including Luis Pacheco speaking on the Ten Diamonds of OB Safety. He will share pearls on caring for our critically ill patients. Innovative workshops including Ultrasound for the OB hospitalist, where participants will learn the basics of the FAST scan for intra-abdominal hemorrhage and other practical obstetrical ultrasound skills.

Our simulation team has developed exciting new scenarios where participants can practice clinical skills and decision making while reviewing up-to-date management of obstetric emergencies. As hospitalists we know seconds and team work count to save lives in obstetrical emergencies.

We have new ways to participate in the meeting, including a daily and individual workshop registration. Register soon as space is limited.

And finally, introducing:

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ANNUAL CLINICAL MEETING

CALLING ALL ALUMNI OF OUR OB EMERGENCY SIMULATION COURSE, WE NEED YOUR HELP!

In honor of the fifth anniversary of the simulation offerings at our annual clinical meeting, SOGH announces the inauguration of Sim Wars! It's time for all of our alumni to show what they have learned, both at our meeting and in their own programs, and to bring it for our Sim Wars competition.

Sim Wars will allow teams of four Ob/Gyn Hospitalists to compete in simulated obstetrical emergencies for the title of Sim War Champion. An expert panel will judge the performance of each team in the areas of teamwork, communication, leadership, and medical management. The audience will vote "American Idol" style based on their direct observations and the judge's input. The scenarios will be familiar to anyone who has taken our courses, or who engages in simulation at their institution. See this YouTube video for an example of the ED doc Sim Wars.

In the spirit of Cleveland's Rock and Roll Hall of Fame, our teams will have rock band names:

- Team Beatles
- Team Supremes
- Team Jackson 5
- Team Rolling Stones

We are seeking four team leads and three additional members per team. You can sign up individually or in a group.

Sim Wars will be held on Saturday Sept 29th at 6 pm, before the OBHG cocktail party. It will be rowdy, loud and fun for you and the audience, who will get to see how entertaining and educational simulation can be.

Please sign up today or forward any questions by emailing Donna Kelly at donna@veritasmeetingsolutions.com. First come gets to choose their team (and theme song)!

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ANNUAL CLINICAL MEETING

CALLING ALL POSTERS! DEADLINE EXTENDED

Dear SOGH Member,

If you are looking to present your research, please consider doing so at the upcoming SOGH ACM, September 27-28, 2018 at the Hilton Cleveland Downtown Hotel in Cleveland, Ohio. We are looking for posters in the range of original research that support Ob/Gyn Hospital Medicine. Projects could consist of any of the following:

1) Original clinical or basic science research

2) Quality improvement project: Impact study on an intervention or innovative protocol or initiative

3) Case report

Your poster will be in the presentation hall for attendees to view starting with the opening session. There will be a poster session from 5-6 pm on September 29 where authors may stand by their posters to answer questions. The author of the winning poster will be given the opportunity to give a 15 minute presentation during the morning session on September 30. Monetary award for the best poster will consist of funding attendance to the 2019 general ACM.

Please submit a paragraph summary of your poster via email with "2018 ACM Poster" in subject line to cschneider@veritasmeetingsolutions.com by August 15, 2018.

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IN THE NEWS

WILL AN OB-GYN HOSPITALIST DELIVER YOUR BABY?

U.S. News & World Report recently published an article about how hospitals are now using the services of Ob-Gyn hospitalists to care for obstetric patients in the hospital. Read about it here.

DR. MEREDITH MORGAN SPEAKS ON CARE OF THE POSTPARTUM PATIENT

ACOG's recent recommendations for changes in the management of the postpartum patient was addressed in a talk by SOGH's immediate past president, Dr. Meredith Morgan. Dr. Morgan spoke on the multiple aspects of caring for the postpartum patients, and ways we as Ob/Gyn hospitalists can facilitate this transition. Dr. Morgan has been kind enough to share with us his own uniquely generated template, What Every Woman Should Know about Recovery After Childbirth that may be used to guide our care of the postpartum patient.

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Lori-Lynne A. Webb CPC, CCS-P, CCP, CHDA, COBGC

Renee Allen, MD MHSc., FACOG

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CODE THIS! CASE OF THE MONTH

FETAL MONITORING DURING LABOR BY THE CONSULTING OBGYN HOSPITALIST

by Lori-Lynne A. Webb, CPC and Renee Allen, MD, MHSc., FACOG

Dr. Harris, a private ob/gyn, calls the ob/gyn hospitalist on duty, requesting assistance. He has a 33 yo G1P0 patient at 38w5d who was admitted in the early morning for premature rupture of membranes. The patient is currently in active labor with pitocin augmentation.

Dr. Harris was called by the labor & delivery nurse and informed that she was having difficulty obtaining a continuous fetal heart tracing. The labor nurse suspected that the patient may be having fetal heart rate decelerations but the poor-quality tracing made interpretation difficult. The nurse also informed Dr. Harris that despite the use of pitocin for labor augmentation, the patient was still 6 cm dilated and had not changed her cervix in over 4 hours.

Dr. Harris, who was very busy in clinic and could not come to the hospital to immediately evaluate the patient, requested that the obgyn hospitalist place internal monitors (ISE and IUPC), as well as supervise and interpret the fetal heart rate tracing while she is in clinic.

The ob/gyn hospitalist placed an ISE and IUPC, as requested, without difficulty. The patient was 6cm dilated, 70% effaced and fetal presenting part was at -1 station. After 40 mins of continuous monitoring, the ob/gyn hospitalist interpreted the fetal tracing and determined that the patient was having repetitive variable decelerations and inadequate MVUs. The ob/gyn hospitalist informed Dr. Harris of her evaluation and suggested that an amnioinfusion may be appropriate while continuing the pitocin augmentation. Dr. Harris agreed and gave the labor nurse a verbal order for amnioinfusion.

The variable decelerations resolved with the amnioinfusion intervention and the ob/gyn hospitalist continued to monitor the fetal tracing throughout the patient's labor course until Dr. Harris arrived later in the evening. Within minutes of Dr. Harris's arrival to the unit, the patient had a successful vaginal delivery.

CODE THIS! CASE OF THE MONTH *continued*

As the OB hospitalist, how would your services be coded?

ANSWER:

ICD 10 Diagnosis Coding considerations include:

- ICD10-CM O76 Abnormality in fetal heart rate and rhythm complicating labor and delivery
- ICD10-CM O42.02 Full-term premature rupture of membranes, onset of labor within 24 hours of rupture
- Z3A.38 38 weeks gestation of pregnancy

CPT Codes

59050 Fetal monitoring during labor by consulting physician with written report; *supervision and interpretation*

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CODING BRIEF:

Under ICD-10, any pregnancy complication diagnosis code must be accompanied by a code in the Z3A family, specifying gestational age. Also per the ICD-10 guidelines, if the trimester is known, it is to be coded, in addition to the weeks of gestation. In this case Z3A.38 denotes 38 weeks gestation.

In our defined role as the ob/gyn hospitalists, we are often called upon as the expert to provide consultative advice regarding labor in the absence of direct care from the primary OB. In this light, we may be called upon to interpret electronic fetal heart monitoring as a "consultant" or "non-attending" physician. In this role, we should bill for monitoring and oversight of labor.

CPT allows us to bill for this as the non-attending physician. However, the codes do change if we assume complete care of the patient.

Code: 59050 Fetal monitoring during labor by consulting physician (ie, non-attending physician) with written report; supervision and interpretation.

Lay Description per CPT: code 59050, a consultant other than the attending physician attaches an electrode directly to the presenting fetus' scalp via the cervix. The electrocardiographic impulses are transmitted to a cardio-tachometer which converts the fetal electrocardiographic pattern into recorded electronic impulses. A catheter is inserted through the dilated cervix into the amniotic sac to measure and record the intervals between contractions. The procedure is supervised during labor until delivery. The recordings are analyzed and accompanied by an interpretive written report (separately identifiable within the medical record noted as the monitoring of labor with supervision (IUPC/ISE).

This billing, 59050, requires face-to-face interaction with the patient, and interpretation of the EFM is including in this charge.

If however, we have been asked to review and provide an interpretation only of the monitoring of the labor process, we can bill with code 59051. The billing/coding for a 59051 does not require face-to-face contact with the patient, as the fetal monitoring strips may be faxed or reviewed from a remote location for interpretation.

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CODING BRIEF:

Code: 59051 Fetal monitoring during labor by consulting physician (i.e., non-attending physician) with written report; interpretation only.

Lay Description per CPT: In 59051, the consultant initiates the monitoring, provides the analysis and interpretive report, but does not supervise the patient during labor.

The clinical documentation requirements for these codes includes:

The request for your expertise for either "supervision and interpretation" or "interpretation only" from the physician, nurse practitioner, PA, or midwife.

Clarify the assistance for any emergency intervention such as a cesarean section, continuing induction, augmentation or aggressive treatment for pre-term labor.

- The indication for the monitoring (medical necessity) such as fetal distress during labor, pre-term labor, maternal fatigue etc.

The documentation will require notation of your ongoing supervision, plan of care, and a formal interpretation and final report with your findings. The documentation in the medical chart should also include the communication regarding this supervision plan of care to the primary attending physician and any recommended changes in the management of the labor process.

LORI-LYNNE A. WEBB, CPC, CCS-P, CCP, CHDA, COBGC and ICD10 CM/PCS Ambassador/ Trainer is an E&M, and Procedure based Coding, Compliance, Data Charge entry and HIPAA Privacy specialist. E-mail: webbservices.lori@gmail.com; blog: http://lori-lynnescodingcoachblog.blogspot.com/.

DR. RENÉE ALLEN served co-author of this column. She is the SOGH Liaison to the ACOG Committee on Health Economics and Coding and Co-Chair of the Development Committee. She currently works as an Ob/Gyn Hospitalist with Mednax/Obstetrix at Eastside Medical Center in Snellville, Georgia.

do you have **QUESTIONS?**
email us **coding@societyofobgynhospitalists.org**

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Stacy Norton, MD

SIM CORNER

AWARENESS, EDUCATE, ACTIVATE! | JULY 2018
by Stacy Norton, MD

On June 4th, 2018 I had the opportunity to attend the Texas AIM Leadership Summit and Orientation held in Austin, Texas. AIM, or the Alliance for Innovation on Maternal Health, works at national, state, and facility levels to promote safe health care for every woman. One of the goals of this summit was to help every hospital that has a labor and delivery unit in our state implement the AIM bundles. I also learned, while listening to Lisa Hollier, M.D., our current President of ACOG, that the second leading cause of maternal death in the State of Texas from 2011-2012 was drug overdose. I was surprised to learn that 80% of these deaths occurred after 60 days postpartum!.(1) So, I spent my afternoon at the Breakout Session for the Opioid Use Disorder Pilot session. We focused on the implementation of the Obstetric Care for Women with Opioid Use Disorder AIM Patient Safety Bundle and how it can be applied at our individual institutions. (2) This bundle is unique; as it will have applications in both inpatient and outpatient clinical settings. There is a screening set in prenatal, intrapartum and post-partum care facilities.

I'd like to focus this Simulation Corner of 2018 to the AIM Obstetric Care for Women with Opioid Use Disorder. The following points are some of the guidelines from the bundle, which I have arranged as I see fitting into the OB Hospitalist care continuum-Awareness, Educate, Activate!

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SIM CORNER *continued*

► DEPARTMENTMENTAL AWARENESS:

- Provide education to promote understanding of opioid use disorder as a chronic disease.
- Emphasize that substance use disorders are chronic medical conditions, treatment is available, family and peer support is necessary, and recovery is possible.
- Emphasize that opioid pharmacotherapy (i.e. methadone, buprenorphine) and behavioral therapy are effective treatments.
- Engage a multidisciplinary team of partners (i.e. social workers, case managers) to assist patients and families in the development of a "plan of safe care" for mom and baby.

► CLINICAL SETTING EDUCATION:

- Provide staff-wide (clinical and non-clinical staff) education on substance use disorder.
- Emphasize that stigma, bias and discrimination negatively impact pregnant women with opioid use disorder and their ability to receive high quality care.
- Establish specific clinical pathways for women with opioid use disorder that incorporate care coordination among multiple providers.
- Develop pain control protocols that account for increased pain sensitivity and avoidance of mixed agonist-antagonist opioid analgesics.
- Know state reporting guidelines regarding the use of opioid pharmacotherapy and identification of illicit substances use during pregnancy

► ACTIVATE:

- Assess all pregnant women for substance use disorders.
- Use a validated screening tool. Incorporate screening, brief intervention and the referral to treatment (SBRIT) approach in the maternity care setting (3).
- Screen and evaluate all pregnant women with opioid use disorder for common occurring co-morbidities: STI's, psychiatric disorders, physical and sexual violence.
- Provide resources matching treatment response to each woman's stage of recovery and/or readiness to change.
- Have lists of local treatment facilities that provide women and child-centered care
- Incorporate a multidisciplinary team for prenatal, intrapartum, and postpartum care: private OB's, OB Hospitalists, Anesthesia, Neonatologist, Psychiatrists, Pharmacists, Social Work, Case Managers, and Addiction Treatment/ Behavioral Health Specialists

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SIM CORNER *continued*

► SIMULATE:

- Conduct regularly scheduled and unscheduled unit-based drills.
- Post drill debriefs publicly.
- Debrief actual substance use situations.
- Post event debrief - identify successes and opportunities for improvement.
- Fill in education gaps, apply process improvements as needed - specific to your facility

► REPEAT & REPORT:

- Review, collect data, and monitor processes and outcome metrics for health care of pregnant women with substance and opioid use disorders.
- Engage child welfare services, public health agencies, court systems, and law enforcement to assist with data collection, identify existing problems and help drive initiatives.

► SIMULATION:

Length: 10-20 minutes depending on end point chosen by user.
Physical Space: OB Emergency Room or OB Triage Room
Primary Issue being assessed: Staff knowledge and use of SBRIT and motivational interviewing.(4)
Drill may be modified to assess:

- Effective communication in OB intake area
- Patient flow in a physical space
- Unit's preparedness with necessary tools and materials to aid in substance use disorders

Scenario:

- Ms. Crystal M is a 27-year-old, G2P0010 at an unknown gestational age. She has had no prenatal care. She complains of "leaking fluid" since early this morning.
- She is bipolar, not on any medications. She does admit to smoking, and using heroin, last used 3 hours ago.
- She has had 1 elective termination and multiple sexual partners in the last year.
- The simulation begins with the triage nurse calling for the MD with the history above.

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SIM CORNER *continued*

Additional Information:

1. Height 152 cm Weight 63 Kg BP 132/71 P 102 T 99.0
2. PMH Bipolar
3. PSH none
4. PGYNH 1 elective termination and hx of chlamydia
5. NKDA
6. Medications none
7. SH polysubstance abuse and multiple partners. Lives in half-way home.
8. Labs: Blood type AB+ WBC 11.6 H/H 10.2/29.6 Plts 353
9. FHT's baseline 130's Category 1
10. Sonogram: singleton vtx presentation EGA 33 6/7 wks

Participants:

1. Triage RN
2. OB Resident
3. OB Hospitalist
4. Social Worker/Case Manager
5. Simulation observer assessing whether objectives and goals are met

Participants should go through steps of:

1. Recognize the need to screen this and all patients for substance abuse and opioid use disorders.
2. Be aware of and try to eliminate any stigma and personal bias that may negatively impact patient care.
3. Establish rapport and open nondiscriminatory lines of communication with patient.
4. Engage appropriate partners in patient care (i.e. social work, case manager, neonatology, anesthesia, pharmacy etc.)
5. Be knowledgeable about community resources for further outpatient health care treatment facilities
6. Be knowledgeable of your county, state, and federal reporting guidelines for substance care and substance exposed infants.
7. Discuss what is happening with patient and if permitted by patient, any support person they may have with them.

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Goals of the simulation include:

1. Participants promptly recognize the diagnosis of substance and opioid abuse disorders.
2. Participants recognize/identify changes in patient's vital signs and symptoms that may occur with substance and opioid use (Clinical Opioid Withdrawal Scale-COWS).
3. Participants use best available evidence to treat substance and opioid abuse.
4. Participants understand the importance of good teamwork and a multidisciplinary team approach to the management of substance and opioid abuse disorders.
5. Tasks are delegated and help is sought and received.
6. Management is based on the antepartum, intrapartum, or postpartum state of the patient. Clinical pathways should be established for care needed at each stage.

Simulation Options:

1. Amnisure test is negative and sonogram shows normal AFI: Antepartum outpatient care pathway initiated.
2. Amnisure test is positive and sonogram shows low AFI: Intrapartum care pathway is initiated.

Simulation concludes with successful teamwork and treatment of the patient.

Debrief:

1. What went well?
2. What were some obstacles?
3. What are some areas for improvement?

I'll have to admit, this simulation was more difficult to write than others. It primarily evaluates emotional and mental healthcare, rather than the physical maneuvers or medical algorithms we are all used to. It may not be the typical emergency we are used to navigating; however, this medical crisis has just as much potential impact on mothers' and babies' lives if not more than the actual birth moment. As OB hospitalists we need to recognize our potential to initiate and coordinate quality healthcare to a patient population that is in great need.

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SIM CORNER *continued*

REFERENCES AND RESOURCES:
1.Texas Health and Human Services: The Role of Opioid Overdoses in Confirmed Maternal Deaths, 2012-2015
2.Council on Patient Safety Women & Mother's Health Care patient safety bundle: Obstetric Care for Women with Opioid Use Disorder
3.ACOG Committee Opinion Number 711, August 2017
4.ACOG Committee Opinion Number 423, January 2009

STACY NORTON, M.D. F.A.C.O.G. | SOGH Simulation Co-Chair
Dr. Norton is the Team Lead physician at Memorial Herman The Woodlands Medical Center.

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