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Long-Term Care Survey Alert

5 Secrets To Lowering Your Pain Quality Measures

High pain quality measure scores can hurt your facility with prospective consumers and surveyors. But theres more to pulling those scores down the flagpole than simply providing pain management.

Experts share these tried-and-true strategies for success:

1. Mitigate the risk adjustor for cognitively impaired residents. The **Centers for Medicare & Medicaid Services** risk adjusts or bumps up the chronic care pain measure for residents who are coded at Section B4 as having moderate to severe impairment in their cognitive skills for daily decision-making. The risk adjustment at B4 aims "to level the playing field because its very difficult to accurately judge pain in residents with cognitive impairment," explains **Rena Shephard**, president of the **American Association of Nurse Assessment Coordinators**.

Your facility can improve its pain QM, however, by taking steps to improve residents cognitive status and daily decision-making capability wherever possible. That way you wont be checking as many residents as moderately to severely impaired. For example, make sure the residents care plan includes measures to prevent common causes of disorientation, such as urinary tract infection, pneumonia and certain medications (for example, anticholinergics). Also sidestep stressors known to cause or increase residents confusion, such as a room change or over-stimulation.

Tip: Does your facility care for a lot of residents with dementia? Be prepared to explain to surveyors and consumers how the risk adjustor is affecting your pain QM. Showcase how your facility is addressing pain in these residents.

2. Choose a realistic assessment reference date (ARD) for short-stay rehab patients. You want to jump on short-stay patients pain as soon as possible to get it under control. But make sure the MDS coordinator selects an ARD for that 14-day MDS that gives the clinical staff enough time to get rehab patients pain under control so they dont trigger the QM. And make a realistic interdisciplinary team decision with the physician about weaning rehab patients from their pain medications. While you never want to keep a resident on his pain meds to avoid triggering the QM during the assessment window for the MDS, its not unrealistic for someone whos had major orthopedic surgery to remain on a pain medication for 7 days, Shephard says.

3. Take credit for pain management on the MDS. "Some facilities think that to justify use of narcotics or strong pain medications, they need to record the resident on the MDS as having pain," says **Karen Feldt**, a nurse practitioner and associate professor of nursing at the **University of Minnesota.** "But thats not how it works you code the patients experience or perception of pain even if he is taking pain medication."

4. Dont rely on PRN meds to treat serious ongoing pain. Patients with that type of pain require continuous medication and then a PRN drug to treat breakthrough pain, Shephard advises.

For optimal relief, some patients require a combination of medications given at high enough dosages to relieve pain and/or inflammation, as well as other non-drug interventions; these include diversion, interpersonal attention, spiri -tual interventions, relaxation therapy, music, massage and hydrotherapy.

5. Continuously monitor your outcomes. Many facilities pain management programs fall short in their ongoing monitoring of residents, cautions **David Gifford**, chief medical officer for the **Rhode Island Quality Partners**. "You want to check to see if the plan is relieving the patients pain to his satisfaction," Gifford tells **Eli**.

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