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ACPA Update
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Editor's Note

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Member, ACPA Advisory Board
Member, ACPA Government Affairs Committee
Editor, ACPA Update

Hopefully you are reading this as you pack to join us in Orlando for the National Physician Advisor Conference April 17 – 19. Did you know you can earn up to 29 CME credits? For under $1,300? That's a bargain compared to other CME offerings out there. My Illinois medical license requires specific CME courses for renewal and they generally cost much more per CME than $45 per credit. And of course, the faculty is second to none. All the gurus in the field will be presenting. Can't be there in person? Stream it! Register and see the agenda here.

Some of you may be on LinkedIn and if you are not, you should be. No, LinkedIn is not like Facebook or Instagram or Twitter, generally limiting discussions to professional topics, although a few political posts do slip through. A recent post caught my eye and actually frazzled me. Here is my summary: “A post yesterday presented the new heart failure classifications with a nice table summarizing stages, types, acuity, and applicable ICD-10-CM codes. In response, this comment was posted – “I am noticing a clinical knowledge deficit on the part of the CDI specialists when it comes to pathophysiology of disease processes. Recently I observed a physician politely ask the CDI staffer who left a query for type and acuity of CHF if she could summarize the pathophysiology of CHF and contributing factors. Needless to say the conversation did not end well when the answer from the CDI staffer did not pass muster for the physician. The query was not answered, if you are querying for a diagnosis one would assume the person querying would know what they are querying for besides catching a CC/MCC.’”

I cannot believe that the person who posted this, a person well known to the CDI community, thought this was appropriate action by the physician. That question to the staffer was not polite in any way. This leader should have defended the CDI staffer and explained to the physician that such a question, no matter how politely asked, was inappropriate. I would hope that all of us, as physician advisors, would act appropriately if this happened to our CDI staff or if a physician asked one of our UR staff to explain the pathophysiology of heart failure because the physician was not happy that the UR staff felt the documentation supported outpatient with observation and not inpatient admission.

Now take the time to read this month’s articles. Yes, there are two articles by Dr. Erica Remer. Why? Because when I read something strange or interesting, I email her asking her opinion and suddenly a full comprehensive article arrives in my inbox. Who am I to not publish these masterpieces? Malnutrition is now on your PEPPER so you must read Dr. McLendon’s excellent article on the issue and Cynthia Fleece’s eye-opening article on the growing incidence of patients with severe chronic illnesses.

Remember, ACPA is here for you. Tell us what you want, what you need, and what you can contribute. You can always contact me at **signaturedoc@gmail.com**.

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SIRS ≠ Sepsis

Erica Remer, MD, CCDS
Member, ACPA Board of Directors
Chair, ACPA CDI Committee

Do your doctors still use SIRS as their criteria for sepsis? Are you skeptical or weary of it? Let me try one more time to give you what you need to dissuade them.

In 1992, the ACCP/SCCM Consensus Conference Committee, Definitions for Sepsis and Organ Failure and Guidelines for the Use of Innovative Therapies in Sepsis was published (sorry, no free link available), defining SIRS and MODS (multiple organ dysfunction syndrome). Systemic inflammatory response syndrome (SIRS) was the term they coined to describe the clinical response to widespread inflammation in a myriad of

disorders including infection, pancreatitis, and trauma. They stated sepsis was a subcategory of SIRS.

In this sentinel article, they stated, “This systemic inflammatory response can be seen following a wide variety of insults and **includes, but is not limited to**, more than one of the following clinical manifestations: (i.e., tachycardia, tachypnea, abnormal temperature or WBC)." The 2001 SCCM/ESICM/ACCP/ATS/SIS International Sepsis Definitions Conference (**2001 Sepsis Definitions Conference.pdf (zirkin.com)**) responded to “impetus from experts in the field to modify these definitions to reflect our current understanding of the pathophysiology of these syndromes,” and subgroups were formed to assess, among other things, signs and symptoms of sepsis.

One of their conclusions was that “While SIRS remains a useful concept, the diagnostic criteria for SIRS [and here they were referring specifically to those conventional vital signs and WBC clinical indicators] published in 1992 are overly sensitive and non-specific,” and they continued, “An expanded list of signs and symptoms of sepsis may better reflect the clinical response to infection.” In Table 1 of that article, they detailed diagnostic criteria for sepsis which included those general parameters, but they added others such as altered mental status, edema, hyperglycemia in the absence of diabetes, as well as numerous other inflammatory parameters (abnormal CRP and procalcitonin), and hemodynamic, organ dysfunction, and tissue perfusion parameters including hypotension, hypoxemia, abnormal renal function, coagulopathy, ileus, thrombocytopenia, hyperbilirubinemia, and hyperlactatemia. As a result, since 2001, there have always been other criteria which are included in the clinical indicators for the potential diagnosis of sepsis.

In 2013, the Surviving Sepsis Campaign International Guidelines for Management of Severe Sepsis and Septic Shock 2012 were released (**https://doi.org/10.1097/ccm.0b013e31827e83af**), which continued to propagate the definition of sepsis as “the presence (probably or documented) of infection together with systemic manifestations of infection.” In the table detailing diagnostic criteria for sepsis, they included those other parameters noted in the paragraph above, along with the original SIRS. The focus of these guidelines, however, was to provide evidence-based recommendations for treatment. This was referred to as Sepsis-2.

The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3) (**https://doi.org/10.1001%2Fjama.2016.0287**) was the evolution born from trying to overcome “limitations of previous definitions” which “included an excessive focus on inflammation, the misleading model that sepsis follows a continuum through severe sepsis to shock, and inadequate specificity and sensitivity of the systemic inflammatory response syndrome (SIRS) criteria.” The definition of sepsis as “life-threatening organ dysfunction caused by a dysregulated host response to infection” (i.e., Sepsis-3) was established in 2016 in this article, and their conclusion was that “these updated definitions and clinical criteria should replace previous definitions, offer greater consistency for epidemiologic studies and clinical trials, and facilitate earlier recognition and more timely management of patients with sepsis or at risk of developing sepsis.”

In 2017, Surviving Sepsis Campaign (**https://doi.org/10.1007/s00134-017-4683-6**) adopted this updated definition. The only reference to SIRS was in the context of noninfectious origin. SIRS as a criterion for diagnosing sepsis was eliminated from the literature. But it has been hard to eliminate it from sepsis dogma and clinical practice.

In 2012, a 12-year-old boy from New York City, Rory Staunton, died from unrecognized sepsis following a seemingly innocuous injury to his arm. His parents became activists in an effort to prevent it from happening to someone else. In 2013, New York State issued a statewide hospital mandate regarding sepsis, colloquially referred to as Rory’s Regulations. Although the regulation Guidance Document 405.1(a)(4) refers to sepsis as being “a confirmed or suspected infection accompanied by two system (sic) inflammatory response syndrome (SIRS) criteria,” it does not stipulate the converse – that is, that an infection with two SIRS criteria is de facto sepsis.

This regulation (**https://www.health.ny.gov/facilities/public_health_and_health_planning_council/meetings/2013-02-07/docs/13-01.pdf**) mandates that hospitals must have a mechanism for early identification of sepsis and a protocol for treatment that are *based on generally accepted*

standards of care (my italics). There should be revisions and updates when appropriate, and the medical staff must be trained when there are substantive changes to the protocols. It actually seems pretty reasonable when read in the original.

Data seem to indicate that NY's sepsis policy has been effective, but it fascinates me to see one of the articles making this claim, A Roadmap for Successful State Sepsis Regulations – Lessons from New York, published in 2021 (**https://doi.org/10.1097%2FCCE.0000000000000521**), defines sepsis as "the dysregulated immune response to infection that results in life-threatening organ dysfunction." This illustrates the rub – SIRS can be an appropriate response and not reflect any organ dysfunction.

When providers or professionals from New York suggest that the regulations there are inconsistent with Sepsis-3, I disagree. I would posit that treating a febrile, tachycardic patient with a streptococcal pharyngitis as sepsis is ill-advised and could even constitute malpractice. Even in New York, if the provider were to document, "This patient has streptococcal pharyngitis with a fever and an appropriate tachycardic response. This does not represent sepsis," I think this would be sufficient to indicate that the patient did not have sepsis by clinical judgment. Blindly following a sepsis protocol for a patient without sepsis can have real consequences – fluid overload or adverse effects from antibiotic administration (e.g., C. diff, allergic reactions) come to mind. Primum non nocere.

On the flip side, if a NY provider was attending to a patient who had a severe infection with organ dysfunction but didn't happen to mount a fever or white blood cell count or become tachycardic, they should obviously be given leeway to make the appropriate diagnosis of sepsis. Resisting the diagnosis merely because the patient didn't meet SIRS criteria is doing the patient a major disservice.

I am willing to wager that a review of Rory's medical records would reflect a very sick boy by the time sepsis had developed from his wound. Sepsis is a real clinical entity which poses a high risk of mortality and morbidity, and clinicians need to recognize it, diagnose it, treat it appropriately, and document it correctly. SIRS needs to be relegated to a screening tool. It should make the clinician take a closer look to see if the patient indeed has a life-threatening organ dysfunction due to dysregulated host response to an infection, but it should not be used as definitive diagnostic criteria for the medical condition of sepsis. Sepsis is a clinical diagnosis.

Dr. Erica Remer is founder and president of Erica Remer, MD, Inc., consulting services for documentation, CDI, and ICD-10, and creator of Documentation Modules for Providers with CME, based in Beachwood, OH.

As physicians caring for our patients, we are trained to identify and address the complex of conditions that can impact the patient's course of illness. Malnutrition is an often-overlooked condition which is "a major contributor to increased morbidity and mortality, decreased function and quality of life, increased frequency and duration of hospital stays, and higher healthcare costs". Malnutrition can exacerbate the decline from chronic illness, impair the patient's immune response during acute illness, and hasten the patient's overall decline in functional capacity due to associated weakness.

The adverse effects of malnutrition may be further compounded in hospitalized patients. Direct results of malnutrition on these individuals include delayed recovery from illness, delayed wound healing, higher risk for infections and increased risk of skin breakdown, and potential development of other hospital-acquired conditions.

It's important to understand not only the benefits that accrue to our patients when we identify and properly treat their nutritional needs, but also the associated opportunities for the hospital and health system when this condition is clinically validated and optimally documented in the medical record.

Patient Quality and Safety of Care

In the FY2023 Inpatient Prospective Payment System rule, the Centers for Medicare and Medicaid Services (CMS) adopted the Global Malnutrition Composite Score (GMCS), to further recognize the importance of malnutrition in hospitalized patients. Stewarded by the Academy of Nutrition and Dietetics, and endorsed by the National Quality Forum (NQF) in their Health Equity Roadmap, the GMCS is the only nutrition-focused quality measure, and electronic measurement, in any CMS payment program. With the goal of reducing/eliminating malnutrition, the measure is designed to identify and focus intervention on malnutrition in hospitalized patients, to mitigate risk, to elevate the identification of this patient risk across the continuum of care, and to educate patients to decrease the occurrence of malnutrition and its impact on health. CMS has included the GMCS as an electronic clinical quality measure which hospitals can self-select to report in their Hospital IQR Program.

Capturing Maximum Risk Adjustment and Resource Utilization

The goal of clinical documentation is to ensure the integrity of the medical record and reflect the patient's condition at any point and time. Capturing the presence and severity of malnutrition reflects the increased complexity of the patient, and thus, the greater resource utilization in caring for the patient.

Unspecified Severe Protein-Calorie Malnutrition (ICD-10 Dx Code E43) is a Major Comorbid Condition/Complication (MCC). Moderate Protein-Calorie Malnutrition (ICD-10 Dx Code E44.0), Mild Protein-Calorie Malnutrition (ICD-10 Dx Code E44.1), as well as Unspecified Protein-Calorie Malnutrition (ICD-10 Dx Code E46) are classified as Comorbid Conditions (CCs). Because CCs and MCCs impact DRG assignment as well as Severity of Illness (SOI) and Risk of Mortality (ROM), the diagnosis of malnutrition impacts most risk adjustment methodologies, impacting both expected Length of Stay and expected Mortality.

Additionally, for hospitals and health systems that participate in Vizient healthcare quality and performance benchmarking, this diagnosis is typically a significantly weighted factor in risk adjustment data across a wide range of DRGs when it is documented as Present on Admission (POA).

Because of the impacts on external quality and safety metrics, and institutional ranking systems that are increasingly important in payer contract negotiations, Value-Based Care contracts, other hospital quality payments, and patient choice of provider, optimal documentation of this and other highly weighted conditions has gained greater visibility and focus with both hospital quality and financial teams.

Minimization of Audit Risk and Payer Denials

Under ICD-9-CM, issues arose in the US especially with adult patients being labeled (coded) incorrectly as having kwashiorkor or marasmus, both of which are classifications

for pediatric populations experiencing severe nutritional deficiencies found most commonly in developing countries. Since 2010, the Office of Inspector General (OIG) has identified multiple and significant overpayments for faulty diagnoses, coding and billing of malnutrition. More recently, in July 2020, a review of 200 records was interpreted by the OIG as indicative of continued widespread incorrect billing of malnutrition with an extrapolation of financial overpayment in excess of $1 billion. As a result of these recurrent findings, malnutrition has remained a focus of interest of the OIG's recent workplans and is a frequent target of the Recovery Auditors/Contractors (RACs), as we started to see under their Targeted Probe and Educate (TPE) audits in the most recent pre-pandemic years.

Given this continued focus and the risk of significant adverse financial repercussions to hospitals and healthcare systems, it is crucial that when malnutrition of any type or severity is documented in the medical record, the diagnosis be correct and clinically validated. Many organizations have developed electronic processes incorporating dietician assessments of a patient's nutritional status, based on the widely accepted A.S.P.E.N. criteria. These criteria were developed in 2012 by the Academy of Nutrition and Dietetics and the American Society for Parenteral and Enteral Nutrition as a standardized set of diagnostic characteristics for use in identifying and documenting adult malnutrition in clinical practice. The organizations most successful under audit for malnutrition have brought the dietician's expert A.S.P.E.N.-based assessment into the broader electronic medical record with supporting physician attestation and validation of the diagnosis. CDI guidelines for compliant querying discourage merely co-signing an ancillary note without also addressing the condition in the provider's documentation. Therefore, it is important that the provider's own physical exam findings and plan of care support the diagnosis as well.

Make It Easy for Your Doctors to Recognize Malnutrition

Encouraging physicians to consider "red flags" prompting an expert nutritional assessment can be helpful in not only identifying the degree and type of malnutrition correctly, but in ensuring appropriate and highest quality treatment of the patient's specific needs. Such "red flags" include: a patient or family's reports of unintentional and/or rapid weight loss; lack of appetite; depression or dementia impacting the desire or ability to self-feed; evidence of muscle wasting, cachexia, anorexic or emaciated appearance; concern for "failure to thrive"; any conditions placing a patient at risk for malabsorption (e.g. post-bariatric procedures, chronic inflammatory or acute infectious gastrointestinal diseases) or in a hypercatabolic state (e.g. hyperthyroidism, malignancies).

Recognizing and treating malnutrition, as it turns out, is important not only to the health and quality of life of our patients but is of growing recognition as important to the continued financial and quality health of our hospitals.

I encourage the reader to visit the CDI Resource Page under the Education tab on the ACPA website for materials on Malnutrition documentation for the Physician Advisor. You will also find a one-page CDI tip sheet on Malnutrition that you may disseminate to your providers, as well as materials on other important CDI topics.

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Using an Acute ICD-10-CM Code Instead of "History of" Can Lead to OIG Peril

Erica Remer, MD, CCDS
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Dr. Ronald Hirsch asked me to address some issues exposed by a recent Office of Inspector General (OIG) report entitled *Medicare Advantage Compliance Audit of Specific Diagnosis Codes that Geisinger Health Plan Submitted to CMS* (**Medicare Advantage Compliance Audit of Specific Diagnosis Codes That Geisinger Health Plan Submitted to CMS**). The Office of Inspector General (OIG) is charged with oversight and protecting the integrity of our governmental agencies and is supposed to prevent and detect fraud, waste, and abuse.

Medicare Advantage (MA) programs are paid according to the disease burden of the patient population. MA programs have been under the OIG's lens with the concern that they are taking credit for conditions which are risk adjusting in the Hierarchical Condition Categories (HCC) but are suspected to not be clinically valid. In this report, the OIG focused on nine groups of high-risk diagnosis codes and then extrapolates alleged overpayment.

Ron noted that most denials in the audit were cases of documented "something" that is actually "history of," and he remarked that he sees this a lot in these audits. This stems from the fact that we, as clinicians, use the words "history of" to reflect that "the past medical history includes," but we are not always distinguishing as to whether it is a current or historical condition. Coders, on the other hand, interpret "history of" to indicate that a condition is in the past, resolved, old, and they find the ICD-10-CM diagnosis code in a completely different section of the code set.

Conversely, when a provider is tasked with selecting their own ICD-10-CM codes, they often take the path of least resistance and click on the first code that populates the pick list. If it is close enough, it is good enough. They are not, and do not aspire to be, coders, and they are trying to pick a code which will satisfy the requirement for a code to put in the field on the bill. So, if they really are seeking a "history of" code but what pops up is the acute condition, they may erroneously select that. They may very well not be trying to perpetrate fraud and jack up the HCC risk adjustment score; convenience may just be too compelling.

These are the conditions which were cited in the report and my interpretation of how they arose:

- Acute stroke: The OIG has targeted inaccurate stroke diagnoses in the past (**Incorrect Acute Stroke Diagnosis Codes**) as having boosted MA organization payments. There are 3 basic buckets that diagnoses/codes regarding cerebrovascular disease land in:
- *Acute cerebrovascular accidents (I60-I63). The specificity of these codes hinge on the type of stroke (e.g., nontraumatic subarachnoid, subdural, or intracerebral hemorrhage; cerebral infarction) and site of bleed or artery involved.*
- *Sequelae of cerebrovascular disease (I69). These codes detail the neurological deficit and the specific type of stroke (e.g., I69.351, Hemiplegia and hemiparesis following cerebral infarction affecting right dominant side).*
- *Codes that designate occlusion and stenosis of arteries not resulting in cerebral infarction (I65-I66) and Z86.73, Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits.*

If the patient has had an acute stroke in the calendar year, then it theoretically wouldn't matter if the provider used it again in their office. You only get one bite at the apple per year. However, if the patient had an historical stroke and the provider used an acute stroke code instead of a sequela or personal history of stroke code, the risk adjustment factor (RAF) of the acute stroke would be credited in a year when it was not valid. Interestingly, since HCCs are weighted toward chronic conditions, paralytic syndromes due to previous stroke happen to have a higher RAF than acute stroke.

Instruct your providers that if they have the urge to use an acute stroke code in their office/clinic, they should reach for the phone to call 911. If they don't have that inclination, then acute stroke is probably not appropriate, and they should look in one of the other buckets. They should be counseled to be sure to document and MEAT (i.e., monitor, evaluate, assess, or treat to justify validity of a diagnosis) any paralytic sequelae of strokes in a given calendar year.

- Acute heart attack: This is more complicated than acute stroke. Again, if the patient is having an acute myocardial infarction (AMI) in the clinician's office, they should call 911 and use an I21.- code. However, there is a coding rule that allows for the application of the AMI code for 4 weeks following the heart attack, assuming that it meets the definition of "other diagnosis" (i.e., MEAT). If you are still monitoring, assessing, or treating the MI, you can still document and code it. As in the stroke scenario, the problem arises if there has not been an AMI in the calendar year and it is really historical. The practitioner who erroneously codes an AMI in that situation will reap an RAF to which they are not entitled. After 4 weeks, if the patient is no longer receiving active treatment for the myocardial infarction, it gets relegated into I25.2, Old myocardial infarction.
- *Acute MI à I21.- code and call 911*
- *Subsequent (Type 1) MI (i.e., a second MI following the index one) within 4 weeks of first one à I22.- code and call 911. You would also code the original I21- code.*
- *Follow up within 4 weeks of an acute MI and monitoring, evaluating, assessing, or treating à I21.- code and treat appropriately*
- *Complications following STEMI/NSTEMI within 28 days à Complication code from I23 or other (e.g., E24.1, Dressler's syndrome)*
- *Follow up after 4 weeks has elapsed since a previous acute MI and no longer providing active treatment for index MI à I25.2*

- Embolism: This is a function of providers not attending to the distinction between acute and chronic forms of conditions or "history of."
- *Is there still a clot there (pulmonary embolism or deep vein thrombosis)? – provider needs to document and code acute or chronic PE/DVT, as the case may be.*
- *Has the clot resolved, been resorbed, been removed? Even if the patient is taking anticoagulation to prevent a future clot, this would now be a Z86.7- personal history code.*
- *And is the patient still taking anticoagulation? There should be a Z79 code for long term (current) use of anticoagulants. This is not included in the HCC list.*

The rest of the conditions had similar objections by the auditors. In the service year, was there any evidence that the conditions were being treated?

- Vascular claudication: auditor consideration: was there a prior diagnosis of this condition within the preceding 2 years and was the patient prescribed medication to ameliorate the symptoms or condition? I would add that if the provider documented a history consistent with claudication (e.g., Patient states that when they walk short distances, they experience severe cramping in their legs which causes them to have to stop and rest until it resolves. Will refer to vascular medicine.), it would be acceptable to make

a clinical diagnosis. Otherwise, it requires some medication management or monitoring to validate the diagnosis.

- Major depressive disorder (MDD): Providers often document, “Depression,” on their impression list without indicating any evaluation/assessment. If there is no treatment, the auditors discounted it as a valid diagnosis. I think this is fair – in order to accrue the RAF, there needs to be some specificity to the diagnosis (e.g., single episode or recurrent, severity of depression, in remission).

In order to be considered clinically valid, the auditors had an expectation that a patient will be on medication. This is not necessarily accurate – some patients opt for therapy, and if the MDD is in remission, the patient may no longer be medicated.

- Lung, breast, colon, and prostate cancer: The criterion that the OIG used for determining if cancer was a clinically valid diagnosis during the service year was whether there had been surgery, radiation, or chemotherapy administered within a 6-month period before or after the diagnosis. I would include immunotherapy or other cancer-specific treatment as well. Additionally, if a patient declined therapy but still had a tumor, that would also count as having cancer as opposed to a history of cancer. Finally, prostate cancer can be managed with active surveillance or “watchful waiting.” This would also render it a valid diagnosis, but best practice would be to explicitly document it that way.

The ICD-10-CM coding guidelines advise using a history of cancer, Z85 code, if “a primary malignancy has been previously excised or eradicated from its site and there is no further treatment directed to that site and there is no evidence of any existing primary malignancy at that site.” Although the OIG uses 6 months, there is no hard and fast rule for length of time cancer-free mandated in the coding guidelines. Also, a patient can be coded as having metastatic secondary malignant disease without having a primary malignancy code.

The key to avoiding the jeopardy of getting caught by the auditors, OIG, or anyone else is for the providers to think in ink. Documentation is the way to support the validity of any coded diagnosis. Providers need to be taught the difference between historical and chronic conditions. Organizations may want to set up systems to have competent coders review provider-selected codes to ensure compliance with coding guidelines.

Besides being embarrassing, it is a boatload of work, time, and money to fight an unfavorable OIG investigation, even if there was no intent to commit fraud. Better you should preemptively educate your medical staff.

Dr. Erica Remer is founder and president of Erica Remer, MD, Inc., consulting services for documentation, CDI, and ICD-10, and creator of Dr. Remer’s Documentation Modules, based in Beachwood, OH.

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The Silent Crisis

Cynthia A Fleece, RN, MBA, ACM-RN, CHCQM-CM
Member, ACPA Advisory Board

Again, I am stuck behind my computer, hands poised on the keyboard hoping that one of the numerous crises' affecting healthcare today sparks enough interest to author an article to an amazing group of Physician Advisors and Nurses. I am usually trying desperately to channel Dr Hirsch's skills. This time the inspiration for the article came during an event I was attending. A gentleman across the table from me at this event was trying to eat his dinner, involuntary muscle contractions resulted in uncontrolled shaking in both hands making even getting a piece of lettuce to his mouth difficult. His speech stammered; I recognized the symptoms.

I was then reminded of the extended length of stay meetings within my hospital that referred to patients with an extended length of stay as "complex patients" with a chronic illness that had caused dementia which made discharging complicated. Parkinson's is one of these diagnoses, however Alzheimer's is the most common. This silent crisis affecting a third of our patients is still something rarely discussed and like cancer there has been wonderful progress in treatment but as of today no cure.

In a Healthcare IT Newsletter, "Social Determinants of Health and the $1.7 Trillion Opportunity to Slash Spending", dated October 9, 2017, the author Tom Sullivan writes, "it is estimated that by 2050 America will have 83.7 million seniors and that three (3) in four (4) citizens over 65 will have multiple chronic conditions". The article said that in 2017 the estimated cost of providing care to patients with Alzheimer's disease was $236 billion and was estimated to grow to $1.4 trillion by 2050.

My question then becomes what is driving the cost; treatment of the disease or treatment of dementia caused by the disease? For those of you that know me, finding an answer to this question became my mission.

According to Dr Jason Karlawish, who is the author of, "The Problem of Alzheimer's", and who is still practicing at Penn Memory Center in Pennsylvania, "the difference between Alzheimer's disease and dementia is that dementia describes disabling cognitive impairments. Alzheimer's disease is the most common cause of those disabling cognitive impairments." There are however other diseases that cause dementia, some of those include Lewy body disease, frontotemporal lobar degeneration, Parkinson's disease, Huntington's disease, HIV infection (if not treated), and Syphilis (if left untreated). It made sense regarding the estimated skyrocketing costs associated with caring for patients who develop dementia because of their disease state.

A ChenMed blog dated March 18, 2022 regarding physician shortages states:

"The U.S. has only 7,300 geriatricians, yielding roughly 1.07 geriatricians for every 10,000 geriatric patients. To put this into perspective, the American Geriatrics Society (AGS) estimates that one geriatrician can care for about 700 patients."

This is adding up to what we are experiencing in our healthcare facilities around dementia regarding diagnosing, staging and education. I don't want this to look like I am pointing a finger at physicians, I am speaking to all healthcare professionals. There are several stages to these diseases and when treating and assessing patients with Alzheimer's we must ensure we are including the caregivers familiar with the patient. Family meetings with the patient and the caregiver who can provide a history and share some of their observations. Assessments should include both cognitive and functional assessments in determining the future needs of the patient for the caregiver.

I often hear of nurses' asking the attending physician for an order for psychiatric evaluation consult for cognition and when I see this on a geriatric patient I will usually

look for documentation in the psychiatric evaluation that there was a conversation with the caregiver, especially if the patient was admitted from home. The attending or consultant documentation should include questions around, Who pays the bills? What medication do you take and do you know what it is for? Do you have a computer at home? And do you drive or take other transportation? These are the earliest cognitive problems associated with the disease. To use the patient's behavior as a way to measure cognitive function is unrealistic as this often changes daily in all stages of dementia. I remember my own experience with my father. Last year when I took him to his favorite restaurant and they gave him the menu, he looked at it and said, "I'll have eggs." On that day, that was the only word that made sense to him, unfortunately this was a polish restaurant.

Dementia can also result from social determinants like obesity, untreated hypertension, lack of proper sleep, often seen with homelessness, and poorly controlled diabetes.

Patients living with dementia as well as other chronic diseases require specialized assessments and testing, discharge planning, and understanding that the patient in front of you is struggling to understand who they are in the discussion.

There are a variety of problems related to discharge planning, however most include the lack of long term care facilities, especially for the patients with aggressive behaviors.

The political lobbying for long term care services and facilities started in 1980 and was supported by caregivers like Hilda Pridgeon, who was one of the founders of the Alzheimer's Association. These efforts stood still until 2010 when President Obama signed the National Alzheimer's Project Act. The funding for these efforts still gets little traction. Meanwhile the current long term care environment either lacks the capacity to care for patients living with dementia or they lack the trained and educated staff that have experience working with these patients and their caregivers. Caregivers who provide care for these patients at home often hit a time when they can no longer care for the patient safely at home. The patient comes into the hospital with no real medical needs other than a need for a safe environment that will allow the patient to remain mobile but under observed care in a safe environment. The caregiver is also a patient, frustrated and burned out, seeking options and often not understanding or able to meet the financial responsibilities for placing the patient into a long term facility that can meet the patient's cognitive needs.

Steven Zauderer posted facts regarding long term care facilities dated 02/02/2023: there are 65,600 regulated long term facilities in the United States, up to 30 million Americans will require long term care in 2050, **70%** of seniors will need some long-term care, which includes assistance with everyday activities like washing themselves, dressing up, and general upkeep of hygiene. This is often from a physical injury or illness, or an issue involving aging and **60%** of people and families can't pay for the expenses that nursing services require for them to house the elderly.

Now is the time to develop protocols, education and structured in-person discharge planning that includes the caregiver's needs and safe environments for the patient's long term placement. We need to contact our government officials and lobby for more regulated facilities, outpatient assistance, regulations and required education for staff and therapists in long term facilities, and safe contained environments. Until we can gain access to facilities like this, patients will continue to come into the hospital environment, challenge our discharge planners and utilize unnecessary resources that could be provided outside the walls of the hospital. When politicians say we can't afford to fund projects like this, hospital administration should reply we already are.

Cynthia A Fleece is the Director of Utilization Review and Denials Management for the BayCare Health System in Clearwater, Florida.

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ACPA Strategic Planning Executive Summary

Ahmed Abuabdou, MBBS, MBA
ACPA Vice President – Operations
Chair, Strategic Planning Committee

The American College of Physician Advisors (ACPA) is a not-for-profit professional organization founded in 2014 to serve the educational and professional needs of the physician advisor community. The ACPA leadership decided during its Board of Directors (BOD) Retreat in October of 2021, to embark on the journey of developing the ACPA strategic plan (Vision 2032). A Strategic Planning Committee (SPC) with representation from various leadership cabinets of ACPA was formed. The SPC launched its first meeting in March of 2022 and concluded its task of presenting the final strategic plan to the ACPA BOD in October of 2022.

The major milestones achieved by the committee included revision of the mission and vision statements, establishment of ACPA core values, completion of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, identification of strategic domains, and surveying stakeholders. Lastly, using SMART (Specific, Measurable, Attainable, Relevant, and Timely) goal methodology, strategic goal(s) were articulated under each strategic domain.

The revised ACPA mission is to promote and enhance the instrumental role of physician advisors across the continuum of healthcare through education and professional development. The revised vision statement is to be the professional home of physician advisors where industry standards are set through education, certification, mentorship, innovation, and advocacy. Five core values were established to be ACPA's core values as a professional organization. The ACPA's core values are integrity, diversity, equity, and inclusion (DEI), collaboration, leadership, and mentorship.

SWOT analysis was completed confirming that the rich intellectual capital, committed leadership, and the National Physician Advisor Conference (NPAC) are the key strengths of ACPA. The volunteer nature of the organization, the suboptimal technological platform used by ACPA, and the absence of guidelines, peer-reviewed publications, and white papers stood out as the key weaknesses of ACPA. There are ample opportunities for ACPA to establish its presence as the pioneer organization in setting the industry standards for the physician advisor profession through the development of physician advisor certification. Creating a sustainable administrative structure is of paramount importance to the success of ACPA and it is an opportunity of the highest order of magnitude.

Stakeholders were identified. ACPA leadership and membership body were surveyed to solicit their opinion and feedback about current and future ACPA offerings. Three separate meetings were held with the current and past ACPA Presidents, BOD, and Advisory Board members where an open forum methodology was used to solicit their opinion and feedback. The common findings between the surveys and the meetings were aligned with the strategic domains and informed the development of strategic goals.

Seven strategic domains were identified including education, advocacy and government relations, institutional relations and alliances, marketing and branding, member engagement, financial and resource management, and leadership. Strategic goal(s) were articulated within each domain aimed at achieving ACPA Vision 2032.

We welcome your comments, questions, and suggestions at this link. [Make "link" be a hyperlink to the following web page: https://www.acpadvisors.org/content.aspx?page_id=4&club_id=90610] Thank you for your time and participation supporting ACPA and the advancement of our work in the field!

Dr. Abuabdou is a practicing Hospital Medicine faculty at the University of Arkansas for Medical Sciences, Little Rock, Arkansas. He serves as Associate Chief Medical Officer for UAMS Medical Center and leads its Physician Advisory Program.

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American College of Physician Advisors

President's Corner

April 2023

The 2023 National Physician Advisor Conference (NPAC 2023) is days away! You're not registered yet? What are you waiting for? Already, over 350 of your peers will be learning from the best physician advisors and leaders in the fields of case/utilization management, clinical documentation integrity, revenue cycle, and medical staff leadership.

Along with absorbing the wisdom from our spectacular speakers, I encourage you to seek out and chat with our board of directors, as well. We're not involved with ACPA as much as we are for the heck of it…we love this time of the year when we get to interact with all of you – our membership! Our efforts year after year are focused on providing you what you need in your roles and what better way to learn that to hear it straight from you?

Ahmed Abuabdou, MBBS, MBA is our Vice President of Operations and my right-hand man when it comes to keeping the organization running smoothly with an eye on the future. He's recently been elevated within his health system to the role of chief clinical officer which makes sense considering one of his passions is encouraging others to cultivate and seek out high-level leadership positions for themselves.

Erica Remer, MD, CCDS – do I even have to say anything more? Yes, this is the same

Dr. Remer from the weekly Talk Ten Tuesday broadcast! Erica is a veritable legend for physician advisors and clinical documentation integrity specialists alike given her renowned skills in breaking down coding and documentation topics into easily-understood tidbits. She has been the chair of our CDI Committee since its inception and is instrumental in the creation of our CDI Resource Pages.

Denise Goodman, MD, MS, FCCM is not only one of the sharpest academic minds I know, she's also a fellow pediatrician! Like hospitalists and the specialized field of hospital medicine, the physician advisor role started out in the adult world. But, over the last number of years it's become crystal clear that physicians knowledgeable in and comfortable with pediatric cases, not to mention the drive to address complex, state-by-state challenges associated with Medicaid plans, are critical to health systems' successes.

Liz Quinn, MD, our NPAC Chair and Emeric Palmer, MBBS, MBA, FACP, our NPAC Champion are the dynamic duo responsible for ACPA's return to the conference stage with NPAC 2022, this year's event along with NPAC 2023 Vice Chairs Stephane Van Zandt, MD, FACOG and Scott Ceule, MD, FACP, FAAP, and planning for future NPACs to come. Their fingers are on the proverbial pulse of our membership when it comes to producing the greatest physician advisor educational event of the year so make sure you share with them your thoughts and hopes for 2024 and beyond!

Ben Kartchner, MD is one of our newest members to the Board and responsible for our largest educational offerings next to NPAC – The Learning Center (TLC) and our Essentials & Fundamentals seminar which debuted last Fall. He has lots of plans in store for TLC in the coming months but is always looking for input on new CME modules our membership wants to round out their fund of knowledge.

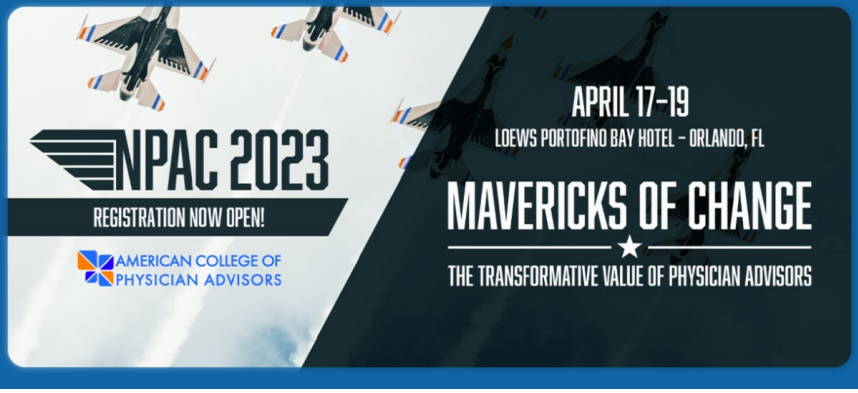
Charlie Locke, MD has all of the gravitas and words of wisdom to share which you would expect from a past president of the ACPA. From originally bringing TLC to life to helping the College survive during the pandemic, he has been intricately involved in our efforts to support our community through thick and thin.

Anuja Mohla, DO's work as chair of the Observation Committee leads to monthly Observation cases of the month within our newsletter and multiple, open-access town halls which are some of the most-attended the College has offered. She is passionate about encouraging new-career physician advisors to get involved and step forward into leadership no matter what their background or experience level.

Finally, Al Gore, MD will be in the thick of collecting data for the biannual 2023 Physician Advisor Survey when NPAC rolls around, so don't forget to participate **here** before coming to the conference! This much-anticipated survey shines a light on everything from salary to role responsibilities and hospital size per physician advisor to reporting structures and job satisfaction. While it's too late to make suggestions about more valuable points of comparison across the country for this year's survey, Al is always looking for more ideas for coming versions.

If you haven't gathered as much by now…I and my leadership team are so extremely excited to spend a few days with you at NPAC 2023! We will be identified by our badges as will the members of our Advisory Board and Emeritus Board so make sure you stop and say hi April 17 – 19 in Orlando!

Juliet B. Ugarte Hopkins, MD
(Pronouns: She/Her)
President, ACPA



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2023 ACPA PHYSICIAN ADVISOR SURVEY

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