Proposed New Measures for HEDIS®[1] 2009:
Care for Older Adults (COA)
Medication Reconciliation (IMR)

NCQA seeks feedback on two proposed measures for the HEDIS 2009 measurement set: *Care for Older Adults (COA)* and *Medication Reconciliation (IMR)*.

The COA measure looks at the percentage of members 65 years of age and older who received a functional status assessment, pain screening, advance care planning and medication review during the measurement year. The measure is proposed for reporting by Medicare plans.

The IMR measure assesses the percentage of discharges for members 65 years of age and older that was followed by a medication reconciliation. There are two rates, one assessing if medication reconciliation was performed within 30 days of discharge and another assessing if medication reconciliation was performed within 60 days of discharge. The measure is proposed for reporting by Medicare plans.

NCQA utilized its Geriatric Measurement Advisory Panel (GMAP) to assist in the development of the measures and the field-test protocols. Supporting documents for the proposed measures include the draft measure specifications and associated measure rationale work-ups, which contain data obtained through field-testing.

NCQA thanks and acknowledges the contributions of the Geriatric Measurement Advisory Panel (GMAP).

1 HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Proposed New Measures for HEDIS 2009:
Care for Older Adults Measure and Medication Reconciliation Measure Work-Up

Information Required	Comment/Standardized Answer
ABSTRACT/IDENTIFYING INFORMATION	
Measure Name: Care for Older Adults and Medication Reconciliation	
Measure Set Name: Identifies the name of the measure set to which the measure belongs (if applicable).	These measures are under development as new measures for consideration of inclusion in HEDIS® 2009.
Measure Description: A concise statement about the measure that includes the specific aspects of healthcare addressed, the level of analysis, care or service settings, the time period the measure addresses (e.g., daily, yearly, monthly). *Measure History:* Past and current state of use of the measure; how long the measure has been used; the vetting process to ensure the integrity of the measure (e.g., use of technical advisory panels, Public Comment period) and any publications of studies (or in public reporting programs, such as the state) in which the performance of the measure is demonstrated. *Attach a list of all publication of studies in which this measure was used (a PubMed list can be attached).*	☐ Publications list attached ☒ There are no publications in which this measure was used. ☒ Measure has been field-tested. *Description:* *Care for Older Adults:* 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. *Medication Reconciliation:* The percentage of discharges from January 1–November 1 of the measurement year for members 65 years of age and older for whom medication were reconciled after discharge. Two rates are reported. 1. The percentage of discharges for which medication reconciliation was conducted within 30 days of discharge 2. The percentage of discharges for which medication reconciliation was conducted within 60 days of discharge *Measure History:* This is a potential new HEDIS measure. NCQA's Geriatric Measurement Advisory Panel (GMAP) and Vulnerable Elder Technical Subgroup (VETSG), composed of experts in the field of geriatrics, measurement methodology and health services research, will meet to advise the development of performance measures focused on review of medications prescribed to older adults. Based on the recommendations from the GMAP and VETSG, NCQA will pursue development of measures focused on comprehensive medication review. This proposed measure is the first step toward developing a spectrum of metrics focused on older adults, and if determined feasible, valid and reliable, it may be incorporated at the plan and physician levels. The CPM approved it to move on to Public Comment as the next phase of development.

Information Required	Comment/Standardized Answer
IMPORTANCE	
	Advance Care Planning—Related CMS Physician Specialty Measure: The percentage of patients aged 65 years and older with documentation of a surrogate decision maker or advance care plan in the medical record. Numerator: Patients with documentation of a surrogate decision maker or advance care plan in the medical record. Denominator: All patients aged 65 years and older. Denominator Exclusion: Documentation of patient reason(s) for no documentation of a surrogate decision maker or advance directive in the medical record (e.g., patient does not wish to discuss advance care planning).
Measure Rationale: The importance of the measure (i.e., why it is used). The rationale should incorporate relevant statistics that illustrate the cost or burden of poor quality in this area and the availability of accepted tools, practices or information for improvement. If this measure is similar to another NQF-endorsed measure (e.g., a diabetes measure), provide an explanation of how the measure will complement or perform better than those in use.	☒ No prior existing measure ☐ Other *Medication Review and Reconciliation:* Medication use affects the health and quality of life for a considerable number of older adults because they regularly take more than one medication (Kusserow 1990). Managing multiple medications is difficult due to issues with noncompliance, nonadherence, misunderstanding of dosage and lack of knowledge about the actual medication (Beckman 2004). Consequences of these challenges include adverse drug events, drug overdoses and underutilization of drugs, all leading to an increase in hospitalizations from adverse drug events (Bikowski 2001). Many of these problems result from a lack of communication between physician and patient. Physicians do not know if their patients do not understand their drug regimen, nor are they aware of the number of medications their patients may be taking at one time (Bikowski 2001; al Mahdy 1990; Sleath 2001). Beyond physician-initiated communication, problems also stem from the fact that older patients do not ask their physicians or pharmacists about their medication (Ostrom 1985; Jones 1997). The vast majority of older adults take medication to address at least three or more chronic conditions. Many have multiple prescribing physicians and use more than one pharmacy, so there is significant potential for medications to be prescribed that could cause an adverse event. Furthermore, approximately two out of five seniors report that they are not taking medication because of the cost, side-effects, perceived lack of effectiveness or belief that they do not need the medication (National Survey of Seniors and Prescription Drugs 2003). Additionally, for those elderly patients who appear to be noncompliant with drug regimens, their regimens tend to be more complex, making it difficult for them to manage medications. The problem of lack of knowledge in many cases is not attributed to cognitive problems (al Mahdy 1990). Reviewing all medications taken by a patient can help identify many adverse drug events, of which at least 27.6% are considered preventable (Gurwitz 2003). Various studies have demonstrated the effectiveness of interventions that prevent medication-related problems (e.g. adverse drug events), which reduce polypharmacy and waste of medicine, as well as drug interactions and ADE-related hospital admissions. A review of medications by a physician, in conjunction with a discussion with the patient, may improve the patient's knowledge about the purpose of their medications. Adverse drug events are common; most are preventable among older patients. There are different interventions for reviewing medications taken by the elderly to identify and to prevent potential problems. Some are linked to the physician or the pharmacist; others combine pharmacist, physician and a computer-based system (Bikowski 2001; Nathan 1999).

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	References al Mahdy, H., D.G. Seymour. How much can elderly patients tell us about their medications? *Postgrad. Med. J.* 1990;116-21. Beckman, G.K., M.G. Parker, M. Thorslund. Can elderly people take their medicine? *Patient Education and Counseling.* Science Direct 2004 (in press). Bikowski, R.M., C.M. Ripsin, V.L. Lorraine. Physician-patient congruence regarding medication regimens. *J. Am. Geriatr. Soc.* 2001;1353-7. Nathan, A., L. Goodyer, A. Lovejoy, A. Rashid. 'Brown bag' medication reviews as a means of optimizing patients' use of medication and of identifying potential clinical problems. *Fam. Pract.* 1999;278-82 National Survey of Seniors and Prescription Drugs. Kaiser Commonwealth/Tufts New England Medical Center. 2003. Ostrom, J.R., E.R. Hammarlund, D.B. Christensen, J.B. Plein, A.J. Kethley. Medication usage in an elderly population. *Med. Care.* 1985;157-64. Sleath, B., R.H. Rubin, W. Campbell, L. Gwyther, T. Clark. Physician-patient communication about over-the-counter medications. *Soc. Sci. Med.* 2001;357-69. *Functional Status Assessment:* According to the 2000 U.S. Census report, there were 35 million people over the age of 65 in the year 2000, representing a 12-fold increase since 1990. Among the older population, those 85 years and older showed the greatest increase. The most rapid growth over the last decade occurred in the population aged 85 years and older, with a 38% increase to 4.2 million people. Physical ability is an important indicator for health and well-being in old age and it decreases with increasing age. Rates of disability are generally higher in women than in men over age 75 years (Guralnik and Simonsick 1993), and mortality rates are lower in elderly women than in men, resulting in a male-to-female ratio of almost 1:1.5 (males-to-females age 65 years and older), and a ratio of about 1:2 in the 85 years and older population (Hobbs 2000). The number of chronically disabled Americans over the age of 65 years exceeds 7 million. Disability is linked to increased mortality and increased physical, emotional, social and financial problems, as well as increased rates of adverse outcomes, such as hospitalizations, admission to a nursing home and use of formal and informal home services. It therefore places a large burden on the elderly, their caregivers and the health care resources they use (Gill et al 2002). Elderly patients with impaired physical abilities are at high risk for decline in physical function *(ibid)*. While studies focusing on the prevention of functional decline in elderly patients are scarce, such prevention has the potential to increase quality of life for many and decrease emotional, social and financial cost (Gill et al 2002). By relying on clinical judgment alone, physicians may overlook important clinical problems common in older patients (Fleming et al 1995). Physical functional decline is often an initial symptom of medical illness in older persons and early detection of functional decline and their initiating events or illnesses will allow for earlier treatment or intervention (*ibid)*. References Fleming, et al. Practical Functional Assessment of Elderly Persons: A Primary-Care Approach. *Mayo Clinic Proceedings*. 1995; 70:890–910. Gill et al. A Program to Prevent Functional Decline in Physically Frail, Elderly Persons Who Live at Home. *The New England Journal of Medicine*, Vol. 347, No. 14. October 3, 2002. Guralnik and Simonsick. Physical Disability in Older Americans. *Journal of Gerontology.* 1993; 48 (special issue): 3-10. Hobbs, F., and The U.S. Census Bureau. *The Elderly Population*. http://www.census.gov/population/www/pop-profile/elderpop.html. March 16, 2007. U.S. Census Bureau. *The 65 Years and Over Population: 2000*. http://www.census.gov/prod/2001pubs/c2kbr01-10.pdf. March 16, 2007.

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	Pain Screening: According to population-based studies, pain-related problems are present in 25–50% of community-dwelling elders (Crook 1984). Pain is a frequent symptom of illness and disease in older ambulatory and hospitalized patients (Chodosh 2004). Elderly individuals are more likely to have arthritis, bone and joint disorders, cancer and other chronic disorders associated with pain (AGS 2002). Under-treating pain can have a negative impact on the health and quality of life of the elderly, and can result in depression, anxiety, reduced socialization, sleep disturbances and impaired mobility (AGS 2002). Pain associated with chronic conditions in older people may be understated because of the myth that pain is part of growing old (Byrd 2005). Appropriate assessment is necessary for effective treatment of pain. There is an increased use of health care services for patients with chronic pain, which translates into increased costs (Byrd 2005; Chodosh 2004). Self-reporting is viewed as the best screening for the presence of pain and the optimal way to assess pain intensity (Cavalieri 2002). Screening for pain is neither difficult nor expensive and requires only simple questions, even in the presence of cognitive impairment (Monti 1998). Due to the importance of recognizing painful conditions and providing adequate therapy, many organizations have implemented pain assessment as a standard of care. • Veterans Affairs healthcare facilities established pain assessment as a fifth vital sign. • The Joint Commission (2000) has mandated new standards for pain assessment and management. • American Geriatrics Society (2002) Panel on Persistent Pain in Older Persons recently released updated clinical practice guidelines. • In 2001, the Medical Board of California implemented a requirement for continuing medical education on pain management for medical licensure (New Laws Related to Continuing Medical Education). References AGS. American Geriatrics Society Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. *Journal of the American Geriatrics Society*. 2002. 50, 6, S205-S224. Byrd J. Assessing pain in older people. *Nursing Standard.* 2005. 19, 19, 45-52. Cavalieri, T.A. Pain management in the elderly. *J Am Osteopath Assoc*. 2002. 102:481-485. Chodosh, J. et al. The Quality of Medical Care Provided to Vulnerable Older Patients with Chronic Pain. *JAGS*. May 2004. Vol. 52, No. 5. Crook, J., E. Rideout, G. Browne. The prevalence of pain complaints among a general population. *Pain*. 1984.18:299–314. Joint Commission on Accreditation of Healthcare Organizations. *Pain Assessment and Management: An Organizational Approach.* Oakbrook Terrace, IL. 2000. Monti, D.A., E. Monti, J.S. Kunkel. Management of Chronic Pain Among Elderly Patients. *Psychiatric Services.* December 1998. Vol. 49, No. 12. New Laws Related to Continuing Medical Education; AB 487. Pain Management and the Appropriate Care and Treatment of the Terminally Ill [on-line]. www.medbd.ca.gov/cmelaws.htm.

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	IMPORTANCE
	Advance Care Planning: Advance care planning is "communication and discussion regarding treatment preferences that should start before a patient is seriously ill" (Bishop 2007). Advance care planning can include deciding on a surrogate decision maker and advance directives. Instructional advance directives, such as living wills and do-not-resuscitate orders, specify the types of interventions that a patient does or does not want in particular circumstances. Proxy directives, such as healthcare proxy and a durable power of attorney for health, authorize another person to make medical decisions if the patient is unable (Basanta 2002). Although these documents can designate wishes for any type of medical treatment, they are most often used to specify wishes regarding life-sustaining treatments and care at the end of life (Bishop 2007). Advance directives (AD) are widely recommended as a strategy to improve compliance with patient wishes at the end of life, and to thereby ensure appropriate use of health care resources at the end of life. There is expert consensus on the need for ADs, as well as a regulatory mandate, but only 15–25% of adults complete them, usually after a serious illness or hospitalization (Emanuel 1991; Cugliari 1995; Stetler 1992). Surveys find that most adults would prefer to discuss ADs while they are well, preferably with a doctor who has known them over time (Cugliari 1995; Johnston 1995; Shmerling 1988; Kohn 1998; Gamble 1991). Most also say they look to their doctors to initiate the discussion (Johnston 1995; Markson 1994; Morrison 1994). A study of ambulatory managed care patients aged 65 years or older found that a doctor's inquiry increased two- to three-fold the chances that individuals would have an AD on file with their health plan (Gordon 1999). Between 1992 and 1996, average annual medical expenditures for individuals aged 65 years and older were $7,365, but grew to $37,581 for those in the last year of life. The use of "heroic" services to extend the life of a dying patient tends to involve costly procedures and multiple doctors, which adds to the increased costs during end-of-life care. On an annual basis, this accounts for between 27% and 31% of elderly Medicare expenditures, although only about 5% of elderly Medicare beneficiaries die annually (Hoover 2002). References Cugliari, A.M., T. Miller, J. Sobal. Factors promoting completion of advance directives in the hospital. *Arch Intern Med.* 1995. 155:1893–8. Emanuel, L., M.J. Barry, J.D. Stoeckle, L.M. Ettelson, E.J. Emanuel. Advance directives for medical care—a case for greater use. *N Engl J Med.* 1991. 324:889–95. Hoover, D.R., S. Crystal, R. Kumar, U. Sambamoorthi, J.C. Cantor. Medical Expenditures During the Last Year of Life: Findings from 1992-1996 Medicare Current Beneficiary Survey. *Health Services Research.* 2002. Dec; 37(6): 1625-42. Gamble, E.R., P.J. McDonald, P.R. Lichstein. Knowledge, attitudes, and behavior of elderly persons regarding living wills. *Arch Intern Med.* 1991. 151:277–80. Gordon, N.P., S.B. Shade. Advance directives are more likely among seniors asked about end-of-life care preferences. *Arch Intern Med.* 1999. 159:701–4. Kohn, M., G. Menon. Life prolongation: views of elderly outpatients and health care professionals. *J Am Geriatr Soc.* 1988. 36:840–4. Johnston, S.C., M.P. Pfeifer, R. McNutt. The discussion about advance directives: patient and physician opinions regarding when and how it should be conducted. *Arch Intern Med.* 1995. 155:1025–30. Morrison, R.S., D.E. Meier. High rates of advance care planning in New York City's elderly population. *Arch Intern Med.* 2004. Dec 13-27;164(22):2421-6. Morrison, R.S., E.W. Morrison, D.F. Glickman. Physician reluctance to discuss advance directives: an empiric investigation of potential barriers. *Arch Intern Med.* 1994. 154:2311–8. Shmerling, R.H., S.E. Bedell, A. Lilienfeld, T.L. Delbanco. Discussing cardiopulmonary resuscitation: a study of elderly outpatients. *J Gen Intern Med.* 1988. 3:317–21. Stetler, K.L., B.A. Elliott, C.A. Bruno. Living will completion in older adults. *Arch Intern Med.* 1992. 152:954–9. Teno, J., S. Licks S, et al. Do advance directives provide instructions that direct care? SUPPORT investigators. Study to understand prognoses and preferences for outcomes and risks of treatment. *J Am Geriatr Soc.* 1997. 45:519-520.

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Key Leverage Point: Provides a description of the current gap between actual and potential performance that allows room for improvement. Key leverage point includes description of: • Variation in quality. Geographic, demographic, coverage, or other factors. • Significant opportunity for improvement. Performance in the area is substandard, and thus significant opportunity exists for improvement. This may be independent of variation, in cases where quality is consistently poor. • Relevance to consumers or purchasers (e.g., safety concerns). Variation in costs/ resource utilization (i.e., underuse, overuse or misuse).	*Medication Review and Reconciliation:* Annually there are more than 2 million serious adverse drug reactions and about 100,000 deaths due to medication problems (Institute of Medicine, National Academy Press 2002). Noncompliance, nonadherence, lack of communication between patients and physicians and the burden of taking multiple medications can result in drug interactions, adverse drug events, drug overuse and drug underuse. Adverse drug events are one of the leading causes of morbidity and mortality in health care. The January 2002 Institute of Medicine (IOM) report stated that annually there are between 44,000 and 98,000 deaths as a result of medical errors, while an estimated 7,000 deaths result from adverse drug reactions (Committee on Quality of Health Care in America, IOM 2002). If medication reviews are used, potential adverse drug events can be identified and prevented. In one study, the percentage of patients affected by adverse drug events fell from 36.9% to 9.3% with the use of medication reviews (Sorensen 2004). In one study, using the decision-tree model, the estimated mean cost for a treatment failure was $977 and for a new medical problem the mean cost was $1,105. The cost of a combined treatment failure and resulting new medical problem was $1,488. Using the model, the overall cost of drug-related morbidity and mortality exceeded $177.4 billion in 2000. Hospital admissions accounted for nearly 70%, or $121.5 billion, of total costs, while long-term-care admissions account for 18%, or $32.8 billion, of the total costs (Ernst 2002). Medications are a significant part of care for elderly patients. Patients 65 years and older take more than 30% of all prescription drugs (Knight 2001). Research has found that medication reviews are most effective when conducted by a retrospective drug-use review (RDUR) program, whereas the general routine use of automated computer screening of prescription-drug regimens does not result in changes in health status, morbidity or mortality (Knight 2001). The Task Force on Medicines Partnership indicated in its summary guide to medications that four out of five people over 75 take prescription medicines, and 36% take four and more. Older adults with multiple drug regimens have a risk of adverse drug events and side effects. Adverse reactions to medicines are implicated in 5–17% of hospital admissions, but many medication problems could be prevented by monitoring drug therapy and identifying patients at risk (Department of Health, London 2001). Medication use in the elderly is an important topic for research and targeted quality improvement in clinical practice. References Committee on Quality Health Care in America. Institute of Medicine. *To err is human: building a safer health system.* Washington, D.C: National Academy Press. 2002. Ernst, F.R., and A.J. Grizzle. Drug-Related Morbidity and Mortality: Updating the Cost-of-Illness Model. *J Am Pharm Assoc.* 2001. 41(2):192-199. Knight, E.L., J. Avorn. Quality indicators for appropriate medication use in vulnerable elders. *Ann. Intern. Med.* 2001. 703-10. Sorensen, L., J.A. Stokes, D.M. Purdie, M. Woodward, R. Elliott, M.S. Roberts. Medication reviews in the community: results of a randomized, controlled effectiveness trial. *Br. J. Clin. Pharmacol.* 2004. 648-64. Task Force on Medicines Partnership. The National Collaborative medicines Management Services Programme. *Room for Review. A Guide to Medication Review.* London, 2002. http://www.medicines-partnership.org/medication-review. September 2005.

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	IMPORTANCE
	Functional Status Assessment: Screening elderly patients is effective in identifying functional decline (Fleming et al 1995; Mort, "Understanding Decline in the Elderly"). Several methods of screening are available, but some are not suitable for use in the outpatient setting due to resource and time restraints (Fleming et al 1995; Extermann et al 2005; Farrell 2004). While the longer, comprehensive tests are more appropriately used in the long-term care or in-patient hospital setting, there exist some modified or condensed versions of effective tests that may be successfully utilized in the out-patient setting (Daltroy et al 1994; Farrell 2004; Fleming et al 1995). Measures of functional limitation may involve observation of the patient's ability to perform certain tasks but may also rely on self-reporting or information from a caregiver or other person close to the patient (*ibid)*. Objective observations provide more valid and reliable results but both methods may help to inform health care providers and allow them to anticipate future disability and provide an opportunity for modifying those factors that may lead to disability or affect other decisions related to treatment. Timely identification of elderly individuals with impaired physical abilities is also important in determining if a referral to a specialist is necessary. References Daltroy et al. Objectively Measuring Physical Ability in Elderly Persons: The Physical Capacity Evaluation. *American Journal of Public Health*. April 1995, Vol. 85, No. 4 (558-560) Extermann et al. Use of comprehensive geriatric assessment in older cancer patients: Recommendations from the task force on CGA of the International Society of Geriatric Oncology (SIOG). *Critical Reviews in Oncology/Hematology.* 2005. 55;241–252. Farrell, M., Using Functional Assessment and Screening Tools with Frail Older Adults. *Topics in Geriatric Rehabilitation*. 2004; Vol. 20, No. 1, pp 14-20. Fleming, et al., Practical Functional Assessment of Elderly Persons: A Primary-Care Approach. *Mayo Clinic Proceedings*. 1995. 70:890–910. Mort, J., Geriatric Essential Tools: Understanding Decline in the Elderly. *Walgreens Health Initiatives: CE Program*. https://webapp.walgreens.com/cePharmacy/programsHTML/5-decline.pdf. March 16, 2007. Expiration Date: March 1, 2009. *Pain Screening:* Documentation of appropriate assessment and management of chronic pain is very limited, compared with the frequency of new episodes of pain among the vulnerable elderly population. Only about 40% of patients reported being screened for pain. The incidence of identified painful episodes (33% of 372 patients) was similar to what has been demonstrated in epidemiological studies. The low prevalence of screening suggests that opportunities to identify chronic pain potentially responsive to treatment are often missed (Chodosh, 2004). There is a misconception that elderly persons are not experiencing pain, but it is one of the major reasons that prompt older patients to visit the doctor. However, once in the office, they rarely report their pain level. Many older patients think symptoms of pain may be a consequence of normal aging, and fear the need for diagnostic tests. Without direct questioning, chronic pain conditions are likely to be undetected, resulting in no treatment plan (Chopra 2006; Mantyselka 2005; Chodosh 2004). Improvements in the detection, assessment and treatment of chronic pain can optimize care provided to the elderly patient (Monti 1998) References Chodosh, J. et al. The Quality of Medical Care Provided to Vulnerable Older Patients with Chronic Pain. *JAGS*. 2004. May; Vol. 52, No. 5. Chopra, A. Pain Management in the Older Patient. *Clinical Geriatrics*. 2006. March; Vol. 14, No. 3. Mantyselka, P., E. Kumpusalo, R. Ahonen, et al. Pain as a reason to visit the doctor: A study in Finnish primary care. *Pain*. 2001;89:175–180. Monti, D.A., E. Monti, J.S. Kunkel. Management of Chronic Pain Among Elderly Patients. *Psychiatric Services.* 1998. December; Vol. 49, No. 12.

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	Advance Care Planning: A large discrepancy exists between the wishes of dying patients and their actual end-of-life care; however, retrospective clinical experience suggests that early advance care planning (ACP) can markedly reduce this discrepancy (Schwartz 2002). It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacitation. Surveys find that most adults would prefer to discuss ADs while they are well, preferably with a doctor who has known them over time (Cugliari 1995; Johnston 1995; Shmerling 1988; Kohn 1998; Gamble 1991). Most also say they look to their doctors to initiate the discussion (Johnston 1995; Markson 1994; Morrison 1994). A study of ambulatory managed care patients aged 65 years or older found that a doctor's inquiry increased two- to three-fold the chances that individuals would have an AD on file with their health plan (Gordon 1999). The most recent edition of the *Dartmouth Atlas of Health Care,* reporting on the last two years of life among Medicare enrollees with severe chronic illnesses, found significant gaps in the quality of end of life care. Given the expressed wish of many patients to avoid aggressive care at the end of life, the study's measure of terminal care intensity—the percentage of all deaths that occurred during a hospitalization involving one or more stays in intensive care—is useful in evaluating the quality of the end of life. Nationally, over the four-year period of the study, about one death in five was associated with one or more stays in an intensive care unit (ICU). In addition, the average number of days spent in ICUs per decedent during the last six months of life, a measure of the aggressiveness of end of life care, ranged from fewer than 2 to almost 5, with a U.S. average of 3.2 days per decedent (Wennberg 2006). Another study found that only 14% of 4,804 terminal patients had written ADs, and only 3% of those directives, as written, would have been able to provide sufficient direction to the physician on any life-extending treatments (Teno 1997). In a recent study, 27% of patients (n = 16,750) with lung cancer and 20% of patients (n = 11,332) with colorectal cancer received hospice care before death. Median length of stay for hospice patients with lung and colorectal cancer was 25 and 28 days, respectively. Overall, 20% of patients entered hospice within one week of death, whereas 6% entered more than six months before death (McCarthy 2003). Bravo's study of advanced directives for health care and research (2003) revealed that the prevalence of informal advance directives ranged from 7.4–42.3%. A study of interactions between Veterans Association (VA) physicians and patients found that the quality of communications may influence the usefulness of advance directives, and that many physicians did not address patient values or attitudes. The study concluded, "Physicians may not have addressed the topic in a way that would be of substantial use in future decision making, and these discussions did not meet the standards proposed in the literature" (Tulsky 1998). References Blackhall, L.J., G. Frank, S.T. Murphy, V. Michel, J.M. Palmer, S.P. Azen. Ethnicity and attitudes towards life sustaining technology. *Soc Sci Med.* 1999. 48:1779-1789. Bravo, G., M.F. Dubois, M. Paquet. Advance directives for health care and research: prevalence and correlates. *Alzheimer Dis Assoc Disord.* 2003. Oct-Dec;17(4):215-22. Eleazer, G.P., C.A. Hornung, C.B. Egbert, et al. The relationship between ethnicity and advance directives in a frail older population. *J Am Geriatr Soc.* 1996. 44:938-943. McKinley, E.D., J.M. Garrett, A.T. Evans, M. Danis. Differences in end-of-life decision making among black and white ambulatory cancer patients. *J Gen Intern Med.* 1996. 11:651-656. Meier, D.E., B.R. Fuss, D. O'Rourke, S.A. Baskin, M. Lewis, R.S. Morrison. Marked improvement in recognition and completion of health care proxies: a randomized controlled trial of counseling by hospital patient representatives. *Arch Intern Med.* 1996. 156:1227-1232. Morrison, R.S., D.E. Meier. High rates of advance care planning in New York City's elderly population. *Arch Intern Med.* 2004. Dec 13-27;164(22):2421-6

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	Morrison, R.S., L.H. Zayas, M. Mulvihill, S.A. Baskin, D.E. Meier. Barriers to completion of health care proxies: an examination of ethnic differences. *Arch Intern Med.* 1998. 158:2493-2497. Phipps, E., G. True, D. Harris, et al. Approaching the end of life: attitudes, preferences, and behaviors of African-American and white patients and their family caregivers. *J Clin Oncol..* 2003. 21:549-554. Schwartz, C.E., et al. , UMass End-of-Life Working Group. Early intervention in planning end-of-life care with ambulatory geriatric patients: results of a pilot trial. *Arch Intern Med.* 2002. Jul 22;162(14):1611-8. Teno, J., S. Licks, et al. Do advance directives provide instructions that direct care? SUPPORT investigators. Study to understand prognoses and preferences for outcomes and risks of treatment. *J Am Geriatr Soc.* 1997. 45:519-520. Tulsky, J.A., G.S. Fischer, M.R. Rose, R.M. Arnold. Opening the black box: how do physicians communicate about advance directives? *Ann Intern Med.* 1998. Sep 15;129(6):441-9.
	SCIENTIFIC ACCEPTABILITY
Evidence Supporting Measure Domain Selected: Supporting evidence appropriate for the measure domain. • For access measures, evidence that an association exists between the access measure and the outcomes of, or satisfaction with care. • For outcome measures, evidence that the outcome measure has been used to detect the impact of one or more clinical interventions. • For patient experience measures, evidence that an association exists between the measure of patient experience of health care and the values and preferences of individuals/the public. • For process measures, evidence that the measured clinical or administrative process let to improved health or cost/ benefit. For structural measures, evidence that an association exists between the structure measure and on six aims for quality improvement (safe, beneficial, patient-centered, efficient, timely, equitable).	☒ Evidence Included ☐ Evidence not available *Medication Review and Reconciliation—Guideline/Quality Indicators Summary:* 1. ACOVE Quality Indicators The ACOVE quality indicators related to medication use include the following. • Drug indication. The prescribed drug should have a clearly defined indication documented in the record, if the patient is prescribed a new drug, because the medication may have been prescribed for an indication that was unclear or transient. • Patient education. The patient (or, if incapable, the caregiver) should receive education and information about the purpose of the drug, how to take it, and the expected side effects or important adverse reactions, if a patient is prescribed a new drug. • Medication list. For all vulnerable elders the outpatient medical record of every physician and the hospital medical record should contain an up-to-date medication list, because a list can make it possible to identify and eliminate inappropriate drugs. It can also correct drug interactions. • Response to therapy. Every new drug which is prescribed to a vulnerable elder on an ongoing basis for a chronic medical condition should have a documentation of the response to therapy within 6 months. • Periodic drug regimen review. All older patients should have a drug regimen review at least annually, because this provides a possibility for discontinuation of unnecessary drugs as well as the addition of necessary drugs not currently prescribed (Knight EL, 1998) • Monitoring of warfarin therapy. If a vulnerable patient is prescribed warfarin, than an International Normalized Ratio (INR) should be determined within four days after initiation of therapy and at least every six weeks. Reference Annals of Internal Medicine. *2001;135 (Suppl.):641-758 is devoted to the ACOVE indicators. Articles cover the project overview, methods for developing the indicators, and the evidence supporting the quality indicators for 11 of the topics.*

Information Required	Comment/Standardized Answer
	SCIENTIFIC ACCEPTABILITY
	2. The Task Force on Medicines Partnership This British panel recommends that all patients over 75 should normally have their medicines reviewed in a clinical medication review at least annually, and patients taking four or more medicines should have a review every six months. A clinical medication review should include all prescribed, over the counter (OTC) and complementary medicines prescribed for or taken by the patient. The discussion should normally cover: • Explanation of the purpose and importance of the review • Evidence of the effectiveness of the treatment • Patient's experience of their medicines, including side effects • Practical issues such as ability to read labels and written information, container preferences, ordering or supply problems • Patient's basic understanding of their medicines and medication devices, including what they are for, the expected benefits, and the implications of failing to take them as recommended • Answering any questions about the medicines or the condition • Agreement about the treatment to be followed, including any changes in medicines • A check to ensure the patient understands how much, how often, when and the way in which their medicines should be taken • Monitoring requirements • Need for counseling or further information for patients and care givers • Requirements for any additional support • Review should conclude with a summary of the agreement with the patient about the treatment and the next date for review Target patient groups for medication reviews—patients at risk of medicine-related problems. • Patients taking four or more medicines every day • Recently discharged patients from hospital with complex medicines • Receiving medicines from more than one source • Significant changes to the medication regimen in the past 3 months • Noncompliance is suspected or known to be a problem • Symptoms suggestive of an adverse drug reaction Reference Task Force on Medicines Partnership. The National Collaborative medicines Management Services Programme. Room for Review. A Guide to Medication Review. London, 2002. http://www.medicines-partnership.org/medication-review. September 2005.

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	3. Improving Medication Management for Older Adult Clients Outcome 1: Reduce Inappropriate Prescribing *Assessment* Community dwelling older adults: Patients or their families will be instructed to bring all medications in their original containers. The directions will include herbs, vitamins, and prescription and nonprescription medications. This assessment will be performed at least yearly (Colt and Shapiro 1989; Fillit et al 1999; Knight and Avorn 2001; Nathan et al 1999). *(Evidence Grade = C)* For individuals residing in long-term care facilities, monthly medication review is completed by consulting pharmacists. These reviews have repeatedly been found to have a positive effect on clinical and economic outcomes (Gupchup, Vogenbeg and Larrat 2001; Harrison, Bootman and Cox 1998). Consultation between pharmacy and nursing is imperative, but given the complexity of medication regimens in long term care, nurses and providers must also evaluate routine and as needed (PRN) usage from the medication administration record. These evaluations should correspond with the admission process and at scheduled periodic reviews (Ouslander and Osterweil 1996; Torrible and Hogan 1997). *(Evidence Grade = C)* The assessment data will then be compared to the Beer's list (Appendix A-1 and A-2 in the original guideline document) to ascertain appropriateness of current medication regimen (Fick et al 2003) *(Evidence Grade = C)* *Assessment Action* Medications found to be in conflict with the Beer's list should be discontinued unless compelling evidence exists for continuance (Fick et al 2003; Doucet et al 1996). *(Evidence Grade = B)* The Beer's list should be used when planning medication initiation, reviewing established medication regimens or making changes in the medication regimen (Fick et al 2003; Doucet et al 1996). *(Evidence Grade = C)* Noncompliance *Assessment* Clients should be asked the following compliance questions. • Are you taking the medication(s) as prescribed? (Schaffer and Yoon 2001) • Do you have any questions about your medications? (Fineman and Delice 1992) • How often do you forget to take your medication? (Horne, Weinman and Hankins 1999) • How often do you miss a dose of your medication, or adjust it to suit your own needs? (Horne, Weinman and Hankins 1999) *(Evidence Grade = C)* • A complete history and physical exam to ascertain whether the client is responding to the therapy as expected (Bedell et al 2000; Donovan and Blake 1992; Edelberg et al 2000; Johnson, Williams and Marshall 1999) *(Evidence Grade = C)* *Assessment Action* • Pre-poured pillboxes, automatic dispensers with voice-activated message and regular or video-telephone call reminders have been useful for enhancing medication compliance for older community- dwelling congestive heart failure patients (Fulmer et al 1999) *(Evidence Grade = D)* • Organizational charts with OTC medication organizer improved adherence for old-old subjects (Park et al 1992) *(Evidence Grade = D)*

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	Although forgetting is the most common reason for missed dose, (Conn, Taylor and Stineman 1992) numerous interventions have been employed successfully to help individuals remember to take their medications. The following are suggestions of possible external and/or internal cues that may help to decrease forgetting. • Leave the pills in a prominent place • Plan medication taking around activities at the beginning of the day • Reread instructions to increase recall • Read regimen instructions slowly • Mentally repeat instructions • Concentrate hard when receiving instructions • Try hard to learn about new medications • Concentrate hard to learn medication times by repeating the process out loud each time (Gould, McDonald-Miszczak and King 1997) • Consider the association between medications and daily activities such as taking the prophylactic aspirin in the middle of the largest meal or taking the daily vitamin when brushing teeth in the morning (Schaffer and Yoon 2001) *(Evidence Grade = D)* • Carry a medication list that is updated at each visit (Conn and Edwards 1999; Haynes, Wang and Gomes 1987) *(Evidence Grade = D)* Outcome 2: Decrease Polypharmacy *Medication Review:* Should be completed every six months or with any medication change. *Assessment* The Medication Review prompts the examiner to query the record and/or the patient regarding the following. • Is the indication for which the medication was originally prescribed still present? • Are there duplications in drug therapy (same class)? Are simplifications possible? • Does the regimen include drugs prescribed for an adverse drug reaction? If so, can the original drug be withdrawn? • Is the present dosage likely to be sub-therapeutic or toxic in light of age and renal status? • Are any significant drug-drug or drug-illness interactions present? (Hamdy et al 1995) *(Evidence Grade = C)* *Assessment Action* • To simplify the regimen, consider and use combination drugs and alternative routes if at all possible. The use of combination tablets improves adherence when compared to dual therapy (Carlson 1996; Lau et al 1996; Melikian et al 2002; Dezii 2001) *(Evidence Grade = B)* • Once a day dosing should be followed if at all possible. Decreasing antihypertensive medication dosing from 3 times to once daily has been shown to dramatically increase adherence (Eisen et al 1990; Gambert, Grossberg and Morley 1994; Pullar et al 1988) *(Evidence Grade = C)* • Discontinue medications that fail to meet any Hamdy et al. criteria (Carlson,1996; Hamdy et al 1995; Hanlon et al 1992) *(Evidence Grade = C)* • Medications should not be prescribed to counteract side effects of other medications (Bergman-Evans and Ranno 1998; Hamdy et al 1995; Rochon and Gurwitz 1997) *(Evidence Grade = C)* • Laboratory studies may require more frequent monitoring (Kane, Ouslander and Abrass 1999; Turkoski 1999) *(Evidence Grade = D)* • Professionals should screen regularly for drug interactions that may result from the drug regimen (Carlson 1996; French 1996) *(Evidence Grade = D)*

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	Outcome 3: Avoid Adverse Events *Assessment* The Cockcroft-Gault Formula (Appendix A.3 in the original guideline document) is a useful method for estimating creatinine clearance based on age, weight and serum creatinine levels (Kane, Ouslander and Abrass 1999) It will be calculated and recorded at least yearly on the Medication Assessment Tool. A decreased creatinine clearance <50 mL/min is a risk factor for drug related problems *(Evidence Grade = C)* *Assessment Action* • In general, lower doses should be initially used with the elderly, and upward titration should be performed at a slower rate (French 1996; Hamdy et al 1995; Turkoski 1999) *(Evidence Grade = D)* • For identified renal failure, dosage for drugs renally excreted will need to be adjusted. Examples of these agents are digoxin, aminoglycoside antibiotics, radiographic contrast media, agents affecting the rennin angiotensin system (e.g., angiotensin-converting enzyme [ACE] inhibitors), or those inhibiting renal prostaglandin production (e.g., nonsteroidal anti-inflammatory drugs [NSAIDs]) (Fang, 2000) *(Evidence Grade = D)* Reference Bergman-Evans B. Improving medication management for older adult clients. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Dissemination Core; 2004 Oct. p 55. *Definitions—Evidence Grading* A. Evidence from well-designed meta-analysis B. Evidence from well-designed controlled trials, both randomized and nonrandomized, with results that consistently support a specific action (e.g., assessment, intervention, or treatment) C. Evidence from observational studies (e.g., correlational descriptive studies) or controlled trials with inconsistent results D. Evidence from expert opinion or multiple case reports. <u>4. Improving medication management for older adult clients</u> The Joint Commission believes that medication reconciliation should be done to prevent medication errors such as omissions, duplications, dosing errors or drug interactions. Reconciliations should be done at every transition of care, such as changes in treatment setting and level of practitioner. The Commission states that the process comprises five steps: 1) develop a list of current medications; 2) develop a list of medications to be prescribed; 3) compare the medications on the two lists; 4) make clinical decisions based on the comparison; and 5) communicate the new list to appropriate caregivers and to the patient. Reference Continuity of care in medication management: Review of issues and considerations for pharmacy. *American Journal of Health-System Pharmacists.* August 15, 2005. Vol. 62, pages 1714-1720. http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_35.htm

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	Functional Status Assessment—Guideline/Quality Indicators Summary: 1. The Physical Performance Test (PPT) can be used to identify and rate frailty in older adults. The test evaluates a patient's ability to write a sentence, simulate eating, pick up, lift and place objects, dress and undress, walk 50 feet and turn 360 degrees. It has been shown to be useful in identifying elderly patients who are frail, assessing functional performance, measuring change in functional capacity, and identifying the patient's risk of falling. The PPT is also able to identify physical functional deficits in patients before the patient self-reports any physical difficulty, identifying deficits before the patients sensed the decline in function and allowing for possible early intervention to prevent further decline toward frailty. The PPT has also been shown to have some predictive abilities for falls. The health care provider may decide between a 7-item version and a 9-item version depending on resource availability. No recommendation on frequency of testing was made. Reference Farrell, M. Using Functional Assessment and Screening Tools with Frail Older Adults. *Topics in Geriatric Rehabilitation.* 2004; Vol. 20, No. 1, pp 14-20. 2. The Physical Capacity Evaluation (PCE) can be used to assess physical abilities needed to perform activities of daily living. Evaluation consists of thirteen tasks. Reliability of results was compared to the results of the Global Health Assessment Questionnaire and shown to be high. A short form of the PCE retained adequate reliability as well. The PCE requires the clinician to have several tools for testing (grip strength, time to write out a sentence, foot tapping on a pressure plate, lock and key for hand function test and peg board for finger dexterity and fine motor test) and may be time consuming. No recommendation on frequency of testing was made. Reference Daltroy et al. Objectively Measuring Physical Ability in Elderly Persons: The Physical Capacity Evaluation. *American Journal of Public Health.* April 1995, Vol. 85, No. 4 (558-560) 3. Physical functional assessments performed in the primary care setting must be efficient and sensitive to time and resource constraints of the primary care office. Fleming et al. give examples of several abbreviated assessment tools that can be used to assess activities of daily living (ADLs), mobility ("Get up and Go" test), balance (modified Romberg test or functional reach test), shoulder function (simple inquiry and ROM observations), and hand function (demonstration of grip strength, pinch strength, and observations of dexterity). These tests are less quantifiable but are more feasible in the primary care setting and will still aid in informing clinicians of the patient's functional ability. No recommendation on frequency of testing or assessment was made. Reference Fleming, et al. Practical Functional Assessment of Elderly Persons: A Primary-Care Approach. *Mayo Clinic Proceedings.* 1995; 70:890– 910.

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	4. Geriatric nursing protocols for best practice in hospitals—Assessment of function: of critical importance to acute care of older adults. Geriatric nursing protocols for best practice recommends comprehensive functional assessment of elderly patients in the hospital setting. This includes independent performance of ADL, social activities, or instrumental activities of daily living (IADL) as well as the level of assistance needed to accomplish these tasks, sensory ability, cognition and ambulation. • Basic ADL • Bathing • Dressing • Grooming • Eating • Continence • Transferring • Instrumental activities of daily living • Meal preparation • Shopping • Medication administration • Housework • Transportation • Managing finances • Use of telephone • Mobility • Ambulation (Get-up and Go Test) • Transferring Guideline recommends that the clinician document baseline functional status and recent or progressive declines in function. Any acute changes in ADL should be further evaluated for underlying, reversible causes. Instruments used to assess functional ability should be standardized, efficient to administer, easy to interpret, and provide useful, practical information for clinicians. The assessment process should be incorporated into routine history taking and daily assessments. Communication regarding functional status, changes and expected trajectory should be interdisciplinary. Multidisciplinary teams should be brought together whenever possible, including the patient, caregivers and family members. *Intended Users:* Nurses

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	Guideline Objectives: • To identify physical functioning as an important clinical indicator of: health/illness, response to treatment, and need for services • To describe common components of standardized functional assessment instruments • To identify unique challenges to gathering information from older adults regarding functional assessments • To assist bedside nurses to monitor function in elders, prevent decline, and to maintain the function of elders during acute hospitalization *Target Population:* Hospitalized older adults *Interventions and Practices Considered:* Assessment of Function • *Routine history:* Baseline and recent functional status, family/caregiver input • *Observations* during dressing, eating, toileting, hygiene, and ambulation (activities of daily living [ADL]) • *Sensory capacity:* Vision, hearing, cognition • Use of standardized functional assessment instruments • Katz ADL Index • Barthel Index of physical function • Older Americans Resource and Services (OARS) instrument for physical function • Functional Independence Measure (FIM™) • Lawton Instrumental Activities of Daily Living (IADL) assessment • "Get-up and Go" test for ambulation • Risk factors for (causing) functional decline Reference Kresevic, D.M., M. Mezey. Assessment of function. In: Mezey, M., T. Fulmer, I. Abraham, D.A. Zwicker, editor(s). *Geriatric nursing protocols for best practice.* 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 31-46. *Pain Screening--Guideline/Quality Indicators Summary:* 1. ACOVE: Quality Indicators for Pain Management in Vulnerable Elders: Quality Indicators 1 and 2 • Screening for Chronic Pain at New-Patient Visits: All vulnerable elders should be screened for chronic pain during the initial evaluation period BECAUSE older people commonly have pain that goes unrecognized by health care providers. • Regular Screening for Chronic Pain: All vulnerable elders should be screened for chronic pain every 2 years BECAUSE older people commonly have pain that goes unrecognized by health care providers.

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	Reference Chodosh, J. et al. The Quality of Medical Care Provided to Vulnerable Older Patients with Chronic Pain. *JAGS.* May 2004; Vol. 52, No. 5. 2. AGS Panel on Persistent Pain in Older Persons. I. On initial presentation or admission of any older person to any health care service, a health care professional should assess the patient for evidence of persistent pain (IIB) Level II Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies, from multiple time-series studies, or from dramatic results in uncontrolled experiments B Moderate evidence to support the use of a recommendation; clinicians "should do this most of the time" Reference *The Management of Persistent Pain in Older Persons.* AGS Panel on Persistent Pain in Older Persons. JAGS 50:S205–S224, 2002 3. Institute for Clinical Systems Improvement (ICSI) *Critical First Step:* Assessment *Key Points:* • Joint Commission requires that all patients have the right to an adequate pain assessment including documentation of pain location, intensity, quality, onset/duration/variations/rhythms, manner of expressing pain, pain relief, what makes it worse, effects of pain, and a pain plan. • A general history and physical exam are essential for assessment of chronic pain. • Baseline functional ability assessment can provide objectively verifiable information about a patient's quality of life and ability to participate in normal life activities. Reference Institute for Clinical Systems Improvement (ICSI). *Assessment and management of chronic pain.* Bloomington (MN): Institute for Clinic. *Advance Care Planning--Guideline/Quality Indicators Summary:* This measure would be consistent with a legislative mandate affecting Medicare beneficiaries, the Patient Self Determination Act (PSDA), approved in 1990. The act requires that beneficiaries be informed about their rights to self determination and the use of advance directives, and identifies particular facilities accountable for providing the information. The use of advance directives is supported in national guidelines for palliative care, and for care of geriatric persons in general. Geriatric nursing protocols recommend the following: (Ramsey, 2007)

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	Target Population • Hospitalized older adults • Nursing home residents • General elderly population *Interventions and Practices Considered* • Approach patients regarding advance directives • Assess decisional capacity • Check for vision/hearing deficits • Obtain language translation/interpreter as needed • Provide culturally appropriate discussion/education for patient and family/health care proxy • Benefit versus burden assessment • Assist with completion and document results • Advance directive forms • Oral advance directives (verbal directives) where permitted by state • Conflict mediation • Refer to social work, patient advocate, or hospital ethics committee as appropriate Reference Ramsey, G., E. Mitty. Advance directives: protecting patient's rights. In: Mezey, M., T. Fulmer, I. Abraham, D.A. Zwicker, editor(s). Geriatric nursing protocols for best practice. 2nd ed. New York (NY): Springer Publishing Company, Inc.; 2003. p. 265-91. Available from the National Guidelines Clearinghouse at: http://www.guideline.gov/summary/summary.aspx?ss=15anddoc_id=3516andstring=advance+AND+directive. January 12, 2007. *Note:* The measure would be reasonably specified and appears to be consistent with expert recommendations and regulatory requirements. However, there appears to be evidence that the use of ADs may not impact care practices or health care costs. There may also be variation in how the measure is implemented. The measure currently does not define what type of AD will be required to meet the measure. The measure does not address any indicators of the quality of the interaction relating to the AD. Given that there are barriers to completion of ADs, including physician and patient reluctance to address them, lack of definition around what is expected may invalidate the measure. For example, the measure allows for broad use of exclusions, including patient desire not to address the topic, which may allow the provider to meet coding requirements without a meaningful intervention relating to development of an AD.

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SCIENTIFIC ACCEPTABILITY		
Data Source: The data source necessary to implement the measure (e.g., administrative data only, clinician survey, medical record only, patient survey only or a hybrid method). • Specifications for using data sources should be described • If more than one data source can be used to calculate the measure, evidence supporting the comparability of the sources should be provided • For EHRs, provide any additional detail necessary specific for use of the measure in this medium	☐ Administrative and laboratory data ☒ Administrative and medical record data ☒ Administrative and pharmacy data ☒ Administrative and provider data ☐ Administrative data only ☐ Administrative and clinician survey ☐ Administrative and patient survey ☐ Clinician survey only	☐ Patient survey only ☐ Laboratory data only ☐ Medical record data only ☒ Paper medical record ☒ Electronic health record/administrative database ☐ Observational data (e.g., compliance measures that require observation of practices) ☐ Other_____
Denominator Inclusions/Exclusions: The specific inclusion and exclusion criteria used to refine the denominator. Include all relevant codes (e.g., ICD-9, CPT, G-codes).	*Inclusions:* Care for Older Adults: Members age 65 years and older as of the December 31st of the measurement year. Medication Reconciliation: Members 65 years and older who were discharged from an acute or non-acute inpatient setting on or between January 1 and November 1 of the measurement year. *Exclusions:* ☐ Contraindications ☐ Age ☐ Comorbid conditions ☐ Stage of illness ☐ Time of index event ☐ Other Exclusion:	
Denominator Time Window: Classifies the time period (in association with the denominator index event) in which patients are reviewed for inclusion in the denominator.	Measurement year	

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SCIENTIFIC ACCEPTABILITY	
Numerator Event: Identifies the event or state that defines a patient eligible for inclusion in the numerator (e.g., clinical condition, diagnostic encounter, office visit, hospitalization).	Functional Status Assessment: Record of function assessment at least once during the measurement year. Medication Review: At least one comprehensive medication review as of the December 31st of the measurement year. Pain Screening: At least one pain screening during the measurement year. Advance Care Planning: Advance care planning during the measurement year. Medication Reconciliation: Medication reconciliation conducted within 30 days and 60 days of discharge
Numerator Inclusions/Exclusions: Specific inclusion and exclusion criteria used to refine the numerator. Exclusions related to patient preferences should also be included where appropriate.	*Inclusions:* *Exclusions:* ☐ Contraindications ☐ Age ☐ Comorbid conditions ☐ Stage of illness ☐ Time of index event ☐ Other _____
Numerator Time Window: Identifies the time period in which patients are reviewed for inclusion in the numerator.	The measurement year.
USABILITY	
Measure Benchmarks: Best performance or range of performance) performance for the measure. How have these benchmarks been used?	☐ Benchmark data included ☒ There are no benchmark data

Information Required	Comment/Standardized Answer
QUALITY OF SUPPORTING EVIDENCE	
Quality of Evidence: To further improve and bring more transparency to the NQF process, all measure developers are required to grade the level of evidence submitted with measures. Developers are requested to use the United States Preventive Services Task Force (USPSTF) rating system on all evidence submitted: The USPSTF grades the quality of the overall evidence for a service on a three-point scale (Good, Fair, Poor). • Good. Evidence includes consistent results from well-designed, well-conducted studies in representative populations that directly assess effects on health outcomes. • Fair. Evidence is sufficient to determine effects on health outcomes, but the strength of the evidence is limited by the number, quality, or consistency of the individual studies, generalizability to routine practice, or indirect nature of the evidence on health outcomes. • Poor. Evidence is insufficient to assess the effects on health outcomes because of limited number or power of studies, important flaws in their design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes. More information on USPSTF and its rating system can be accessed at http://www.ahrq.gov/clinic/3rduspstf/ratings.htm.	Overall the supporting evidence is good. The evidence identifies direct correlations to cost and quality of life and overall patient health.