CODING CARDIAC DISEASES: WHEN TO TICK 'USE IN MDS'

The interRAI LTCF and HC Assessments - Section I has a pre-populated list of diagnoses that includes coronary heart disease and congestive heart failure. In order to code these diagnoses accurately you must know the definitions.

DEFINITIONS:

Cardiovascular disease

This is an umbrella term for all diseases of the heart and blood vessels.

Coronary heart disease (CHD)

Also known as coronary artery disease is atherosclerosis (the formation of plaque in coronary arteries): it is therefore **STRUCTURAL**, e.g. ischaemic heart disease (IHD). **Angina** refers to the chest pain caused by IHD.

Congestive heart failure (CHF)

This is **PUMP** insufficiency & is distinct from left /right sided heart failure. CHF refers to fluid build-up around/outside the heart.

Atrial fibrillation/flutter (AF) and other arrhythmias

This refers to **ELECTRICAL** defects & are not included in the section I pre-populated list of diagnoses. AF and coronary heart disease are different diseases [ref.: John Mandrola MD: Cardiac Electrophysiologist]. AF and CHD may co-exist/be linked in an individual.

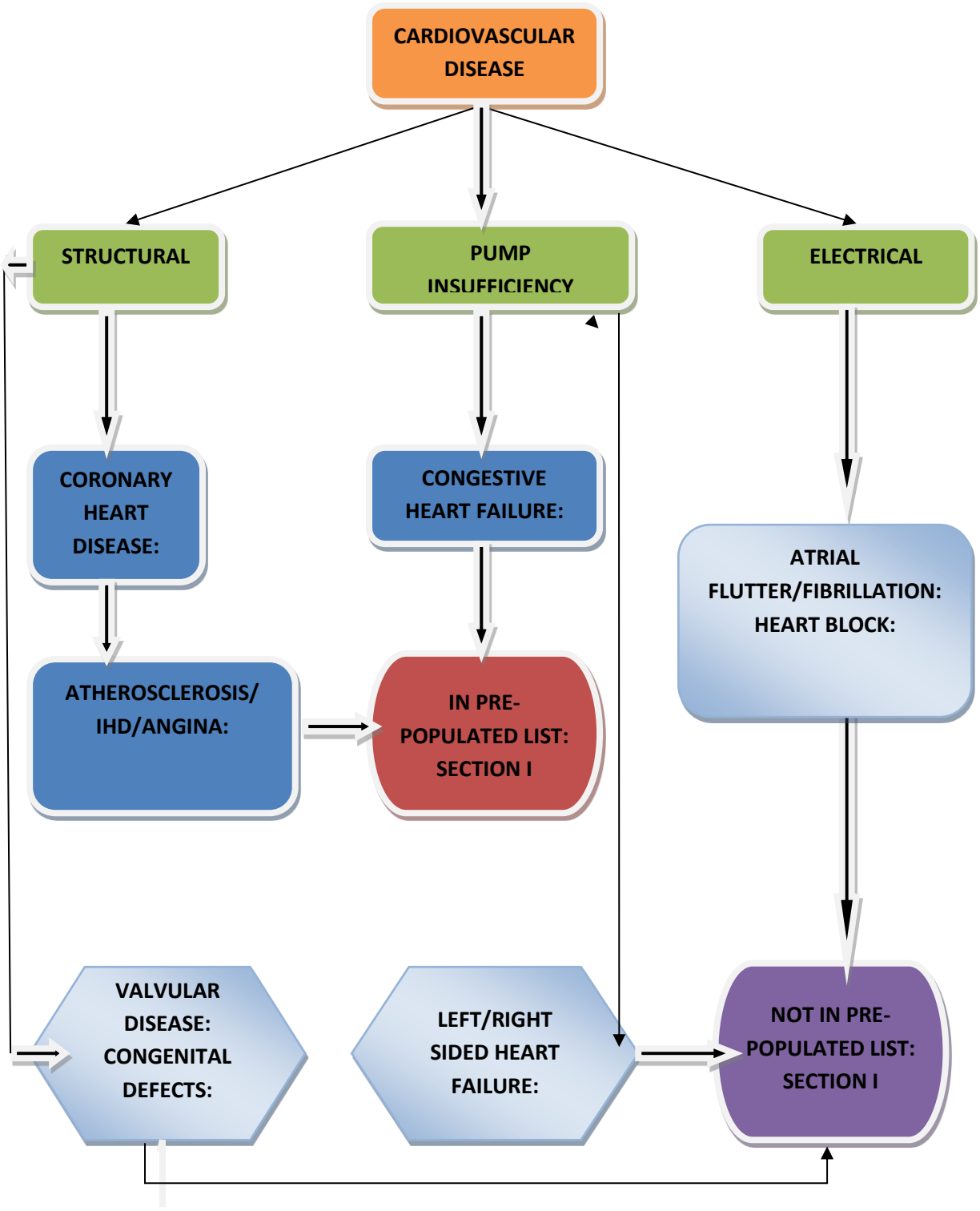
OTHER HEART CONDITIONS:

Myocardial infarctions (heart attacks)

These are usually, not always, caused by CHD.

Cardiomyopathy

A disease of the heart muscle: various causes.


CARDIOVASCULAR DISEASE
STRUCTURAL
PUMP INSUFFICIENCY
ELECTRICAL
CORONARY HEART DISEASE:
CONGESTIVE HEART FAILURE:
ATRIAL FLUTTER/FIBRILLATION: HEART BLOCK:
ATHEROSCLEROSIS/ IHD/ANGINA:
IN PRE-POPULATED LIST: SECTION I
VALVULAR DISEASE: CONGENITAL DEFECTS:
LEFT/RIGHT SIDED HEART FAILURE:
NOT IN PRE-POPULATED LIST: SECTION I

Purpose of coding items in Section I1 & I2 in the MDS

The *intent* of this question is not to be confused with a standardised medical model of listing diagnoses.

The interRAI organisation have identified a list of common & /or important diseases/disorders that are listed in section I1. All these listed conditions feed into the algorithms that inform various outcomes/CAPs and RUGs at assessment completion for care planning consideration.

The *intent* of the section coding is:
"To document the presence of diseases or infections relevant to the person's current ADL status, cognitive status, mood or behaviour status, medical treatments, nursing monitoring, or risk of death…."

Diseases/Infections are to be recorded in one of the two sections:
I1 – the list of common or important diseases relevant to care OR
I2 – "Other disease diagnosis" – important to the person's current situation and treatment

The assessors can list AF as a 'stand alone' diagnosis **IF** there are any current medical treatments/nurse monitoring that is required for this condition.

If the person has had an MI (Myocardial Infarct) and is undergoing cardiac rehabilitation or monitoring then there is no issue with listing it as a separate item under section I2 in the context of an interRAI MDS assessment as it fits with the intent of the coding.