MDS Alert

Quality Reporting: Master The Ins And Outs Of The Chronic Care And Post-Acute Pain Quality Measures

Know how the measures work and what you need to explain to surveyors.

To get a handle on the pain quality measures, you have to know what information they capture. In a nutshell, here's what you need to know.

The Chronic Care Pain QM

Only three coding combinations in Section J2 will flag on the chronic care pain QM, according to **Christie Teigland, PhD**, director of health informatics research at the **New York Association of Homes and Services for the Aging/ EQUIP for Quality**, in a presentation at the 2008 **American Medical Directors Association**'s meeting.

• Horrible or excruciating pain less than daily;

• Moderate pain daily;

• Horrible or excruciating pain daily.

Good news: If the resident has pain on admission, it won't count against the facility, Teigland says (see the coding and exclusions for the chronic care pain measure, p. 81).

The facility-reported chronic care pain QM rate is risk adjusted using a covariate based on residents' decision-making ability (B4). That is, if more residents are relatively independent in daily decision-making (B4 = 0 or 1), they are better able to readily report pain; thus, the facility expected rate of reported pain will be higher, Teigland reported. And the facility risk-adjusted rate will be lower than the observed QM rate, giving the facility "credit" for the fact that more residents are cognitively intact and can readily report pain. **Alternatively**, if more residents are moderately-to-severely impaired in decision-making ability (B4 = 2 or 3), or not able to make make their own decisions, which indicates cognitive impairment, the facility expected rate will be lower, Teigland noted. "And the facility risk-adjusted (reported) rate will be higher than the observed QM rate, taking into account the fact that pain is under-reported and under-identified for cognitively impaired residents," she said.

The problem: Coding at B4 doesn't correlate to the dementia population very well, Teigland relayed. People with Alzheimer's type dementia, for example, often don't code badly for daily decision-making ability, she noted. So you can see how this QM can be "skewed" depending on how you identify and code B4, she said.

Tip: If residents aren't good at making daily decisions, make sure you code it at B4, Teigland advised. The chronic care pain measure doesn't look only at that item for residents coded as having pain and risk adjust for that -- it looks at the facility's whole population in applying the risk adjustment, she says. (See "Make Coding B4 Easy By Using These 2 Strategies" in the July 2006 MDS Alert in the Online Subscription System archive.)

Give surveyors a heads up: If your facility has a lot of residents with dementia and does a good job of identifying those who have pain, it may look worse on the chronic care pain quality measure than other facilities. If so, be ready to show surveyors how the facility uses best practices to identify and manage pain for residents with dementia.

The Post-Acute Pain Measure

The numerator for the post-acute care pain measure is composed of short-stay residents at SNF PPS 14-day assessment

with moderate pain daily or horrible/excruciating pain at any frequency (the same coding as for the chronic care measure). The denominator is all patients with a valid SNF 14-day assessment. (Review the exclusions related to coding omissions and inconsistencies at J2 at http://www.qtso.com/download/mds/qiqm_rpt/Appendix_A_Technical_Specs_v1.1.pdf.)

There's no risk adjustment for the post-acute pain quality measure, which assumes most of these residents aren't cognitively impaired. But "obviously, that may or may not be true," Teigland said.

Coding and clinical tips: If you see most residents coded routinely as "2, 2" for daily moderate pain, take a closer look, advised Teigland. Monitor whether a resident with dementia is receiving adequate pain management by using the pain assessment tool to see if previous behavioral symptoms have resolved, advises **Joy Morrow, RN, PhD**, a consultant with **Hansen, Hunter & Company** in Beaverton, OR.