The CA ACDIS Connection

JOURNAL OF CALIFORNIA ACDIS CDI CHAPTER

Welcome to the 19th issue of the CA ACDIS journal!

Social Determinants of Health

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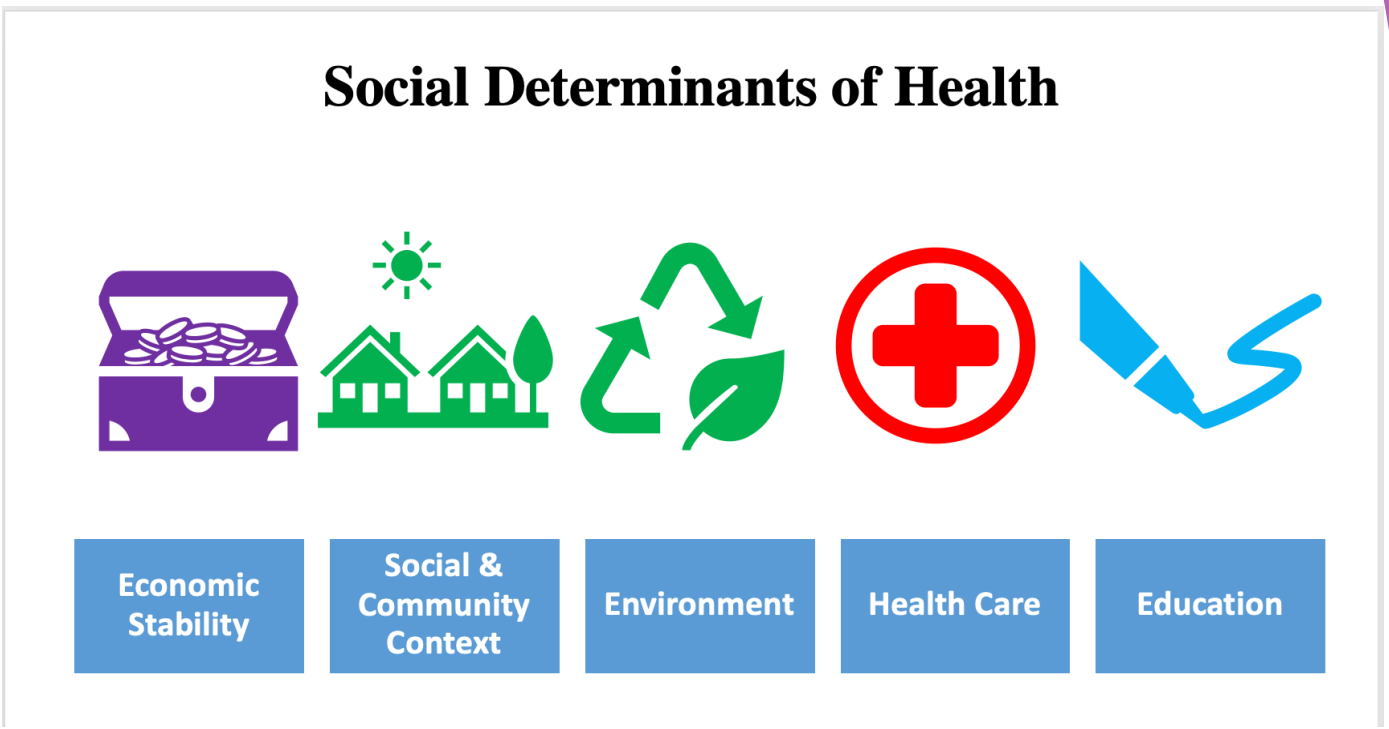
UCSD Trauma/Burn Surgery CDI Program

According to the Centers for Disease Control and Prevention, human health is influenced by several factors, which are divided into five health determinants: genetics, behavior, environment, medical care, and social aspects, and people's health depends on these five related categories (1).



As medicine has evolved, each category has revealed its impact on population health. Many years ago, social determinants were not the primary focus of many countries' health strategies and policy development. Later, healthcare professionals noticed that to improve population health, we need to consider social determinants.

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In recent decades, social determinants of health are no longer marginalized in the health system. They are considered essential components in population and public health (1). The World Health Organization defines social determinants of health as conditions that can be influenced by political, social, and economic forces in which people are born, work, live, age, and grow (2). The concept of social determinants of health was developed when it was noticed that socioeconomic inequities are significant forces that create variation in diseases locally, nationally, and globally. Social determinants of health can positively impact population health, well-being, and life quality, such as safe housing, transportation, job opportunities, education, financial stability, and access to healthy food and physical exercises. Also, social determinants of health can increase the gaps in health disparities and inequities. For example, when people do not have access to healthy food, they will have a higher risk of developing chronic conditions (e.g., heart disease, diabetes, hypertension, and obesity).

Study results suggest that people with limited access to shelter and food have more health problems than those with financial stability and education. Such disparities are present in even industrialized countries. Improvements in the health system and patient health are only feasible when the factors that can lead to poor outcomes are addressed (3). The population with lower socioeconomic status might live and work in suboptimal environments that can increase their exposure to risk factors for diseases. Thus, they are prone to having worse health and might die prematurely (4).

How can we prevent the risk factors?

Prevention medicine is still functioning under a risk factor blueprint centered on lifestyle modification, such as smoking cessation and decreasing salt intake. However, this strategy is only efficacious in some situations, especially not when people have less control over the risk factors that can make them sick such as inadequate access to healthy food. Therefore, on many occasions, healthy behaviors require creating a more supportive environment to make fulfilling healthy choices accomplishable and improve population health and preventive medicine(5).

Why is a coding condition related to social determinants critical?

Addressing challenges related to social determinants of health improves health equity, and organizations committed to improving people's lives need data to create policies and strategies which address these issues. Coders and clinical documentation specialists are critical in adequately capturing and reporting the data.

Conclusion

Social factors are a significant category of health determinants for improving population health. Capturing condition-related social factors that the Centers for Medicare and Medicaid have highlighted is the backbone for policymakers and stakeholders in launching strategies that will enhance the well-being of people in the community.

References

1. Commission on Social Determinants of Health (CSDH), *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. 2008, World Health Organization: Geneva.

2. Lucyk K, McLaren L. Taking stock of the social determinants of health: a scoping review. *PLoS ONE* (2017) 12:e0177306. 10.1371/journal.pone.0177306

3. CSDH *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization; (2008)

4. Van Lerberghe W, Evans T, Rasanathan K, et al. World health report 2008 — Primary health care: now more than ever. Gene-

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In Memoriam

Melissa Varnavas

We will miss you!

va: World Health Organization; 2008.

5. Why Are Some People Healthy and Others Not? The Determinants of Health of Populations. Evans RG, Barer M, Marmor T, editors. Hawthorne (NY): Aldine de Gruyter; 1994.
6. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep 2014; 129(Suppl 2):19–31

In Loving Memory of Rabia Jalal

Rabia was a cheerful and caring friend to many of us. Her contributions in the ACDIS community was a testament to her passion in this profession.

We are grateful and privileged to have known and built great memories with Rabia!

ACDIS-Diversity and Inclusion Task Force

and

California ACDIS Leadership

Take aways from 2022 Live CA ACDIS Conference in San Diego

By Miriam Gallahue, RN, CCDS

Laura J. Werner, DC, MSN-ed, RN, CDIP, CCS, System Director of CDI for Adventist Health started the morning presentations with There's No Place Like Home: Remote CDI

Laura explored what is involved in successfully managing a remote team with ideas for employee engagement, maintaining productivity, and stress reduction. She outlined the difference between management and leadership, addressed setting up remote workspaces, protecting privacy, using technology, and helping people feel connected.

Some key takeaways include: The importance of checking in and fostering trust and connection in the remote work environment. This contributes to more efficient and satisfying work and can help with employee retention while maintaining productivity.

Next, Cassi Birnbaum, MS, RHIA, CPHQ, FAHIMA Administrative Director of Healthcare and Professional Coding and Documentation at Stanford Healthcare presented Unleashing Technology in HIM for Population Health.

Cassi identified the bigger changes in healthcare in recent years as; increased chronic lifestyle illnesses, innovative technology, move to value-based reimbursement and projected skill shortage. She shared PeaceHealth's journey to Value Based Care and what impacts risk adjusted reimbursement. Outlining the process, goals, CDI opportunities discovered, efficiency achievements, financial impacts

- Using 3M's ProMonitor direct -to – bill (DTB) system for sending out clean claims directly to the billing system without coder intervention for increased efficiency.
- Capturing HCC's and risk adjusted diagnoses
- PeaceHealth's pilot social determinants of health (SDoH) project, which emphasized the impact SDoH have on health outcomes, the cost of not addressing these, and the impact of coding these on risk – based payments.
- Use of 3M Clinical Risk Groups (CRGs), population-focused methodologies to highlight social determinants of health and 3M PFEs for population health analysis.

Key take-aways:

Value-based care and risk-based payment models have made clinical documentation improvement more critical than ever.

Accountable care risk-based payments are tied to metrics influenced by social risk identified by reporting SDoH, Z codes and health outcomes are highly correlated.

Challenge: CMS only accepts the first 25 diagnosis codes with MCC/CC's historically being prioritized in top 25. SDoH, HCC's PSI impacting diagnoses, quality, Risk adjusting diagnoses among others are not always sequenced in the top 25 and can have negative impact on many different metrics.

After the break, Emily Emmons MSN, RN, CCDS, CHFP, CRCR who is the Regional Director of Clinical Documentation Integrity at Kaiser Permanente in NCAL presented Patient-centered CDI: Best Practices for

Better Outcomes.

Emily outlined the benefits of patient -centered CDI is, and how accurate, complete documentation improves patient outcomes, improves quality reporting, and achieves accurate reimbursement. The importance of reducing risk by diversifying review and query scope and focus. She went over query compliance following ACDIS/AHIMA Query Practice Brief (2022). She explained how many RAC requests for charts are allowed and gave examples of how to calculate that. Examples of Consensus definitions for AKI from KIDGO, Malnutrition from ASPEN and AND, Respiratory Failure from American College of Chest Physicians and MI's from American College of Cardiology, were included.

Key take-aways:

- Encourage organizational consensus for diagnostic criteria & care pathways based on best practices & nationally or internationally recognized standards

- Encourage contracting department to include standardized organizational diagnostic criteria in payer contract negotiations to prevent unnecessary and clinically questionable claims denials

- Utilize readmission, mortality, & surgical complication rate reports to identify opportunities & drive CDI focus

Up next; The Journey into a SNF CDI Program by **Madhu Subherwal, MHA, MBBS, CCDS**, who is the CDI manager at Torrance Memorial Medical Center (TMMC) and outgoing CoChair or CA ACDIS.

Madhu was asked to start a CDI program at the Torrance Memorial, Skilled Nursing Facility (SNF).

Lots of useful information on the logistics of starting a program from scratch, SNF's reimbursement, the RUGS scoring system, the MDS and Patient Driven Payment Model (PDPM) which Medicare moved to in 2019. CDI opportunities were identified under the new Medicare reimbursement PDPM.

Key takeaways:

- Similar CDI review process as acute care hospital. The PDPM is driven by primary clinical diagnosis and medical co-morbidities.

-The first five days of admission are critical to capture the principal diagnosis and any secondary diagnoses.

- After the principal diagnosis is established, reviews are not necessary unless there is a change in the patient's condition.

-All payor review was decided on because historically commercial payers follow Medicare's lead and likely will adopt the PDPM reimbursement model going forward.

Even though the pilot was interrupted by the COVID –19 Pandemic when all CDI staff and resources were needed to focus on acute care reviews, there was a lot here for anyone interested in pursuing a CDI program for SNF's.

Of note, during the pandemic the SNF's bed capacity was reduced by 50 %, by State and Los Angeles DOH rules and regulations.

This was an example of another potential area where a CDI can have an impact.

At the end of day, **Pamela Stence, RN, BSN, MSN, CCDS** Director, Clinical Documentation Improvement

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As the new year approaches, we reflect on 2022

Madhu Subherwal, MHA, MBBS, CCDS, CDIP
Co-Chair CA ACDIS

As we move into the new year, it is always insightful to look at the past. 2022 opened with the Omicron surge that impacted hospitals across the country. The highly transmissible strain of COVID-19 caught patients and frontliners by surprise as the new variant spread like wildfire through hospital departments and the community alike. It seemed like an ominous start to the year. However, as the surge subsided, we finally began to see and feel relief. Over the year, mask mandates began to end; public events and get-togethers returned. We moved into a lifestyle that began to feel like normal. Or was it a new normal? We began to breathe a sigh of relief as the year rolled on, with a hope that we have turned a corner on the pandemic.

The CA ACDIS Chapter also took a sigh of relief. With the COVID numbers beginning to recede, we decided to host a live conference after 3 years in beautiful San Diego. While bimonthly virtual educations remained on our calendars, the CA ACDIS leadership was looking forward to meeting our members face-to-face and enjoy a day of education that was not in front of a computer monitor. At the same time, for those who were not as comfortable meeting in-person, we provided a virtual conference. Each event had exceptional speakers. It was good to see the members in person, and we appreciate the virtual event attendees for their faith in the CA chapter to deliver engaging events. The quarterly newsletter has provided further insight on how different CDI programs across California are running, different educational articles, and kept the community connected over the year. We thank all who have participated – speakers, writers, conference volunteers, and those who took the time to organize. We appreciate your dedication in providing the best.

The chapter is as strong as its members. The leadership team of CA ACDIS is grateful to the membership for putting your trust in us as we try to offer the best possible opportunities. This year, we were excited to see you in-person this year and look forward to a bigger event next year. We appreciate our virtual conference attendees as well. Your membership inspires the leadership team to provide you the best events possible. Thank you for supporting us.

To our sponsors – thank you for the support. We appreciate all of you.

My fellow leadership members – there are no words that convey my appreciation for each one you. Your dedication is apparent in the time spent to make our conferences successful, and it is always fun working with all of you. Thank you for another successful year.

As the new year approaches, we also bid farewell to two familiar faces that were part of our leadership team for many years. Thank you for all you have done Emily Emmons and Dr. Joel Lipin. We will miss you.

We cannot move forward without remembering an influential ACDIS leader who has been part of our lives for as long as I can remember. The loss of Melissa Varnavas weighed heavy on our hearts and has left a void that will be hard to fill. We dedicate this year to her, as we know she looks down on us, smiling her beautiful smile.

I would also like to thank everyone for the opportunity to lead this chapter over the past three years. As I step down as the Co-Chair, I am appreciative of this amazing experience. It was tough at times, but the leadership team and you, the members, made every minute worthwhile.

So, as 2022 ends, we look forward to 2023 and to providing more opportunities to connect, learn and network. As this year ends, I wish the new year brings everyone hope, joy and a step closer to your normal. Take time for yourself, as well as your family. We look forward to seeing all of you next year.

On behalf of the CA ACDIS Chapter Leadership:

Happy Holidays to you and your family!

Congratulations to CA ACDIS's Analyn Dolopo-Simon

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Sharp Healthcare San Diego, presentation asked; Do HealthSystem Defined Diagnoses Make a Difference?

Pam explained where it started, struggling with the various Sepsis definitions and how they created a system wide agreed upon definition. Working directly with service-line stakeholders, quality, using practice-based evidence, to establish other diagnosis definitions. This had the effect of improving quality metrics, accurate reimbursement, can be utilized in appeals and incorporated into payor contracts.

All of these are stored in digital form and easily accessible. Overall, it was well received by physicians and had the effect of reducing queries. CDIs were supported in formulating compliant queries with system wide agreed upon definitions.

Shirlivia Parker also spoke and her talk is reviewed in the article about the virtual conference following.

CA ACDIS VIRTUAL CONFERENCE REVIEW

Ann Marie Gould, AHIMA-Approved CDI Trainer, MAOM, BSN, CDIP, CCDS
Cristy Zielinski, BSN, CCDS
RN LINK

With the slowing trend of the COVID-19 outbreak, the California Chapter of the national organization, ACDIS, held both an in-person conference in San Diego, CA as well as a virtual day conference, on Thursday, December 1, 2022. This article will focus on a review of the virtual conference day speakers as well as the virtual platform used.

There are various platforms to perform online education today, Zoom, RingCentral, Webex, Microsoft and Accelevents, to name a few. Accelevents was used for the CA ACDIS conference.

Accelevents, the virtual platform, had a variety of features to maneuver within the platform. It not only comprised of the agenda, participants, and chat boxes for regular discussion as well as Q&A, it also offered participants to browse through the virtual network of vendors and post pictures during the event.

Speakers during the virtual event:

Prior to the start of the agenda topics, Pamela Stence and Emily Emmons performed the welcome introduction and discussed several items relating to the agenda and simple tricks to utilize the virtual platform. For any online seminar glitches during the day, there was an IT specialist from Accelevents available throughout the online seminar!

The first speaker of the day, **Hassan Rao, MD/MD Advisor with Brundage Group**, discussed "Cardiovascular Diagnoses that Challenge Providers – A Physician Advisor Perspective." Dr. Rao's presentation focused on differences between myocardial injury and myocardial infarction. He stated that troponin elevations play a role in differentiating the type of myocardial diagnoses upfront; however, lots of providers struggle with diagnosis specificity – what is the real cause of the troponin elevation – is it related to the troponin elevation that is > 99th percentile, is it ischemic, is it non-ischemic, is it a Type II MI??? Dr. Rao also discussed the new diagnosis of myocardial injury. Myocardial injury is usually related to an underlying etiology, such as ESRD or structural heart disease. Most myocardial injuries are chronic, stable, and non-ischemic in nature and the delta troponin is < 20%. Dr. Rao did suggest to the participants that if a provider documents "non-ischemic troponin injury," there is a potential query for "non-ischemic myocardial injury."

Additionally, Dr. Rao discussed the denials relating to the Type II MI. The key to prevent Type II MI denials, all providers – both attending physician and cardiologists – need "consensus, consistency and precision" in documentation when diagnosing a patient with Type II Myocardial Infarction.

Myocardial infarction diagnosis must include signs/symptoms, ischemic changes on imaging, high sensitivity troponin elevation (> 99th percentile) as well as treatment focused on the myocardial infarction. Dr. Rao also shared the diverse types of Myocardial Infarctions and etiology associated with each type. The end of his presentation focused on the CMS quality initiatives for myocardial infarctions and injuries, thus the reasons why diagnosis specificity is key with myocardial infarctions or myocardial injuries.

The second presenter, **Shirlivia M. Parker, MHA, RHIA, CDIP**, discussed "OP CDI: Taking CDI to the Next Level." Main point for outpatient CDI: Quality of care instead of quantity of care. Quality of care focuses on the value-based purchasing program designed by Centers for Medicare and Medicaid Services (CMS). When these programs were developed, other plans arose, namely the Medicare Shared Savings Program which included MIPS (Merit-based incentive payment system) and ACO (Affordable Care Organization) programs. All these programs focused on providing the highest quality of care to Medicare/Medicaid beneficiaries while minimizing costs and being more efficient with care provided to the beneficiaries.

Ms. Parker went on to state that the MIPS program was further broken down into the Hierarchical Condition Categories, aka HCCs. The purpose of the HCCs was to provide quality of care to patients who have chronic conditions/comorbidities and diagnosis specificity documentation again was the key! Beginning in 2023, the MIPS program has been modified by CMS and renamed "MIPS Value Pathways." This program optimizes disease management, minimizes costs for CMS as well as provide coordinated care services to the patients. There are quite of few calculations that are involved with MIPS and HCCs due to the risk adjustment factor (RAF) scores and are overly complex.

Additionally, Ms. Parker discussed the definition of an ACO and what type of services ACO's are involved in – mainly focused on HCCs risk adjusted bundled payments and risk adjusted value-based purchasing performance measures. Outpatient CDI teams can focus on the CMS-HCCs as well as the PSI 90 composite conditions that will enhance the diagnosis specificity relating to chronic disease conditions and provide quality incentives to all providers. Lastly, Ms. Parker stated that key stakeholders (diagram below) are **VITAL** to the success of an OP CDI program.

The third presenter, **Cassi Birnbaum, MS, RHIA, CPHQ, FAHIMA**, spoke about "Unleashing Technology in HIM for Population Health." Ms. Birnbaum discussed the top three barriers: (a) Difficulty with documentation sharing; (b) Lack of physicians to adopt electronic records; and (c) prioritization of improvement areas within the organization. With the many challenges healthcare has been facing over the past several years, one's organization can still set the stage for success by following a holistic, system-wide approach within the inpatient and outpatient settings. Several steps to help an organization move toward success as outlined in Ms. Birnbaum's presentation included: Remove barriers between the inpatient/outpatient CDI, coding and provider documentation; eliminate duplication of effort to improve all aspects of the programs; set up an implementation pathway to capture risk adjustment documentation; provide physician education on the rationales related to risk adjustment diagnoses and why diagnosis specificity is so important; examine implementation strategies to incorporate all inpatient and outpatient services; and lastly, connect the dots to improve population health strategies.

Incorporating technology, artificial intelligence platforms, which capture diagnosis specificity, HCCs, as well as Social Determinants of Health (SDoH) will allow better communication between providers and payers, reduce administrative burdens, and improve quality of care for all patients. Lastly, Ms. Birnbaum focused on social determinants of health and indicated that socio-clinical risk may lead to more reasonable care and complete, thorough coding of all diagnoses.

The fourth presenter, **Pamela Stence**, current CA ACDIS Co-Chair, spoke to the topic of "Do Health System Defined Diagnoses Make a Difference?" Pam's presentation all began with a ACDIS Quarterly Membership Conference Call where another colleague discussed the numerous denials received from payers on the sepsis diagnosis and how to use hospital resources to get an even playing field for denials between hospitals, providers, and payers. A multidisciplinary approach was utilized that involved various hospitals departments, e.g., quality, CDI, clinical informatics, and pharmacy, as well as physicians, chief medical officers along with HIM and coding professionals. The goal for monthly meetings with this advisory group was to identify the gaps between clinical documentation and coding language, is Sepsis 2 criteria or Sepsis 3 criteria being utilized at the hospital, and the core measures utilized at the specific hospital. A table was created (with the assistance of a consultant) for the defined Sepsis 1, Sepsis 2, and Sepsis 3 criteria, inclusive of CMS Sepsis core measurements. The advisory group voted for consensus on a formalized definition of Sepsis and developed an education plan that involved all physicians, CDI, quality department and Coding/HIM professionals as well as the Revenue Cycle department. The educational presentations were disseminated to all medical staff, CDI specialists and coders which minimized sepsis queries, created a laminated pocket guide and Compliance Bulletin that not only incorporated Sepsis criteria but also included **HAC 6** (CATHETER-ASSOCIATED URINARY TRACT INFECTION (UTI)) and **HAC 7** (VASCULAR CATHETER-ASSOCIATED INFECTION). This advisory group also performs annual reviews on the educational materials developed and update the materials based on CMS coding conventions and/or coding clinic guidelines.

Emily Emmons, our fifth speaker, focused her presentation on: "Patient-Centered CDI: Best Practices for Better Outcomes." Ms. Emmons discussed the purposes behind patient centered CDI: focus on patient safety, consistent high-quality care, and improved patient outcomes, to name a few. In order to improve patient outcomes, strong physician leadership and knowledgeable physician champions/advisors are a big piece of the pie as well as other hospital departments, including HIM/coding, Quality, Clinical informatics/IT, Compliance, and medical staff to improve current best practices which, in turn, will improve patient outcomes. It takes a village to promote high quality patient outcomes, based upon the picture below: "Don't Go It Alone!"

Ms. Emmons further stated that best practices minimize risk – diversify chart selection process for CDI specialists, expand query topics, maintain query compliance best practices, and automate CDI and coding processes with caution as well as minimize denials through monitoring of clinical data within the medical record.

Last speaker of the day, **Laura J. Werner, DC, MSN-ed, RN**, discussed "There's No Place like Home: Remote CDI."
Ms. Werner discussed remote CDI work from a managerial perspective. Three fundamentals in managing remote CDI staff included: structure and accountability of the team, maintaining productivity, and time management. Ms. Werner stated that maintaining engagement is the key to successful, remote CDI programs. She discussed the adult learning process and how sustaining communication in various areas help remote workers stay connected, either from written and oral communications- i.e., emails, verbal discussions and/or nonverbal queues. Lastly, Ms. Werner provided several options for managers/supervisors that may be utilized to engage their own remote CDI teams: involve workers in regularly scheduled monthly meetings, establish communication guidelines, offer professional development opportunities, and have regular onsite meetings.

SUMMARY

The CA ACDIS Virtual Conference offered a variety of presentations, from inpatient to outpatient opportunities as well as denials management and how to make CDI teams more uniform within the inpatient and outpatient settings. Additionally, management of remote CDI programs need to adapt to continuous communication engagement in order for all CDI programs to strive within the current healthcare challenges we face in today's world.

REFERENCES:

2022 ACDIS pocket guide – The Essential CDI Resource.
Online Webster dictionary; https://www.webster-dictionary.org/definition

Capturing 2023 Dementia Codes

By Maggie DeFilippis, RN, JD, CCDS, CDIP, CCS, CPC
Clinical Documentation Integrity and Appeals Specialist
UCLA Health

Because dementia is an increasingly costly health concern, the 2023 ICD-10-CM expanded dementia codes with the addition of 87 new codes for dementia alone. Several of the new codes are CCs and or add Severity of Illness ("SOI") and/or Risk of Mortality ("ROM") weight. CMS has officially stated they want more detailed information on dementia, so they can support improvements in clinical care and identify levels of dementia related expenditure. CDI has an important role to play in assuring accurate dementia documentation exists so that the new codes can be captured.

Because many physicians are not used to documenting dementia severity and associated behavioral disorders, CDI will need to query more than they have in the past regarding dementia diagnoses.

Most Dementia codes are found in Chapter 5 (Mental, Behavioral and Neurodevelopmental disorders [F01-F99]) of the 2023 ICD-10-CM. The new coding structure includes codes for Vascular Dementia and Dementia in Diseases classified elsewhere (such as Alzheimer's disease at [G30.-], dementia with Lewy bodies or Parkinsonism [G31.83 or G20], Frontotemporal dementia [G31.09]). The type of dementia is coded first, if known. Then, a code from a pattern describing severity and behavioral disturbance may *also* be coded if supported by physician documentation.

Dementia Type (AD, FTD, Vascular, HIV Dementia, Unspecified Type)		
	Mild	F0_-.A0 ***without*** behavioral disturbance, psychotic disturbance, mood disturbance and anxiety
		F0_.A1 *with behavioral disturbance*
		F0_.A11 *with* agitation
		F0_.A18 *with* other behavioral disturbance
		F0_.A2 *with* psychotic disturbance
		F0_.A3 *with* mood disturbance
		F0_.A4 *with* anxiety
	Moderate	F0_-.B0 ***without*** behavioral disturbance, psychotic disturbance, mood disturbance and anxiety
		F0_.B1 *with* behavioral disturbance
		F0_.B11 *with* agitation
		F0_.B18 *with* other behavioral disturbance
		F0_.B2 *with* psychotic disturbance
		F0_.B3 *with* mood disturbance
		F0_.B4 *with* anxiety
	Severe	F0_-.C0 ***without*** behavioral disturbance, psychotic disturbance, mood disturbance and anxiety
		F0_.C1 *with* behavioral disturbance
		F0_.C11 *with* agitation
		F0_.C18 *with* other behavioral disturbance
		F0_.C2 *with* psychotic disturbance
		F0_.C3 *with* mood disturbance
		F0_.C4 *with* anxiety

For all severities of Dementia, the terms above are defined to include the following behaviors and symptoms:

behavioral disturbance includes verbal and physical aggression/wandering/hoarding, etc.

agitation includes aberrant motor activity such as rocking/pacing/inability to be still
psychotic disturbance includes hallucinations/delusions/misidentifications
mood disturbance includes depression, disinhibition and sleep disorders)
anxiety includes tiredness/dyspnea/nausea/irritability/inability to focus

The severity groupings for Dementia are part of the diagnosis and are often based upon the "Clinical Dementia Rating ("CDR") which are global staging measures originally used only for Alzheimer's patients. These ratings provide guidance in assigning dementia severity. A patient need not have all symptoms in a severity grouping. The severity grouping is meant to provide a snapshot of several behaviors which may differ with dementia type and patient

MILD

Moderate memory loss (esp. recent events) interfering with ADL, Moderate difference in handling problems, Difficulty distinguishing similarities and differences, Needs prompting for personal care/hygiene.

Difficulty coping, social withdrawal, mood changes, decreased ability or perception of ability to perform normal tasks, may get lost or think lost when not. Difficulty with names and date. Others may not be aware, but the patient senses something is not right and may hide it.

MODERATE

Severe memory loss of learned material, new material rapidly lost, severely impaired ability to handle problems and distinguish similarities and differences, requires assistance dressing, hygiene and keeping track of personal effects.

Difficulty with comprehension, social withdrawal, mood changes, decreased ability or perception of location, frequent episodes agitation or confusion, Unable to cook, bank, shop, increasing inability to perform normal tasks, may get lost or think lost when not. Disoriented to date and place. May forget to finish eating a meal or forget to flush, or change clothes. Others are now aware of changes in the patient's behavior.

SEVERE

Severe Memory Loss. Disoriented to person, place and location. Physical problems predominate with loss of bodily functions including incontinence. Frequent falls. May become wheelchair bound or bedridden.

Inability to comprehend situation of health issues. Requires complete care. May lose language skills. Frequent bouts of agitation.

Dementias documented as moderate or severe will usually add a CC and a SOI of 2. Most dementias documented as Mild will add a CC. Note that even if the type of dementia is not specified, the physician's documentation of severity will add weight to the code. F03.90, Unspecified Dementia without any behavioral disturbance (F03.90) adds a ROM of 2. F03.C11 Unspecified Dementia, severe, with agitation adds a CC and an SOI of 2. If the documentation does not mention severity, the coder should default to the appropriate unspecified code. In addition, the updated guidelines stipulate that if a patient with dementia gets worse during their admission, the coder should assign the highest severity level reported during the stay. Episodes of stress or delirium can permanently accelerate Dementia progression.

Capturing accurate dementia documentation aids in research determining the impact of dementia on the healthcare system. Also, adding accurate and specific dementia documentation allows a more specific picture of the patient's risk of mortality and need for resources. Capture of this documentation also prevents denials in claims including encephalopathy or delirium cases. By distinguishing which behaviors are associated with the patient's dementia and which are associated with other neurologic diagnoses, all codes are less likely to be denied.

References

PRB Fact Sheet, US Dementia Trends *reported at* https://www.prb.org/resources/fact-sheet-u-s-dementia-trends/ (2022)

Lima, R., Three Things to Know about the 2023 ICD-10 Code Updates, Health July 25, 2022 *reported at* https://www.wolterskluwer.com/en/expert-insights/2023-icd10-code-updates

Behavioral Disturbances in Dementia *reported at* Behavioral disturbances in dementia - PMC (nih.gov) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/#:~:text=Behavioral%20disturbances%20in%20dementia%20are,aggression%2C%20wandering%2C%20and%20hoarding.&text=These%20symptoms%20create%20patient%20and,lead%20to%20nursing%20home%20placement.

Behavior Disorders of Dementia *reported at* Behavior Disorders of Dementia: Recognition and Treatment | AAFP www.aafp.org/pubs/afp/issues/2006/0215/p647.html#:~:text=Psychotic%20features%20of%20dementia%20include,therefore%20may%20not%20require%20treatment.

Alzheimer's Society Anxiety and Dementia *reported at* https://www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/anxiety-dementia

Clinical Dementia Rating *reported at* https://www.cambridge.org/core/journals/international-psychogeriatrics/article/clinical-dementia-rating-a-reliable-and-valid-diagnostic-and-staging-measure-for-dementia-of-the-alzheimer-type/23991FF301D879DD717F1814DBC2534F and
International Psychogeriatrics , Volume 9 , Issue S1 , December 1997 , pp. 173 - 176
DOI: https://doi.org/10.1017/S1041610297004870

Welcome to new Co-Chair

Janna Kalish

Janna has served as the Secretary for California's local chapter of ACDIS since 2021. She currently works as a Clinical Documentation Improvement Specialist for Sharp Healthcare in San Diego, CA. Her clinical background is primarily in Adult Intensive Care. She has also held a role in Case Management for a local Home Health company. She plans to take the CCDS exam soon, and encourages those who qualify but haven't already taken the exam to do so, too!

Janna is pictured here on the right with our current co-chair

Thank you

Over the years, there have been consistent faces associated with CA ACDIS. With the new year, we are saying a heartfelt goodbye to two of our influential leadership members.

Emily Emmons, MSN, RN, CCDS, CHFP, CRCR, CSBI

Emily Emmons has been part of CA ACDIS leadership for the past 10 years. With six years as Co-Chair, and then an additional four years as board member, she has been influential in making the California chapter what it is. Her leadership set a precedent for her predecessors, and as a board member, she supported the leadership team with her ideas and guidance.

With the new year, we bid goodbye to Emily as she steps down from her position as board member. Saying thank you is not enough. There are no words to convey what she has done for the chapter. Her commitment to the chapter to bring the members the best experience possible is an example of her dedication to the chapter.

Joel Lipin, MD, MPH

Dr. Joel Lipin joined CA ACDIS as the Co-Chair in 2017. Through Dr. Lipin's leadership, the CA chapter of ACDIS obtained recognition as a non-profit organization and has led the leadership to organize successful conferences over the years. He stepped away as the Co-Chair at the end of 2019 but remained on the leadership team as Treasurer. He has always been available to help the leadership achieve its goals and ensure our conferences attendees' experience was exceptional each year. Not to mention the unwavering sponsor support that would not have been possible without Dr. Lipin's guidance.

As the new year approaches, we also bid Dr. Lipin goodbye as he steps away from his position as Treasurer. The leadership team is deeply appreciative of all he has done for the chapter and his support is incomparable.

Joel – thank you for all you have done. We will miss you!

Pets on Parade

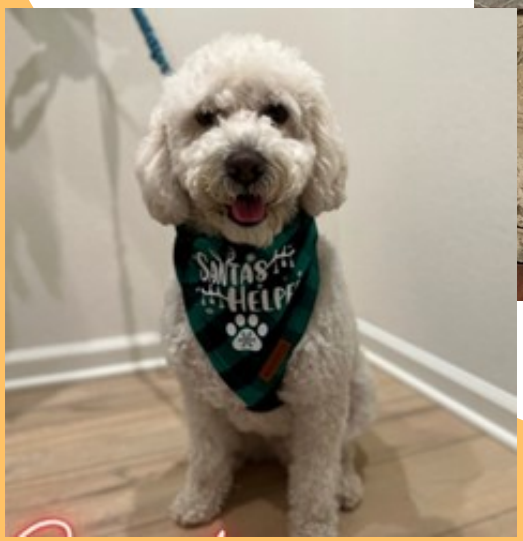
The Pets on Parade contest had three winners of the $25 Amazon gift cards:

Christine Strange, Alejandra Contreras and Debie (cruisegirl)

Here are the winners and runners up:

Pets on Parade

Here are some more:



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Don't forget to Save the Date for the next **LIVE** CA ACDIS Conference October 23rd, 2023 - Venue TBD

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Contact: Analyn Dolopo at adolopo@ucsd.edu

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