## Pain Assessment and Follow-Up for Patients with Dementia

### Measure Description
Percentage of patients with dementia who underwent documented screening * for pain symptoms at every visit and if screening positive also had a documentation of a follow-up plan.

### Measure Components

#### Numerator Statement
Patients with dementia who underwent documented screening * for pain symptoms at every visit and if screening positive also had a documentation of a follow-up plan.

*Screening is defined as use of a validated screening tools approved for use in this measure include, but are not limited to:

- Pain Assessment in Advanced Dementia (PAINAD) (1)
- Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC or PACSLAC-II) (2,3)
- Visual Analog Scale and Verbal Pain Intensity Scale (4)
- Pain Assessment for the Dementing Elderly (PADE) (5)
- Likert Pain Scale
- Minimum data set (MDS)–version 3.0, Section J (6)

OR evaluation of verbal and non-verbal expressions of pain behaviors (i.e., changes in breathing quality, negative types of verbalization separate from breathing, facial expression, body language) medication usage.

#### Denominator Statement
All patients with dementia

#### Denominator Exceptions
None

#### Supporting Guideline & Other References
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

- “Pain-assessment results should be used to evaluate the efficacy of pain management interventions” (7)
- “Recommendations Specific to Self-Report Measures
  1 Use of synonyms when asking about the pain experience (e.g., hurt, aching) will facilitate the self-report of some patients who have limitations in ability to communicate verbally.
  2 Self-report scales should be modified to account for any sensory deficits that occur with aging (e.g., poor vision, hearing difficulties).
  3 Use self-report tools that have been found to be most valid among seniors (e.g., the Coloured Analogue Scale, Numeric Rating Scales, Behavioural Rating Scales, the 21 Point Box Scale).
  4 Use of horizontal visual analogue scales should be avoided, as some investigators have found
unusually high numbers of unscorable responses among seniors.” (7)

- “Recommendations Specific to Observational Measures

1. Observational tools that have been shown to be reliable and valid for use in this population include the PACSLAC and DOLOPLUS-2. The PACSLAC is the only tool that covers all six behavioural pain-assessment domains that have been recommended by the American Geriatrics Society. Nonetheless, clinicians should always exercise caution when using these measures because they are relatively new and research is continuing.

2. When assessing pain in acute-care settings tools that primarily focus on evaluation of change over time should be avoided.

3. Observational assessments during movement-based tasks would be more likely to lead to the identification of underlying pain problems than assessments during rest.

4. Some pain-assessment tools, such as the PACSLAC, do not have specific cut off scores because of recognition of tremendous individual differences among people with severe dementia. Instead, it is recommended that pain be assessed on a regular basis (establishing baseline scores for each patient) with the clinician observing score changes over time.

5. Examination of pain-assessment scores before and after the administration of analgesics is likely to facilitate pain assessment.

6. Some of the symptoms of delirium (which are seen frequently in long-term care) overlap with certain behavioural manifestations of uncontrolled pain (e.g., behavioural disturbance). Clinicians assessing patients with delirium should be aware of this. On the positive side, delirium tends to be a transient state, and pain assessment, which can be repeated or conducted when the patient is not delirious, is more likely to lead to valid results. It is important to note also that pain can cause delirium, and clinicians should be astute in order to avoid missing pain problems among patients with delirium.

7. Observational pain-assessment tools are screening instruments only and cannot be taken to represent definitive indicators of pain. Sometimes they may suggest the presence of pain when pain is not present, and at other times they may fail to identify pain.” (7)
“Recommendations for pain assessment in older adults with advanced dementia unable to self-report that are unique from the general recommendations include the following. Self-Report…Search for Potential Causes of Pain…Observation of Patient Behaviors…Use of Behavioral Pain Assessment Tools…Proxy Reporting of Pain.” (8)

| Measure Importance          | “Under-treatment of pain in dementia is a frequent and frightening observation; its risk increases with the severity of dementia.” (10) Pain symptoms in a patient with dementia can present as non-verbal expressions or pain behaviors that can include: changes in breathing quality (rapid breathing, short or long bursts of hyperventilation), negative types of verbalization separate from breathing (e.g. moaning, negative speech), facial expression (e.g. frowning, grimacing), body language (e.g. increased muscle tension, threatening postures), disinterest in engaging in relationships and favored activities, depression symptoms, cognitive decline, functional decline, neuropsychiatric symptoms. People with dementia are typically of geriatric age and have a higher incidence of age-related degenerative joint pain which is known to exponentially increase with advancing age. (12) People with dementia can feel pain but often cannot isolate the source of the pain. (10) The number one modifiable risk factor for dementia in the United States is physical activity. (13) Hence, pain symptoms should be measured so they can be assessed and effectively treated so that pain does not become a barrier to movement or unknowingly negatively affect other outcome measures being studied.

The Work Group encourages providers to consider referral to appropriate therapy services as therapy can address pain that is a barrier to movement. Treatment of chronic pain conditions should be conducted by a specialist.

| National Quality Strategy Domains | ☐ Patient and Family Engagement
☒ Patient Safety
☐ Care Coordination
☐ Population/Public Health
☐ Efficient Use of Healthcare Resources
☒ Clinical Process/Effectiveness

| Exception Justification | Not Applicable
Harmonization with Existing Measures

2015 PQRS Measure 131: Pain Assessment and Follow-up for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present. The work group determined a separate measure for patients with dementia is needed. The current PQRS measure focuses on adults with normal ability to communicate. This measure of pain assessment and follow-up does not take into account people with dementia, their caregivers, pain behaviors and nationally recognized standardized non-verbal pain assessment tools (e.g. Pain Assessment in Advanced Dementia)(14). The measure excludes people as not eligible for pain assessment and/or follow-up if the following reasons exist: “patient refused to participate, and/or severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, when pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools...”(11)

Measure Designation

<table>
<thead>
<tr>
<th>Measure Purpose</th>
<th>☒ Quality improvement</th>
<th>☒ Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Measure</td>
<td>☒ Process</td>
<td>☐ Outcome</td>
</tr>
<tr>
<td>☐ Structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level of Measurement</td>
<td>☒ Individual Provider</td>
<td>☒ Practice</td>
</tr>
<tr>
<td>☒ Practice</td>
<td>☒ System</td>
<td></td>
</tr>
<tr>
<td>Care Setting</td>
<td>☒ Outpatient</td>
<td>☒ Inpatient</td>
</tr>
<tr>
<td>☒ Emergency Departments and Urgent Care</td>
<td>☒ Residential (i.e., nursing facility, domiciliary, home care)</td>
<td></td>
</tr>
<tr>
<td>Data Source</td>
<td>☒ Electronic health record (EHR) data</td>
<td>☒ Administrative Data/Claims</td>
</tr>
<tr>
<td>☐ Chart Review</td>
<td>☒ Registry</td>
<td></td>
</tr>
</tbody>
</table>

References


### Technical Specifications: Electronic Health Record (EHR) Data

The AAN is in the process of creating code value sets and the logic required for electronic capture of the quality measures with EHRs. A listing of the quality data model elements, code value sets, and measure logic (through the CMS Measure Authoring Tool) for each of the measures will be made available at a later date.

### Technical Specifications: Administrative Data (Claims)

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

<table>
<thead>
<tr>
<th>Denominator (Eligible Population)</th>
<th>See Appendix A for Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>AND</strong></td>
</tr>
<tr>
<td></td>
<td><strong>CPT® Code:</strong></td>
</tr>
<tr>
<td></td>
<td>• 99201, 99202, 99203, 99204, 99205 (Office or other outpatient visit-New Patient);</td>
</tr>
<tr>
<td></td>
<td>• 99211, 99212, 99213, 99214, 99215 (Office or other outpatient visit-Established Patient);</td>
</tr>
<tr>
<td></td>
<td>• 99241, 99242, 99243, 99244, 99245 (Office or Other Outpatient Consultation-New or Established Patient);</td>
</tr>
<tr>
<td></td>
<td>• 99201, 99202, 99203, 99204, 99205 (E/M Codes);</td>
</tr>
<tr>
<td></td>
<td>• 99211, 99212, 99213, 99214, 99215 (E/M Codes);</td>
</tr>
<tr>
<td></td>
<td>• 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838 (Psychiatric Diagnostic Evaluation and psychotherapy);</td>
</tr>
</tbody>
</table>
- 96116, 96118, 96119, 96120 (Neurobehavior status exam and neuropsychological testing);
- 96150, 96151, 96152, 96153, 96154, 96155 (Health and behavior assessment and interventions);
- 99490, 99487, 99489 (Complex Chronic Care Management);
- 99497, 99498 (Advance care planning);
- 97003, 97004 (Occupational therapy evaluation and re-evaluation);
- 97001, 97002 (Physical therapy evaluation and re-evaluation);
- 99221-99223 (Initial Hospital Care);
- 99231-99233 (Subsequent Hospital Care);
- 99238-99239 (Hospital Discharge);
- 99251-99255 (Initial Inpatient Consultation);
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (Nursing Home Consultation);
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (Domiciliary, Rest Home Care Services);
- 99339, 99340 (Domiciliary, Rest Home Care Services Care Plan Oversight);
- 99341, 99342, 99343, 99344, 99345 (Home Care);
- 99347, 99348, 99349, 99350 (Home Care);
- 99281-99285 (Emergency Department);
- 99201-99205 or 99211-99215 (Urgent Care).