

Care for Older Adults (COA)

SUMMARY OF CHANGES TO HEDIS 2009

- First-year measure.

Description

The percentage of adults 65 years and older who received the following during the measurement year.

- Advance care planning
- Medication review
- Functional status assessment
- Pain screening

Report each of the four rates separately.

Eligible Population

Product line	Medicare.
Ages	66 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than 1 gap in continuous enrollment of up to 45 days during the measurement year.
Anchor date	December 31 of the measurement year.
Benefit	Medical.
Event/diagnosis	None.

Rate 1: Advance Care Planning

Administrative Specification

Denominator	The eligible population.
Numerator	Advance care planning during the measurement year. A member had advance care planning if a submitted claim/encounter contains any one of the codes in Table COA-A.

Table COA-A: Codes to Identify Advance Care Planning

CPT II	HCPCS	Description
1080F	G8259	Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service).

Hybrid Specification

- Denominator** A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.
- Numerator** Advance care planning as documented through either administrative data or medical record review.
- Administrative** Refer to the *Administrative Specification* above to identify positive numerator hits from the administrative data.
- Medical record** **Advance care planning** is a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Advance care planning includes any of the following.
- *Advance directives*. Directives pertaining to treatment preferences and designation of a surrogate decision maker in the event that a person becomes unable to make medical decisions on his or her own behalf. Advance directives may take the form of a living will, power of attorney or health care proxy.
 - *Oral statements*. Documented conversations with relatives or friends about life-sustaining treatment and end-of-life care. Patient designation of an individual who can make decisions on the patient's behalf.
 - *Actionable medical orders*. Written instructions regarding initiation, continuation, withholding or withdrawal of particular forms of life-sustaining treatment.
 - *Living wills*. Legal documents denoting preferences for life-sustaining treatment and end-of-life care.
 - *Surrogate decision maker*. A written document designating someone other than the patient for making future medical treatment choices for the patient.

Evidence of advance care planning must include one of the following criteria.

- The presence of an advance care plan in the medical record, **or**
- Documentation of an advance care planning discussion and the date on which it was performed

Rate 2: Annual Medication Review

Administrative Specification

Denominator	The eligible population.
Numerator	At least one medication review conducted by a prescribing practitioner during the measurement year and the presence of a medication list in the medical record. A member had a medication review if a submitted claim/encounter contains any code in Table COA-B.

Table COA-B: Codes to Identify Medication Review

CPT II
TBD

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.
Numerator	At least one medication review conducted by a prescribing practitioner during the measurement year and the presence of a medication list in the medical record, as documented through either administrative data or medical record review.
Administrative	Refer to the <i>Administrative Specification</i> above to identify positive numerator hits from the administrative data.
Medical record	<p>A medication review is a review of a patient's medications, including prescription medications, over-the-counter (OTC) medications or herbal therapies, in addition to providing counseling about the medications.</p> <p>A medication list is a list of patient's medications in the medical record, which may include prescriptions, OTC medications and herbal therapies or supplements.</p> <p>Documentation in the medical record must include the following.</p> <ul style="list-style-type: none"> • A medication list in the medical record • Evidence of a medication review and the date on which it was performed <p>A review of side-effects for a single medication at the time of prescription alone is not sufficient.</p>

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Rate 3: Functional Status Assessment

Administrative Specification

Denominator	The eligible population.
Numerator	At least one functional status assessment during the measurement year. A member had a functional status assessment if a submitted claim/encounter contains any one of the codes in Table COA-C.

Table COA-C: Codes to Identify Functional Status Assessment

CPT II
TBD

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year’s administrative rate. Refer to the <i>Guidelines for Calculations and Sampling</i> for information on reducing the sample size.
Numerator	At least one functional status assessment performed in the measurement year as documented through either administrative data or medical record review.
Administrative	Refer to the <i>Administrative Specification</i> above to identify positive numerator hits from the administrative data.
Medical record	Documentation in the medical record must include evidence of functional status assessment and the date on which it was performed. Evidence of functional status assessment may include notation of any of the following. <ul style="list-style-type: none"> • Functional independence • Loss of independent performance, activities of daily living (ADL), social activities, or instrumental activities of daily living (IADL) • The level of assistance needed to accomplish various tasks • Result of assessment using a standardized functional status assessment tool, such as: <ul style="list-style-type: none"> – SF-36® – List of ADLs – Assessment of Living Skills and Resources (ALSAR) – Barthel ADL Index Physical Self-Maintenance Scale (ADLs) – Bayer Activities of Daily Living Scale (B-ADL) – Barthel Index

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- Extended Activities of Daily Living Scale (EADL)
- Independent Living Scale (ILS)
- Katz Index of Independence in Activities of Daily Living
- Kenny Self-Care Evaluation
- Klein-Bell Activities of Daily Living Scale
- Kohlman Evaluation of Living Skills (KELS)
- Lawton & Brody's IADL scales

Rate 4: Pain Screening

Administrative Specification

Denominator	The eligible population.
Numerator	At least one pain screening during the measurement year. A member had a pain screening if a submitted claim/encounter contains any code in Table COA-D.

Table COA-D: Codes to Identify Pain Screening

CPT II
TBD

Hybrid Specification

Denominator	A systematic sample drawn from the eligible population. The organization may reduce the sample size using the current year's administrative rate. Refer to the Guidelines for Calculations and Sampling for information on reducing the sample size.
Numerator	At least one pain screening during the measurement year, as documented through either administrative data or medical record review.
Administrative	Refer to the Administrative Specification above to identify positive numerator hits from the administrative data.
Medical record	Documentation in the medical record must include evidence of pain screening and the date the screening was performed. Evidence of pain screening may include the following. <ul style="list-style-type: none"> • Notation of the presence or absence of pain • Notation of the results of a screening using a standardized tool, such as: <ul style="list-style-type: none"> – Multidimensional Pain Inventory – Faces Pain Scale – 0–10 Numeric Rating Scales (verbal or visual) – Verbal Descriptor Scale – Brief Pain Inventory (Short Form)

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table COA-3: Data Elements for Care for Older Adults

	Administrative	Hybrid
Measurement year	✓	✓
Data collection methodology (Administrative or Hybrid)	✓	✓
Eligible population	✓	✓
Number of numerator events by administrative data in eligible population (before exclusions)		✓
Current year's administrative rate (before exclusions)		✓
Minimum required sample size (MRSS) or other sample size		✓
Oversampling rate		✓
Final sample size (FSS)		✓
Number of numerator events by administrative data in FSS		✓
Administrative rate on FSS		✓
Number of original sample records excluded because of valid data errors		✓
Number of administrative data records excluded		✓
Number of medical record data records excluded		✓
Number of employee/dependent medical records excluded		✓
Records added from the oversample list		✓
Denominator		✓
Numerator events by administrative data	✓	✓
Numerator events by medical records		✓
Reported rate	✓	✓
Lower 95% confidence interval	✓	✓
Upper 95% confidence interval	✓	✓