



Oklahoma State
Department of Health
Creating a State of Health

NEWS YOU CAN USE

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

MDS

Special points of interest:

- Plain Talk About Pain—MDS Section J
- MDS Coding Tips
- Automation Tips, Reminders & Updates

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Focus on Pain
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Residents who are suffering from pain experience functional decline and are not achieving their highest practical level of well-being.

Did you know that nearly half (41.78%) of Oklahoma’s nursing home residents reported they had moderate to severe pain on their MDS assessment? This data comes from the MDS 3.0 Frequencies Report which reflects MDS assessments for the second quarter of this year. Clearly, we still have opportunity for improvement when it comes to managing the resident’s pain.

To assist you in caring for your residents, the Oklahoma State Department of Health— QIES Help Desk, and Long-term Care (LTC) Survey Department, teamed up with the QIO, Oklahoma Foundation for Medical Quality, to provide seven

regional trainings across Oklahoma.

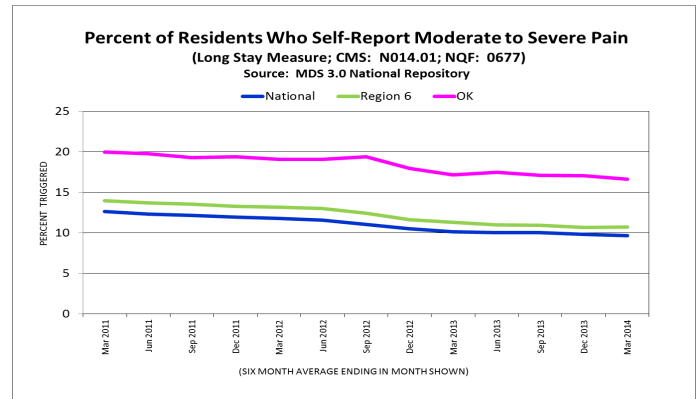
The interaction and feedback received during the training sessions benefited all who attended.

However, there is still a lot of work to do. From the data on the Pain Quality Measure Chart below, Oklahoma’s current percentile ranking is 16.63% for the long stay measure, “Percent of Residents Who Self-Report Moderate to Severe Pain”. As you can see, Oklahoma is far

above the Regional average of 10.7% as well as the National percentile of 9.6%. These numbers come directly from MDS 3.0 Section J and represents the resident’s voice.

QIES staff encourages you to call our office for additional assistance with your pain management concerns or any other question you may have.

Diane Henry—Clinical
Wanda Roberts—Clinical
Bob Bischoff—Automation



Plain Talk About Pain
Know The Facts

Clinicians serve as advocates for the resident’s health, welfare, comfort and safety. As an advocate, you must take all reasonable means to alleviate the resident’s pain and suffering. This may be accomplished through both medication and non-medication pain interventions.

Develop an individualized-

care plan and include interventions specific to that resident that will help decrease their pain.

Include what the resident’s goals are for pain management. Identify what is an acceptable pain level for the resident and include this information in the care plan. Most residents pain management goal should be to

achieve a consistent level of comfort while maintaining as much function as possible.

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Plain Talk About Pain *(continued from page 1)*

Know The Facts

BASIC FACTS *(continued)*

- Pain is whatever the resident says it is, and exists whenever they say it does.
- Residents with moderate to severe pain will require a regularly dosed pain medication along with PRN medication for breakthrough pain.
- Residents may exhibit behavior symptoms related to unresolved pain.

Pain is very subjective. We all feel pain differently. Therefore, we must thoroughly assess each aspect of the resident to know about their pain. Residents tell us he/she has pain in many ways— both verbally and non-

verbally. Therefore, it is our job, as clinicians, to properly assess the resident for pain using a variety of methods.

INTERVIEW



You never want to miss an opportunity to relieve pain

- Follow the resident interview guidelines in the RAI Manual and ask each interview question as it is written. These interview questions will assess the resident's pain presence, frequency, effect on function and intensity.
- Interview staff across all shifts and all disciplines.
- Ensure all staff members are trained to identify pain and know to whom they are to report the pain.

OBSERVE

Indicators may include moaning, crying out, grinding teeth, and other vocalizations such as “help me, help me”. *(continued on page 3)*

Residents know their pain best! Listen to their voices and observe their actions!

SCREENING FOR PAIN—A Self-Check

1. Are all staff trained to recognize pain?
2. Do all facility staff know when and to whom to report symptoms of resident's pain?
3. Do you know *pain is often the underlying cause of behavior problems and depression*?
4. Do you continually assess if residents are in pain?
5. If the resident has Dementia, do you expect him/her to verbally tell you about pain?
6. If the resident has Dementia, do you observe for physical manifestations of pain?
7. Is the resident able to ask for PRN pain medication?
8. Do your residents know how to report pain?
9. Are you judgmental or biased when you assess pain?
10. Are validated assessment tools used?

MDS Assessment Tip

J0500 targets “pain effect on function” by asking “Over the past 5 days has pain made it hard for you to sleep at night?” Clinicians may only focus on that section when assessing for pain. As a result, they do not draw information from the other MDS areas that possibly indicate pain and, thereby, enable the clinician to assess their resident holistically. Consider the fol-

lowing MDS Sections which may also be indicative of pain (not all inclusive):

- D0200 Mood Interview
- E0200 Behavioral Symptoms
- E0500 and E0600 Impact on Resident and Others



- E0800 Rejection of Care
- E1100 Change in Behavior
- Section G ADLs
- G0400 Range of Motion
- Section I Diagnoses
- J1100 Shortness of Breath
- J1700 Fall history
- K0100 Swallowing Disorder

Plain Talk About Pain *(continued from page 2)* **Know The Facts**

OBSERVE *(continued)*

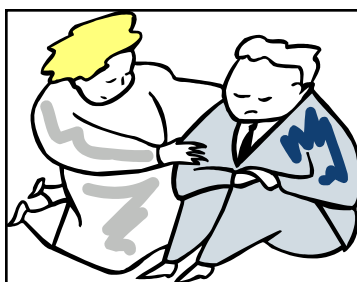
Other pain indicators may include:

- Wincing or frowning and other facial expressions
- Body posture such as guarding/protecting an area of the body, or lying very still.
- Restlessness or frequent rocking.
- Decrease in usual activities.
- Resisting care and other behaviors such as criticizing, cursing, yelling, screaming, pacing, refusing to eat, or striking out at a nurse assistant, may be a sign of pain.

not be *solely* indicative of pain, investigate that behavior further and identify if the root cause could possibly be caused by the resident experiencing pain.

CLINICAL RECORD

- Review the Medication Administration Record (MAR) to **determine if any PRN**



Pain is whatever the resident says it is.

pain medication has been given in the 5-day look-back period. Code “yes” at J0100B—Received PRN Pain Medication if the PRN medication has been given, **OR even if you offered the PRN pain medication and the resident declined.**

- Determine if the PRN medication needs to be changed to a scheduled medication such as every 12 hours, or a pain patch.
- Code J0100C Non-Medication Intervention for Pain as “yes” if the intervention is included as part of the care plan and documented that the intervention was actually received and assessed for efficacy.

Although such behaviors may

Are you holistically assessing the residents pain level?

Nursing Home Goal—Highest Practicable Level of Functioning Assure your resident reaches this goal—Ask the Right Questions

It is the resident who best knows his/her pain. In addition to the interview questions, listen to your resident and ask open-ended questions to gain additional information, e.g. “Tell me about your pain.” This gives the resident the chance to tell you the details that will help you assess the underlying cause of

their pain.

Other questions include:

- What do you call your pain?
- What do you think caused your pain?
- Why do you think it started when it did?

- What does your pain do to you?
- What problems does your pain cause you?
- What do you fear most about your pain?
- What are the most important results you hope to receive from treatment?

SCENARIO QUIZ HOW WILL YOU CODE FREQUENCY & INTENSITY?



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 Mr T, “Have you had pain or hurting at any time in the last 5 days?”, he tells you that he has

been having horrible cramps in his legs every night. He has only been resting, and feels tired upon rising.

How would you code J0300 Pain Presence and J0400—Pain Frequency?

J0300 = ?

J0400 = ?

Although Mr. T may look comfortable to staff, he reports to you he has terrible cramps. The best clinical judgment for coding these items for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants further evaluation.

(Answer on Page 4)

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MARK YOUR CALENDAR!

Upcoming MDS Training

December 9th, 10th, 11th
MDS 3.0 Basic
Clinical Workshop and
review of MDS Changes
Gordon Cooper
Shawnee

MDS Automation Tips

Bob Bischoff—Program Manager, MDS/OASIS Automation



Accessing and Interpreting Quality Measure (QM) Reports

In order to determine where you stand and rank with the State, review your Quality Measure (QM) reports in CASPER. To access these reports, click on “MDS 3.0 QM Reports”, under “Report Categories.” Reports may be ordered individually or by selecting “MDS 3.0 QM Package Report.” The package contains all reports available for the QMs. By default, all the pertinent reports are checked for you and will automatically be placed in your Folders. Once in Folders, select “My Inbox” to view and print reports requested. After reviewing the reports, you may ask, “why are my numbers so high”? Consider this an opportunity for improvement and if needed, additional MDS training. Begin a root cause analysis by reviewing what MDS item triggered for each QM. You can identify the triggered items by viewing the “QM User’s Manual.” Download your QM Manual online by going to www.qtso.com. Click on “MDS 3.0”, then click “QM User’s Manual v8.0.” Scroll to the bottom under “Downloads” and click to view or print the manual.

Windows XP and Internet Explorer 8

Effective October 1, 2014, the QIES systems will no longer support IE 8 or Windows XP. For security reasons, the CASPER system will be programmed to block IE 8 or below. Once in effect you will receive a message to upgrade. Be aware, this could possibly cause delays in submitting assessments or retrieving data from CASPER. Make sure you are prepared in advance of this date in order to ensure that your continuity of operations continues to avoid compliance or report issues.

Answer From Page 3

J0300 = 1 Yes (pain in last 5 days)
J0400 = 2 Frequently (Since Mr. T. didn’t indicate he had cramping in his legs during the day). **Did you code correctly?**

Reminder!

NEW CMS Agenda again

In a recent CMS All-State Call, accuracy of the Roster Report was mentioned again. It is imperative that the **Roster Report**, located in **CASPER** be accurate. Order the report and make sure all residents appearing on the report are still in your facility. In the event residents appear on the report, but are no longer in your facility, verify that the Discharge assessment has been submitted. If the Discharge was submitted, make sure that the Discharge has the same personal identifiable information that appears on the report. For any discrepancies or questions contact us at the QIES Help Desk, 405-271-5278.

How Does Your Missing Assessment Report Look?

The Missing Assessment Report is a report that lists all residents that have not had an assessment or tracking form submitted to the CMS data base for over 138 days. These missing assessments and tracking forms may indicate you are out of regulatory compliance with completion and submission timeframes.

Where is it?

The report is located in CASPER under “Report Categories”. Click on “Report Categories” and click “MDS 3.0 Provider Reports.”



Locate the Missing Assessment Report and click submit. This report will appear in your Folders. In Folders, click “My Inbox” and the report will appear on the right.

AUTOMATION NO-NO

When entering your assessment data, do not routinely override your software warning that indicates “a significant change in status assessment is required.” It may be necessary for you to complete a Significant Change in Status Assessment in order to assist your resident in obtaining the highest practicable level of functioning.