

Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP) Provider Training



Section C: Cognitive Patterns

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Section C: Objectives

- Define Section C: Cognitive Patterns.
- Explain new items for LTCH CARE Data Set v3.00.
- Explain the intent of Section C.
- Discuss coding instructions and needed information for items.
- Accurately code scenario(s).

Section C: New Items

NEW:

- Section C is NEW.
 - All items in this section are new.
- Complete only if:
 - A0250 = 01 Admission,
 - A0250 = 10 Planned Discharge,
 - A0250 = 11 Unplanned Discharge.

Section C: Intent

The intent of the items in this section is to determine if the patient has **signs and symptoms of delirium** using The Confusion Assessment Method (CAM[©]).

CAM[©] Adapted with permission from: Inouye SK et al, Clarifying confusion: The Confusion Assessment Method. A new method for detection of delirium. *Annals of Internal Medicine*. 1990; 113: 941-948. Confusion Assessment Method: Training Manual and Coding Guide, Copyright 2003, Hospital Elder Life Program, LLC. Not to be reproduced without permission.

Section C: C1610. Signs and Symptoms of Delirium (from CAM ©)

C1610. Signs and Symptoms of Delirium (from CAM©)	
Confusion Assessment Method (CAM©) Shortened Version Worksheet (3-day assessment period)	
CODING: 0. No 1. Yes	↓ Enter Code in Boxes
	<input type="checkbox"/> Acute Onset and Fluctuating Course A. Is there evidence of an acute change in mental status from the patient's baseline?
	<input type="checkbox"/> B. Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?
	<input type="checkbox"/> Inattention C. Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?
	<input type="checkbox"/> Disorganized Thinking D. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?
<input type="checkbox"/> Altered Level of Consciousness E. Overall, how would you rate the patient's level of consciousness? E1. Alert (Normal)	
<input type="checkbox"/> E2. Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)	

Applies to Admission, Planned Discharge, and Unplanned Discharge Assessments.

SECTION C: Rationale

- Health-related Quality of Life.
- Delirium is associated with:
 - Increased mortality,
 - Functional decline,
 - Development or worsening of incontinence,
 - Behavior problems,
 - Withdrawal from activities,
 - Rehospitalizations and increased length of stay.
- **Delirium can be misdiagnosed as dementia.**
 - However, patients with dementia can experience delirium.

SECTION C: Rationale (cont.)

- A recent deterioration in cognitive function may indicate delirium, which may be reversible if detected and treated in a timely fashion.
- Delirium may be a symptom of an acute, treatable illness such as infection or reaction to medications.
- Prompt detection of delirium is essential to identify and treat or eliminate the cause.

SECTION C: Definitions

- **DELIRIUM:** A mental disturbance characterized by new or acutely worsening confusion, disordered expression of thoughts, change in level of consciousness, or hallucinations.
- **FLUCTUATION:** The behavior tends to come and go and/or increase or decrease in severity. The behavior may fluctuate over the course of an interview/discussion or the assessment period. Fluctuating behavior may be noted by staff or family or documented in the medical record.

SECTION C: C1610A & C1610B.

Acute Onset and Fluctuating Course

STEPS FOR ASSESSMENT:

- Assess for acute change in mental status.
- Evidence of acute change:
 - Patient interactions,
 - Medical record,
 - Reports from family,
 - Staff reports.

SECTION C: C1610A

<input data-bbox="125 428 202 506" type="checkbox"/>	<p>Acute Onset and Fluctuating Course</p> <p>A. Is there evidence of an acute change in mental status from the patient's baseline?</p> <div data-bbox="266 528 1883 642"></div>
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CODING INSTRUCTIONS:

- **Code 0, No**, if there is no evidence of an acute change in mental status from the patient's baseline.
- **Code 1, Yes**, if there is evidence of an acute change in mental status from the patient's baseline.

Section C: C1610A Coding Scenario (1)

The nurse reports that a patient who has been quiet and has short-term memory problems suddenly becomes agitated, calling out to her husband who died several years ago, removing her clothes, and being disoriented to time, person, and place.

How would you code C1610A?

What is your rationale?

Section C: C1610A Coding Scenario (1)

CODING: C1610A – Acute Onset would be coded **1, Yes.**

RATIONALE: The new behaviors represent an acute change in mental status compared with the patient's baseline status.

Section C: C1610A Coding Scenario (2)

The certified nursing assistant reports that Mr. D is consistently confused about where he is and why he is at the facility. The certified nursing assistant reports to the nurse that Mr. D does not appear to recognize his family when they visit him. Mr. D's vision and hearing do not appear to be impaired, thus not the causes of his confusion. The family confirms that this behavior is typical for Mr. D.

How would you code C1610A?

What is your rationale?

Section C: C1610A Coding Scenario (2)

CODING: C1610A – Acute Onset would be coded **0, No.**

RATIONALE: Throughout the 3-day assessment period the patient's behaviors represent his baseline mental status.

Section C: C1610B

<input data-bbox="137 411 208 482" type="checkbox"/>	<p>Acute Onset and Fluctuating Course</p> <p>B. Did the (abnormal) behavior fluctuate during the day, that is, tend to come and go or increase and decrease in severity?</p>
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CODING INSTRUCTIONS:

- **Code 0, No**, if the (abnormal) behavior did not fluctuate during the day (i.e., did not tend to come or go or increase/decrease in severity).
- **Code 1, Yes**, if the (abnormal) behavior fluctuated during the day (i.e., tended to come and go and/or increase/decrease in severity).

Section C: Definition


INATTENTION: Reduced ability to maintain attention to external stimuli and to appropriately shift attention to new external stimuli. Patient seems unaware or out of touch with environment (e.g., dazed, fixated, or darting attention).

Section C: C1610C. Inattention

STEPS FOR ASSESSMENT:

- Assess **attention** separately from **level of consciousness**.
- Evidence of inattention:
 - Patient/clinician interactions,
 - Medical record,
 - Reports from family,
 - Staff reports.
- An additional step to identify difficulty with attention is to ask the patient to count backward from 20.

Section C: C1610C. Inattention (cont.)

	<p>Inattention</p> <p>C. Did the patient have difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said?</p>
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CODING INSTRUCTIONS:

- **Code 0, No**, if the patient remains focused, and was not easily distracted or having difficulty keeping track of what was said.
- **Code 1, Yes**, if the patient had difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was said.

Section C: C1610C Coding Scenario (1)

Mrs. T tries to answer all questions during an interaction with the clinician. Although she answers several items incorrectly and responds “I don’t know” to others, she pays attention to the clinician. The medical record and staff indicate that this is her consistent behavior during the assessment period.

How would you code C1610C?

What is your rationale?

Section C: C1610C Coding Scenario (1)

CODING: C1610C – Inattention would be coded **0, No.**

RATIONALE: Mrs. T remained focused throughout the interaction, which was constant during the 3-day assessment period.

Section C: C1610C Coding Scenario (2)

Questions during patient and clinician interactions must be frequently repeated because Mrs. W's attention wanders. This behavior occurs throughout interactions, and the medical record notes and staff reports agree that this behavior is consistently present during the 3-day assessment period.

How would you code C1610C?

What is your rationale?

Section C: C1610C Coding Scenario (2)

CODING: Item C1610C – Inattention would be coded **1, Yes**.

RATIONALE: The patient had difficulty focusing her attention throughout the 3-day assessment period. Staff needed to frequently repeat information during interactions with Mrs. W.

Section C: Definition

DISORGANIZED THINKING: Evidenced by rambling, irrelevant, and/or incoherent speech.

SECTION C: C1610D. Disorganized Thinking

STEPS FOR ASSESSMENT:

- Assess for disorganized thinking.
- Evidence of disorganized thinking:
 - Patient interview,
 - Medical record,
 - Reports from family,
 - Staff reports.

Section C: C1610D. Disorganized Thinking (cont.)



Disorganized Thinking

D. Was the patient's thinking disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject?

CODING INSTRUCTIONS:

- **Code 0, No**, if the patient's thinking was organized and coherent, even if the answers were inaccurate or wrong.
- **Code 1, Yes**, if the patient's thinking was disorganized or incoherent, such as rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject.

Section C: C1610D Coding Scenario (1)

The clinician asks Mrs. L, who is often confused, to give the date, and the response is: “Let’s go get the sailor suits!” The patient continues to provide irrelevant or nonsensical responses throughout the conversation, and medical record and staff indicate this is constant.

How would you code C1610D?

What is your rationale?

Section C: C1610D Coding Scenario (1)

CODING: C1610D – Disorganized Thinking would be coded **1, Yes**.

RATIONALE: All sources agree that the disorganized thinking is constant.

Section C: C1610D Coding Scenario (2)

Mr. D responds that the year is 1937 when asked to give the date. The medical record notes and staff reports indicate that Mr. D has not been oriented to time, but has coherent conversations. For example, staff reports he often discusses his passion for baseball.

How would you code C1610D?

What is your rationale?

Section C: C1610D Coding Scenario (2)

CODING: C1610D – Disorganized Thinking would be coded **0, No**.

RATIONALE: The patient's answer was related to the question, even though it was incorrect. No other sources report disorganized thinking.


Section C: C1610E1 & C1610E2.

Altered Level of Consciousness

STEPS FOR ASSESSMENT:

- Assess for altered level of consciousness during the assessment period.
- Evidence of altered level of consciousness:
 - Patient/clinician interactions,
 - Medical record,
 - Reports from family,
 - Staff reports.

SECTION C: C1610E1

	<p>Altered Level of Consciousness</p> <p>E. Overall, how would you rate the patient's level of consciousness?</p> <p>E1. Alert (Normal)</p>
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CODING INSTRUCTIONS:

- **Code 0, No**, if the patient was not alert.
- **Code 1, Yes**, if the patient was alert.

SECTION C: C1610E2

<input type="checkbox"/>	Altered Level of Consciousness
	E. Overall, how would you rate the patient's level of consciousness? E2. Vigilant (hyperalert) or Lethargic (drowsy, easily aroused) or Stupor (difficult to arouse) or Coma (unarousable)

CODING INSTRUCTIONS:

- **Code 0, No, if the patient did not exhibit any of the following:**
 - vigilant (hyperalert): patient startles easily to any sound or touch; his or her eyes are wide open;
 - lethargy (drowsy, easily aroused): patient repeatedly dozes off while you are asking questions, and may be difficult to keep patient awake for interview, but does respond to voice or touch;
 - stupor (difficult to arouse): patient is very difficult to arouse and keep aroused for the interview, requiring shaking and/or repeated shouting; or
 - coma (unarousable): patient cannot be aroused despite shaking and shouting.
- **Code 1, Yes, if the patient exhibited any of the following:** vigilant (hyperalert), lethargy (drowsy, easily aroused), stupor (difficult to arouse), or coma (unarousable).

Section C: C1610E Coding Scenario (1)

Mr. Q is alert and conversational and answers all questions during the discussion, although not all answers are correct. Medical record documentation and staff reports during the 3-day assessment period consistently note that the patient was alert.

How would you code C1610E1 and C1610E2?

What is your rationale?

Section C: C1610E Coding Scenario (1)

CODING: C1610E1 would be coded **1, Yes**, the patient was alert.

C1610E2 would be coded **0, No**, the patient is not exhibiting an altered level of consciousness.

RATIONALE: All evidence indicates that the patient is alert during conversations and activities.

Section C: C1610E Coding Scenario (2)

Mr. B is lying in bed. He arouses to soft touch, but is only able to converse for a short time before his eyes close, and he appears to be sleeping. Again, he arouses to voice or touch, but only for short periods during the conversation. Information from other sources indicates that this was his condition throughout the assessment period.

How would you code C1610E1 and C1610E2?

What is your rationale?

Section C: C1610E Coding Scenario (2)

CODING: C1610E1 would be coded **0, No**, the patient was not alert.

C1610E2 would be coded **1, Yes**, the patient is exhibiting an altered level of consciousness.

RATIONALE: The patient's lethargy was consistent throughout the interaction, and there is consistent documentation of lethargy in the medical record during the assessment period.

Section C: Summary

- All of Section C is new.
- The purpose of Section C is to determine if the patient has signs and symptoms of delirium.
- Delirium is sometimes unrecognized and undocumented by clinicians. Early recognition and treatment can improve outcomes.

Section C: Action Plan

- Educate staff about The Confusion Assessment Method (CAM[®]).
- Evaluate current documentation to ensure terminology aligns with items in the LTCH CARE Data Set v3.00.
- Practice coding a variety of scenarios with staff.
- Review and update processes/procedures that may need to change in preparation for the implementation.