Long-Term Care Survey Alert

Quality Initiative FINE-TUNE YOUR PAIN ASSESSMENT FOR QUALITY MEASURES

How many of your facility's residents would tell a surveyor today that they are in moderate pain daily or in horrible pain at any time?

The answer to that question will be public knowledge this fall when the government's new quality initiative goes live nationwide (see Long-Term Care Survey Alert, Vol. 4, No. 5, pp. 44-46).

Your facility's percentage score on the pain quality measure could win you points with surveyors and consumers or leave you holding a potential F tag (F309) for failing to meet the resident's right to receive necessary care and services.

In the pilot quality initiative now underway in six states, CMS calculated facilities' percentage score on the pain measure based on Section J2 of the MDS, which asks for the frequency and intensity of a resident's pain. The proposed pain measure for the national initiative follows the same formula.

"To be included in the pain quality measures, a resident has to have moderate pain at least daily so that'd be a J2a (2) and J2b (2)," explains Cheryl Field, director of clinical and reimbursement
services at LTCQ Inc. in Bedford, MA. "Or horrible or excruciating pain J2b (3) of any frequency during the assessment period will include the resident in the percentage score."

How would you code a resident whose excruciating pain is under control thanks to a morphine pump, as an example?

"There is a frequent misperception among facilities in the pilot states ... that you code a resident as being in pain even though the person says he is pain free while on a medication regimen," says David Gifford. Gifford is chief medical officer for Rhode Island Quality Partners, a quality improvement organization working with facilities on pain management and other clinical issues as part of CMS' quality initiative. "You would code any break through pain the resident has while on a pain medication and probably many residents will report some break through pain during the assessment period," he tells Eli.

Experts agree that the pain quality measure will provide some incentive for facilities to undercode pain, especially horrible pain.

"Over time, one would expect the Centers for Medicare & Medicaid Services to focus more on the items that trigger the quality measures," cautions Ruta Kadonoff, a quality initiative expert at the
American Associations of Homes & Services for the Aging. Kadonoff, in fact, predicts that CMS may develop more specific investigative protocols as the result of the quality initiative, including one for pain. CMS is also focusing on MDS accuracy through its Data Assessment and Verification Evaluation (DAVE) initiative, with onsite pilot testing already underway in
Indiana and Georgia.

Take Steps to Ensure Accuracy

To ensure accurate assessment and coding, MDS coordinators should interview residents about their pain. "If the MDS assessment nurse relies on the medication administration record [or MAR] to ascertain the frequency of a resident's pain," Field cautions, "she may assume the resident had minimal pain because he only received Tylenol for pain twice in a week. Yet, often residents will only take medication on a really bad day and, when asked, report they have learned to live with daily pain."

Nurses should also routinely ask family members if they think their resident is comfortable. Families can oftentimes "read" the body language of a cognitively impaired member better than anyone can. Changes in a nonverbal resident's behavior, such as pacing, rocking or agitation, may signal pain rather than worsening dementia, according to the American Geriatrics Society's new pain guidelines (www.americangeriatrics.org/education/ painrelease.shtml).

One clue that the patient may be having serious daily pain lies in the diagnosis Section (I) of the MDS. Field notes that certain diagnoses like arthritis and multiple sclerosis are known to be painful.

Assessing the severity of pain (item J2b) can be difficult because pain is a subjective experience. And the Resident Assessment Instrument user's manual provides no guidance at this point on how to define moderate pain. By contrast, the RAI defines mild pain as allowing residents to usually continue with their normal activities and "horrible or excruciating" pain as "the worst possible pain ... usually interfering with the resident's routine, socialization or sleep."

"It'd be great if we could just use a scale of 1-10 and report moderate pain as being 4-6," says Field. "But some people will say their pain is a '4' and that pain is actually interfering with their ability to go to morning coffee or participate in their usual activities," which meets the definition for horrible pain.

Gifford agrees that the RAI does not currently do a good job of translating a 0-10 scale into mild, moderate or excruciating pain. Nevertheless, he suggests facilities use a pain scale to assess and monitor/track residents' pain. "Certain individuals or those with cognitive impairment may respond better to one scale or another, but as long as the facility is consistent, any sort of scale is fine."

Some facilities are adapting pain scales to their own unique patient populations. Leesburg Regional Medical Center, Nursing Center in Leesburg, FL, for example, uses a scale of 1 to 5 to asses pain.

"We've found that our patients many of whom are post surgical either have mild pain or severe pain with little in between," DON Laura Fain tells Eli. "The nurses screen patients using the scale each time they administer pain medication and then document the pain's intensity and location on the medical administration record."