Oklahoma State Department of Health

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Oklahoma State Department of Health
Quality Improvement & Evaluation Service (405) 271-5278

MDS

Special points of interest:

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Volume 9. Issue 3
July 2016

Fond Farewell

By Nancy Atkinson, Service Director, QIES Help Desk

It was August 18, 1994 when I first walked into the Oklahoma State Department of Health to begin my career with the Protective Health Services area. I had worked at the Department of Human Services in the long term care area for many years, so I had background on the payment process, medical eligibility, and PASRR (known as PASARR at that time). I knew nothing about the survey process or Medicare certification, and had only seen a copy of the MDS one time (OASIS did not exist). After a couple of years of concentrated training, I was assigned the new federal program titled SAQIP (State Agency Quality Improvement Program) and because there was no other staff to do it, I received the designation as the MDS Automation Coordinator. At the time I had no idea how much those two assignments would affect my life. Long story short—the experience I obtained working on the SAQIP program and my involvement with the electronic side of MDS, eventually brought me to the position of Director of Quality Improvement and Evaluation Service. It is here that my career with the Oklahoma State Department of Health will end with my retirement on May 31, 2016. Many changes have occurred in the MDS-OASIS programs over the last 16 years and I'm certain that will continue. I trust that in the past you have found the MDS-OASIS staff willing and able to assist you. That will not change with my retirement. The same dedicated group of individuals will be here to assist you with any problems or questions you encounter.

It has been my privilege to work with you throughout the past years. You have taught me many things and helped to shape my life both professionally and personally. I am deeply grateful for our experiences together and for the collaborative spirit with which we have all worked to assist residents and clients to reach their highest practicable level of functioning.

Points to Ponder

One of the Governor's Healthy Aging initiatives is to reduce depression in Oklahoma's elderly population. When an individual is in pain, they may feel depressed and clinicians can help by incorporating effective pain management strategies.

The goal of pain management is to address the levels of pain and provide maximum pain relief with minimal side effects.

One of the primary roles of nursing is serving as a patient advocate. As an advocate, you will identify all possible ways to help relieve the patient's pain and suffering. Being a patient advocate in a nursing home is critical to help ensure the resident's pain is properly managed. Many times you will be the resident's voice and report to the interdisciplinary team the different characteristics of the resident's pain. Such as, type, location, frequency, impact on ADLs, etc.

The standard of care for pain management is ongoing pain assessment and pain management. This includes: 1) acknowledging and accepting the resident's pain; 2) identifying the source of the pain; 3) assessing the resident's level of pain using a pain assessment tool at regular intervals; 4) implement pain management strategies and evaluate their effectiveness; 5) document the resident's response and outcome of the intervention and 6) advocate for the resident.[1]

1. Pain Management Nursing Role/Core Competency A Guide for Nurses; Maryland Board of Nursing

Inside this Issue

Falls and Pain

Falls and pain are both events that are concerning to individuals, families, and caregivers. Falls can be debilitating and in some cases life threatening. Frequently we think of pain occurring when a person falls. due to an injury.

In truth people who have chronic pain may be falling as a result of chronic pain.

Can you remember an individual that you have known, who usually stayed in bed all day because they had such high levels of pain. They were very weak, tired, didn't sleep well, pain medications were ineffective, sometimes developed orthostatic hypotension as a result of being in a recumbent position so much of the time. These individual's were at a very high risk to fall due to general debility secondary to their pain.

When an individual has chronic pain they frequently decrease their activities. This can result in a decrease in muscle mass, strength, and stamina/endurance. Which also can lead to shortness of breath and increased pain with activity. Chronic pain is a vicious cycle, which is very difficult to control.

As medical caregivers education on the subject of pain can be beneficial not only to us but also to the individual's we serve and their families. It is standard practice today to routinely evaluate an individual's pain level. It is important to report relevant information concerning pain to the physician and team. This should include the level of pain experienced, any precipitating factors, interventions to decrease pain (visualization, meditation, medication, topical applications, etc.), acceptable levels of pain, and the effectiveness of interventions.

If interventions need to be implemented or adjusted this information that should be communicated with the physician and team. At times some physicians may not be prompt at responding to this information and the team may have to have a meeting regarding this issue.

At this time there are numerous non pharmacological interventions that can be attempted. Therapy sometimes can decrease pain, may build strength and endurance. Which can also decrease the risk of falls. Relaxation techniques, visualization, massage, and exercise are some other things that may help decrease pain.

Many times the actual pharmacological interventions themselves may need to be reevaluated. Of course, we all know to follow up with an individual to determine the effectiveness of the intervention.

If you have been in the medical field for very long you have probably come in to contact with an individual who has continuous chronic high levels of pain. In the past it has been very frustrating to try different high potency medications that do not seem to phase the pain an individual is experiencing.

Today Pharmocogenics can determine the effectiveness of a number of medications for individuals, including pain medication.

It is necessary to holistically view the entire individual. If pain can be managed successfully, an individual can become more active. This can have numerous benefits. Here are a few benefits:

1. Decrease pain
2. Decrease Falls
3. Increase mobility
4. Build Stamina
5. Decrease depression
6. Increase appetite
7. Decrease in Constipation

This list could go on and on with the benefits.

The most important items to remember is that pain is caused by many issues some are treatable and may be eliminated such as a toothache. Other pain may be chronic such as arthritis, headaches, sciatica, etc. In the case of chronic pain we need to use all assessment and interventions at our disposal to manage the pain. The improvement that adequate pain control can have in an individual's life can be transforming.

Years ago I had a patient who had Rheumatoid Arthritis. This individual consistently rated their pain level at a 10 out of 10 with the use of pain medication. This individual had falls frequently while ambulating with the use of their walker. I talked to the individual numerous times about PT. Eventually the individual agreed to PT. This made a tremendous difference in the individual's life. The pain level decreased to a more tolerable 5 out of 10. This person was able to socialize with friends and family, they had increased strength, falls dramatically decreased, the individual's mood improved, the individual was happier and experienced a better quality of life.

J0100: Pain Management

Questions regarding J0100: Pain Management are some of most frequent on the MDS. The primary question asked when coding here is, "Can I code for pain medication on section J0100 even if the drug is not an analgesic (pain reliever medication)?"

The intent of the items in section J is to document a number of health conditions that impact the resident's functional status and quality of life. The items include an assessment of pain which uses an interview with the resident or staff if the resident is unable to participate. The pain items assess the presence of pain, pain frequency, effect on function, intensity, management and control. Other items in the section assess dyspnea, tobacco use, prognosis, problem conditions, and falls.

J0100 A. Asks if the "Resident received scheduled pain medication regimen." To properly answer that question it is necessary to be aware of the RAI definition of "pain medication regimen."

The definition according to the RAI is as follows: "Pharmacological agent(s) prescribed to relieve or prevent the recurrence of pain. Include all medications used for pain management by any route and any frequency during the look-back period. Include oral, transcutaneous, subcutaneous, intramuscular, rectal, intravenous injections or intraspinal delivery. This item does not include medications that primarily target treatment of the underlying condition, such as chemotherapy or steroids, although such treatments may lead to pain reduction."

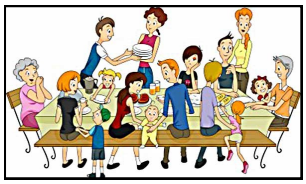
Notice, the definition does not include the requirement that the pain medication be an analgesic. When a medication is given routinely to manage pain (even if it is not an analgesic), and the medical record contains documentation that the scheduled medication is being given to manage pain, then the facility may code that the resident received a scheduled pain medication.

"Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being…" (Code of Federal Regulation, 42 CFR 483.25)

Quality Measure Updates

In April 2016, CMS began posting data for six new quality measures (QMs) on Nursing Home Compare:

1. Percentage of short-stay residents who were successfully discharged to the community (Claims-based)
2. Percentage of short-stay residents who have had an outpatient emergency department visit (Claims-based)
3. Percentage of short-stay residents who were re-hospitalized after a nursing home admission (Claims-based)
4. Percentage of short-stay residents who made improvements in function (MDS-based)
5. Percentage of long-stay residents whose ability to move independently worsened (MDS-based)
6. Percentage of long-stay residents who received an antianxiety or hypnotic medication (MDS-based)



Beginning in July 2016, five of the measures will be used in the calculation of Five-Star Quality Rating QM ratings. Antianxiety/hypnotic medication measure will not be used in Five-Star due to concerns about its specificity and appropriate thresholds for star ratings.

- Addition of these new measures has several key benefits:
- Increase the number of short-stay measures
- Cover important domains not covered by other measures Claims-based measures may be more accurate than MDS-based measures

In particular, development of readmission measures is a high priority for CMS. The Protecting Access to Medicare Act calls for public reporting of readmission measures on Nursing Home Compare. SNF Value-Based Purchasing (VBP) will use a claims-based readmission measure.

This includes:

- hospitalizations that occur after nursing home discharge but within 30-days of stay start date.
- observation stays
- excludes planned readmissions and hospice patients

A 'stay-based' measure is one that includes both those who were previously in a nursing home and those who are new admits.

You will find the above information as well as further information here: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/Improvements-NHC-April-2016.pdf

MDS Automation Tips

Upcoming CMS Events

The retention time period for the MDS 3.0 Facility-Level Quality Measure and MDS 3.0 Resident-Level Quality Measure Preview reports will be changing. These automatically-created preview reports are stored in each nursing home's shared facility folder for a period of 230 days. **Effective November 1, 2016, the above-mentioned early preview reports will only be stored in the shared facility folder for a period of 90 days.**

Any reports not printed or saved prior to the retention period time change will be permanently deleted from the facility shared folder if the date the report was added to the folder is older than 90 days. These reports cannot be recreated once they have been deleted.

The report retention time period change does **not** affect the MDS 3.0 Five Star Preview reports. The Five Star Preview reports will continue to be retained for a period of 60 days in the shared facility folder.

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Make sure you are ready to go with the **mandatory July 1, 2016 PBJ** reporting requirements related to staffing. You will need PBJ passwords in order to submit data through the CASPER system. You will be required to request **special password permissions** if you currently have existing passwords for CASPER.

Be Prepared

CMS plans to release the new MDS Manual with an effective date of October 1, 2016. This release incorporates a new section called GG, along with some other areas of concern. New Data Specs will also be incorporated. Some of this information is available at www.qtso.com. The release is also available at the available at the above web address **and is not finalized**.

Questions to Ponder:

Are you prepared?
Is your software vendor ready to go with the new assessments?
How about your OBRA and PPS assessment scheduler?
Is billing good to go?
Will all your individual computers need to be upgraded?

After your upgrade I recommend submitting one of each assessments with the old and new data specs. In the event of the worst scenario, which is, the records all reject, you only would need to correct a minimal number of assessments that are fatal records.

Contact Us

Oklahoma State Department of Health

QIES Help Desk

1000 N. E. 10th Street
Oklahoma City, OK
73117-1299

Phone: (405) 271-5278
Fax: (405) 271-1402

Tip:

The final upcoming October 1, 2016 release of the new MDS manual has been released. Be aware that some early information you obtain is not necessarily the final version. Information available is in draft format.

MARK YOUR CALENDAR!

Note

The September 8, 2016 training event has been cancelled.

Next Clinical Training
December 7-8, 2016
Shawnee
Will cover all new MDS updates!

QIES Team:
Diane Henry RN
Wanda Roberts RN
Stephanie Sandlin RN
Bob Bischoff

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