Finger Lakes Region

**Regional Perinatal Center Dept. Of Health Sciences**

U of R Medical Center **Data Coordinator**

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Perinatal Program

**November 10th, 2016 Coder Meeting Minutes**

1. **Introductions:** @ hospitals were represented, Unity in person and Newark Wayne via Conference Call, also, Ann-Marie Yeates, Clinical Support Specialist 2, OTDA (Office of Temporary and Disability Assistance and Rosemary Varga
2. Topics that you need to be aware of:
3. Anne Kern from the Monroe County Health Department wrote to Ann Dozier saying that they were unable to release the Infant Mortality Study as the Birth Data was incomplete. There were 12 data fields mentioned, the primary missing areas are in the interview questions. That being said, there were 12 areas mentioned. Most of them were in the prenatal fields. With Dr. Glantz I will be formulating a letter to the OB providers’ offices to the attention of the Office Manager to help them be aware of the requirements the state has requested.

 The percentages for missing data were 0.5%, 2.1%, 4.0%, 4.6%, 11%, 13.9%, 15%, 20%, and 95%. I will be sending individual emails so that you know what your actual % was.

You will be receiving a letter from Dr. Glantz addressing the issue.

1. Newark-Wayne had the pleasure of being the first hospital to have their annual review with me. With their help I began fine tuning a chart review. It will be different than done before as electronic charting increases the difficulty in finding the needed information.

I will be asking for at least two Coders to review one chart with me, one Coder with your copy of the workbook, one Coder working the computer and me attempting to code.

This will continue to be a learning experience for me with you all as my teachers.

If you are unavailable on the day of the 2017 Outreach I will be scheduling a time when we can meet.

I will then formulate a report which will be sent to you and to your supervisors. This report will include the results of the chart review as well as your participation in the ongoing training provided through Coder Meeting attendance and participation in the monthly scenarios.

1. As part of the AOP presentation, Ann-Marie emphasized the need to present the AOP form in both written AND oral formats. The written part is easy. You’re already doing it. You give them the form with a brief explanation and ask if they have any questions. The second part is a bit more difficult. She said there are two choices – you can read the whole form to them or ask them to watch the 13 minute video available from the DOH website.

Several, if not the majority, already have this video on their closed circuit system. And, it is a part of the info you share with the family. If you do not have the video available, you will need to check with your IT department, find out what format they need, call or write to the state dept. and request a copy.

I will be asking what your process is as part of the annual review.

Remember you are not policemen or their mother’s. Your responsibility is to be sure they have the necessary information available. You cannot force them to watch the video or listen to you read the form. But you can keep track of whether or not the offer was made and if they followed through on watching or listening to you read.

As most of you separate the workbook into parent and coder section and add special highlighted items, maybe you could add something to effect of: Oral notification \_\_\_\_, form read\_\_\_, video watched\_\_\_, patient declined\_\_\_.

1. AOP presentation: Ann-Marie stated that while watching the webinar gave you some of the information re: filing an AOP, it was not all inclusive as her supervisor asked that she just present touch points. Due to firewalls the webinar will only be available when the office announces it. There will be another showing in the Spring. Ann-Marie is willing to set up conference calls or webinars to present AOP training and reinforcement if requested

Now for touch points from her presentation:

1. Once signed and witnessed the form is a legal document. It is equal to a court order. It commits the putative father to 21 years of care and support for this child. NYS is one of 4 states that require 21 years.

If after the form is signed and the parents have ‘second thoughts’ they will need to have a judge decide the outcome. One example Ann-Marie used was a significant other agreeing to sign the form, then, after 5 years they have decide to separate and he tries to end his commitment to the child. The judge can and has ruled that since he has been in the child’s life for 5 years as the only father the child knows, in the child’s best interest, he will remain the legally responsible person.

If the mother fills out the entire form but the father has not signed it can and should be destroyed.

Ann-Marie reiterated that it is encouraged but not required that ID be requested from the signers. Once signed and witnessed it is totally up to the parents to answer to the court system if the information is not correct. The witness has no further responsibility. The witness can ask for identification from the signer but it is only encouraged not mandatory.

The parents need to know that if the woman is not divorced her husband remains legally responsible for her children even if they have been separated for many, many years. They will need to go to court and request an Order of Filiation. They should not file an AOP.

If a man insists on signing the form despite your careful explanations, do not stand in his way. Witness the form and send it in with the other paperwork. Remember that you are only witnessing that he signed it not that it was legally correct.

If the father signs his portion but the mother does not sign hers the form can still be submitted. He will not have responsibility for the child but he can be involved if the child were to be put up for adoption and the child may be eligible for death benefits from him. You or he will need to mail the form separately to the Office of Putative Paternity – the address will be forthcoming.

He / they will still need to go to court if both desire to be named as parents on the Birth Certificate.

Financially, if the process is started at the time of birth, the father can be responsible for the doctor bills through the prenatal period. If the process is started after the child is several years old, the father will only be responsible from the point process initiation.

1. If the father is not available to sign the form at the time of birth, the mother can sign and have her signature witnessed, send it to the father at which time he can sign and have his signature witnessed. The form can then be submitted Office of Vital Records in the County of the child’s birth. It will then be sent to the Birth Certificate office and to the Office of Putative Paternity
2. The child can have the last name of either parent without affecting the legal rights of the child.
3. Can you get a new Birth Certificate after the form is signed? Yes. If the form is not signed in the hospital at the time of birth, a new Birth Certificate will be issued with both parents name on it after it is submitted to the Office of Vital Statistics. The last name (and only the last name) of the child can be signed with completion of the AOP. There is no charge for the Birth Cert. at this time. If they lose it, they will have ti pay for a replacement
4. The AOP can be withdrawn within 60 of signing if there is the fraud, duress (if either is being pressured) or material mistake effect (if the father discovers that he is indeed not the biologic father).

The one exception to this is for minors. A child has 60 days after her 18th birthday to withdraw the AOP

1. Be sure to note the position of the Hospital code and the med rec number. They are reversed from previous formats.

1. The Social Security number of the mother IS NOT a required field. The mother does not have to put her SSN on the AOP. If not provided just leave the spaces blank. Do not insert 999 99 9999. You might want to add a reminder to the Office of Vital Statistics that The Putative Paternity Office validated that the SSN# is not required.
2. Cross outs: The only field on the AOP that CANNOT be altered in any way is the child’s name. If a correction is requested for this field a new form needs to be filled out. All other fields can be corrected with a single line through the wrong entry and legibly entering the new information.
3. Only blue or black ink
4. There is a training form for new Coders available on the DOH site
5. Re: name change: In the hospital the names should be the same. If the AOP is filed later the names will be different and other identifiers will be used if both forms are required at a later date

Two questions were asked –If DNA testing is required by the court does DSS pay for genetic testing?

What is the address of the Putative Paternity Registry Office

Ann-Marie is your go to person for AOP questions. If she is not available and you need an immediate answer, you can contact Monique (Ann-Marie’s supervisor), You can also call the Helpline. This will not get you an immediate response. You can also give the Helpline number to parents.

Ann-Marie Yeates 518-474-0997 Ann-Marie.Yeates@otda.ny.gov

Monique Rabideau 518-408-4008

Child Support Helpline 518-208-4485

1. **Data Integrity**
2. There was a question about documentation of reduction of implanted eggs. In the real world, a reduction is a therapeutic termination of Pregnancy. It can be a touchy issue as the parents may not want the reduction acknowledged. It also can have a strange impact on the G’s and P’s. If the woman has 3 eggs implanted and reduces to one which she carries successfully to term, she will be a G1 P 1 0 1 1, having had two outcomes from one pregnancy. Despite the fact that she had three eggs reduced, it is counted as one procedure, the same as a twin birth would be G1 P1 0 0 2. It may make the G’s and P’s look strange but that is the reality. So, if reduction is acknowledged in the chart you can document a TOP
3. Quick review of Estimated Date of Delivery. The Provider has the last word. So, you need to use the prenatal. The admit note may be correct but… Check your prenatal for the final date determined by the provider.
4. Define ‘delivery’ - As far as I can tell the folks who created this form are not all medical and the medical consultants did not necessarily consult the best obstetrical resources for wording to make the info gathering easier for both those who know a lot about the process and those who knew nothing before they started trying to figure out what ‘AROM’ or any of the multitude of Ob terms meant.

 In this particular case, I think semantics are a hindrance. From Deb’s response I surmise that they are looking for drugs that may affect the baby and nothing more. The wording is ambiguous and incorrect for those of us who know that the delivery is not complete until placenta and repair are finished BUT for the purposes of the SPDS we need to stop coding anesthesia / analgesia when the baby is born- validated by Dr. G.

The question of local use was raised. This should be coded if administered before the baby was born, otherwise it is an added procedure.

1. **Scenarios:**

*September*

 On arriving at the hospital at 1900 hr. the woman said her waters broke at 1700 hr. At 2030 hr, with no real cervical change and irregular contractions the MD ordered Pitocin and continuous EFM.

 Correct coding: PPROM, Induction-medicinal, and External EFM

|  |  |  |  |
| --- | --- | --- | --- |
| Number of coders who participated | # correct answers Q1 PPROM | # correct answers Q2 induction med | # correct answers Q3 external |
| 23 of 31 | 22 | 15 | 21 |

 *October*

 After having her epidural placed and the bolused with medication the mother has a severe hypotensive episode with accompanying fetal heart rate deceleration. This led to a C-sect.

 *(There’s a potential twist here – so, think about it for a minute - R)*

Correct coding: Non-reassuring fetal heart status

|  |  |
| --- | --- |
| Number of coders who participated | # correct answers Q1 NRFHT |
| 18 | 18 |

 As I accidentally gave the answer away and requested only that you acknowledged having read the scenario, it surprised me that there were still 12 Coders who couldn’t find a few minutes for a learning experience

1. **Coder questions:**
* When entering AOP info into SPDS, if 'Is an AOP to be executed?’ a ‘no’ answer will block further questions.
* Can an AOP be destroyed if completely filled out by the mother but not signed by the ‘father’ – Yes.
* Multiples reduction – a tough question. More to be added after the meeting.
* If a C-sect is performed at 41 weeks for fetal distress and presumed CPD, code ‘Fetus at Risk’ ONLY

##### We will be holding our next Coder Meeting January 11th 2017 at the Saunders Research Bldg., 265 Crittenden Blvd. on the Strong Hospital Campus, room 2420 A&B, (top of the stairs). Parking passes will be available.