CHAPTER 6 – SECTION J

PERCENT OF RESIDENTS WHO HAVE MODERATE TO SEVERE PAIN

QM Description

This measure reflects the percent of long-term residents who are reported to have pain occurring daily, reaching a moderate level at least once during the assessment period ***or*** horrible/excruciating pain at any frequency.

Rationale for Pain QM

Pain is a common experience with older people because the prevalence of musculoskeletal problems (e.g. arthritis, fractures) and other medical conditions such as peripheral vascular disease, wounds, neurological conditions and cancer diagnoses which tend to increase with age. Studies have shown that pain is significantly under-reported in nursing facilities especially amongst the oldest old, females, minorities and the cognitively impaired. Although pain can be relieved in up to 90% of cases, a significant number of nursing home residents receive inadequate or no treatment. Additional information about pain management, as well as quality improvement strategies, can be found on CMS's website at www.MedQIC.org.

MDS Assessments Used

- **Target assessment**: OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Latest assessment with assessment reference date (A3a) within the 3-month target period. Note that admission assessments (AA8a = 01) are excluded from measure calculations.
- **Prior assessment**: OBRA Full (AA8a = 01, 02, 03, or 04) or Quarterly Assessment (AA8a = 05 or 10). Assessment reference date (A3a) must be in the window of 46 days to 165 days preceding the target assessment reference date. Prior assessments are used for covariate calculations.

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QM Specifications

NUMERATOR

Residents with pain occurring daily, reaching a moderate level at least once during the assessment period (J2a = 2 and J2b = 2) OR horrible/excruciating pain at any frequency (J2b = 3) on the target assessment.

DENOMINATOR

All residents with a valid target assessment after exclusions are applied.

RISK ADJUSTMENT STRATEGIES USED

Exclusion….Yes Stratification….No Regression….Yes

EXCLUSIONS

Residents satisfying any of the following conditions are excluded:

- ♦ The target assessment is an admission (AA8a = 01) assessment.
- ♦ Either J2a or J2b are missing on the target assessment.
- ♦ The values of J2a and J2b are inconsistent on the target assessment (An example of inconsistent coding would include the coding of pain frequency as "no pain" while intensity of pain is simultaneously coded as "moderate" pain).

COVARIATES USED IN REGRESSION

Clinical covariate:

1. Indicator of independence or modified independence in daily decision making on the prior assessment:
   Covariate = 1* if B4 = 0 or 1
   Covariate = 0 *if B4 = 2 or 3
   *If covariate = 1, the covariate is present and it contributes to the risk-adjustment. If covariate = 0, the covariate is not present and therefore does not contribute to the risk-adjustment.

See Chapters 4 and 5 for more information on risk adjustment and the use of covariates.

MDS Elements Related To QM

J2a Pain Symptoms - Frequency with which resident complains or shows evidence of pain

J2b Pain Symptoms - Intensity of pain

B4 Cognitive Skills for Daily Decision-Making - Resident's actual performance in making everyday decisions about tasks or activities of daily living.

MDS RAI Coding Instructions

SECTION J. HEALTH CONDITIONS

NOTE: MDS ITEMS THAT DO NOT TRIGGER THE QUALITY MEASURES ARE INTENTIONALLY IN GRAY TEXT.

l. **Shortness of Breath** - Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the resident has shortness of breath while lying flat, also check Item J1b ("Inability to lie flat due to shortness of breath.").

m. **Syncope (Fainting)** - Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.

n. **Unsteady Gait** - A gait that places the resident at risk of falling. Unsteady gaits take many forms. The resident may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

o. **Vomiting** - Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic).

p. *NONE OF ABOVE (Not Used on the MPAF)*

Process: It is often difficult to recognize when a frail, chronically ill elder is experiencing dehydration or, alternatively, fluid overload that could precipitate congestive heart failure. Ways to monitor the problem, particularly in residents who are unable to recognize or report the common symptoms of fluid variation, are as follows: Ask the resident if he or she has experienced any of the listed symptoms in the last seven days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the resident, directly if possible, since the health problems being experienced by the resident can often be remedied.

Coding: Check all conditions that occurred within the past seven days unless otherwise indicated (i.e. lung aspirations in the last 90 days). If no conditions apply, check *NONE OF ABOVE (Not Used on the MPAF)*.

J2. Pain Symptoms (7-day look back)

Intent: To record the **frequency** and **intensity** of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

MDS 2.0 only captures pain symptoms. Documentation of pain management/interventions are recorded elsewhere in the resident's clinical record, such as in the nurses' notes, progress notes, medication records, and care plans.

CMS anticipates that few residents on pain management measures will not have some level of breakthrough pain during the 7-Day assessment period that should then be coded on the MDS. For example, if through assessment or clinical record review you note that the resident has received pain medications or other pain relief measures, investigate the pain need and capture the pain event on the MDS. However, if the resident does not experience ANY breakthrough pain in the 7-Day assessment window, the assessor would indeed code "0", no pain. Remember that the assessment covers a 7-day period and should reflect the highest level of pain reported by any staff member, not just the assessment of the professional completing the MDS.

Definition: **Pain** - For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

Shows Evidence of Pain - Depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

Process: Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgment it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain in the last week.

Coding: Code for the highest level of pain present in the last seven days. Code for the presence or absence of pain, regardless of pain management efforts; i.e., breakthrough pain. If the resident has no pain, code "0" (No Pain) then Skip to Item J4.

a. **FREQUENCY** - How often the resident complains or shows evidence of pain.

Codes: **0. No pain (Skip to Item J4)**
1. Pain less than daily
2. Pain daily

b. **INTENSITY** - The severity of pain as described or manifested by the resident.

Codes: **1. Mild Pain** - Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2. Moderate Pain - Resident experiences "a medium" amount of pain.

3. Times When Pain is Horrible or Excruciating - Worst possible pain. Pain of this type usually interferes with daily routines, socialization and sleep.

Facilities should have a consistent, uniform and standardized process to measure and assess pain. Use your best clinical judgment when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain. ***Rationale*:** Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain. Pain control often enables rehabilitation, greater socialization and activity involvement. The 5 coding examples shown below were designed to assist you in making appropriate coding decisions. Please note that the last 3 examples are new, and did not appear in the original MDS manual.

Examples	Pain Frequency	Pain Intensity
Mrs. G, a resident with poor short-and-long-term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. ***Rationale for coding*:** It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgment calls for coding that reflects that Mrs. G has mild, daily pain.	2	1
Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He's only been resting, but feels tired upon arising. ***Rationale for coding*:** Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgment for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.	2	3
Mr. C is cognitively intact. He has long-term degenerative joint disease and his pain is well managed on Celebrex daily. He stated that on most days he feels little to no pain. However, Mr. C was unable to ambulate for long distances on two days last week, as he was experiencing moderate pain in his knees. Mr. C stated that he needed additional assistance from the CNA to walk to the dining room on those days and required additional pain medication. He says that he no longer feels that intensity of pain.	1	2

Examples (continued)	Pain Frequency	Pain Intensity
Mrs. S is severely cognitively impaired. She is unable to make decisions and requires extensive assistance in daily ADL care. The CNA responsible for her care and daily ambulation reports to the charge nurse that she has noticed Mrs. C to have "pain in her back" when the CNA attempts to position her in bed and transfer her to a chair. The nurse observes Mrs. C's physical, facial and verbal expressions during care and determines that the resident is experiencing moderate pain. The physician is notified and orders Tylenol q 6 hours. The resident appears relieved later in the day. The resident is observed by nursing staff and they determine that she is no longer experiencing a moderate level of pain. The physician determines that the resident should continue on the medication for several days.	1	2
Mr. W had abdominal surgery 5 days ago. He is alert with short-term memory problems. He is on pain medication daily and is able to participate in daily activities. On the evening shift, Mr. W complained to the nurse that he was experiencing severe pain near his wound site. Upon examination, the nurse determined that the wound appeared clean with no signs of infection. The physician was notified and determined that Mr. W required a change in the type of medication. Mr. W reported relief and remained on the new medication for 3 additional days.	1	3

J3. Pain Site (7-day look back)

Intent: To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes it is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

Definition: a. **Back Pain** - Localized or generalized pain in any part of the neck or back.