Proposed Changes to Existing Measure for HEDIS®[1] 2020: Care for Older Adults (COA)

NCQA seeks comments on a proposed modification to the HEDIS Health Plan *Care for Older Adults* measure:

- Remove the fourth bullet from the hybrid specification for the Functional Status Assessment indicator.

Reported by Special Needs Plans (SNP) and Medicare-Medicaid Plans (MMP) only, the intent of the *Care for Older Adults* measure is to ensure that older adults enrolled in these plans receive appropriate screenings and services. The measure includes four indicators; a separate rate is reported for each. The proposed modification concerns *one* indicator: Functional Status Assessment.

The indicator assesses the percentage of members 66 years of age and older who had at least one functional status assessment (FSA) during the measurement year. This rate can be reported using administrative data alone or in combination with medical record review (hybrid). Mean performance rate for measurement year 2018 was 88.3%.

The current hybrid specification allows any of the following forms of documentation to count as a complete FSA:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring (e.g., getting in and out of chairs), using the toilet, walking.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
- Result of assessment using a standardized functional status assessment tool (with examples provided).
- Notation that at least three of the following four components were assessed:
  - Cognitive status.
  - Ambulation status.
  - Hearing, vision and speech (i.e., sensory ability).
  - Other functional independence (e.g., exercise, ability to perform job).

Assessing and optimizing functional status has long been regarded as a cornerstone of high-quality care for older adults,[2,3] but recent research shows that common approaches to assessing and documenting functional status for older adults vary widely in ambulatory care settings.[4,5] The fourth bullet allows significant variation in what "counts" as an FSA, and is also a major source of confusion among health plans and other measure users based on the number of questions we receive about the FSA.

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

[2] Bierman, A., W. Spector. 2001. AHRQ Task Force on Aging. *Improving the Health and Health Care of Older Americans: Report of the AHRQ Task Force on Aging.* Rockville, Md: Agency for Healthcare Research and Quality; 2001.

[3] Bierman, A.S. 2001. "Functional Status: the Sixth Vital Sign. *Journal of General Internal Medicine* 16(11), 785–6.

[4] Nicosia, F.M., Spar, M.J., Steinman, M.A., Lee, S.J., and Brown, R.T. 2018. Making Function Part of the Conversation: Clinician Perspectives on Measuring Functional Status in Primary Care. *Journal of the American Geriatrics Society*. [Epub ahead of print.]

[5] Spar, M.J., F.M. Nicosia, M.A. Steinman, and R.T. Brown. 2017. "Current approaches to measuring functional status among older adults in VA primary care clinics." *Federal Practitioner: For the Health Care Professionals of the VA, DoD, and PHS* 34(9), 26–31.

NCQA continues to support regular assessment of older adults' sensory and cognitive abilities, and these may be targeted in future measure development. Removing the bullet will encourage standardized assessment and documentation of functional status and will improve clarity for health plans and other measure users. Our Geriatric Measurement Advisory Panel strongly supports this recommendation.

Supporting documents include the draft measure specification.

NCQA acknowledges the contributions of the Geriatric Measurement Advisory Panel

Care for Older Adults (COA)

SUMMARY OF CHANGES TO HEDIS 2020

- Removed the fourth bullet of the *Functional Status Assessment* indicator.

Description

The percentage of adults 66 years and older who had each of the following during the measurement year:

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

Definitions

Medication list	A list of the member's medications in the medical record. The medication list may include medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies.
Medication review	A review of all a member's medications, including prescription medications, OTC medications and herbal or supplemental therapies.
Advance care planning	A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care.
Standardized tool	A set of structured questions that elicit member information. May include person-reported outcome measures, screening or assessment tools or standardized questionnaires developed by the health plan to assess risks and needs.

Eligible Population

Note: *Members in hospice are excluded from the eligible population. If an organization reports this measure using the Hybrid method, and a member is found to be in hospice or using hospice services during medical record review, the member is removed from the sample and replaced by a member from the oversample. Refer to General Guideline 17: Members in Hospice.*

Product line	Medicare (only SNP and MMP benefit packages).
Ages	66 years and older as of December 31 of the measurement year.
Continuous enrollment	The measurement year.
Allowable gap	No more than one 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.

Administrative Specification

Denominator The eligible population.

Numerators

Advance Care Planning Evidence of advance care planning during the measurement year (Advance Care Planning Value Set).

Medication Review Either of the following meet criteria.

- Both of the following during the same visit during the measurement year where the provider type is a prescribing practitioner or clinical pharmacist:
  - At least one medication review (Medication Review Value Set).
  - The presence of a medication list in the medical record (Medication List Value Set).
- Transitional care management services (Transitional Care Management Services Value Set) during the measurement year.

Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Functional Status Assessment At least one functional status assessment (Functional Status Assessment Value Set) during the measurement year. Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Pain Assessment At least one pain assessment (Pain Assessment Value Set) during the measurement year. Exclude services provided in an acute inpatient setting (Acute Inpatient Value Set; Acute Inpatient POS Value Set).

Hybrid Specification

Denominator A systematic sample drawn from the eligible population. Organizations may reduce the sample size using the current year's administrative rate or the prior year's audited, product line-specific rate. Refer to the *Guidelines for Calculations and Sampling* for information on reducing the sample size.

Numerators

Advance Care Planning Evidence of advance care planning as documented through either administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Evidence of advance care planning must include one of the following:

- The presence of an advance care plan in the medical record on or before December 31 of the measurement year.
- Documentation of an advance care planning **discussion** with the provider ***and*** the date when it was discussed. The documentation of discussion must be noted during the measurement year.
- Notation that the member previously executed an advance care plan. The notation must be dated on or before December 31 of the measurement year.

Examples of an advance care plan

- **Advance directive.** Directive about treatment preferences or the designation of a surrogate who can make medical decisions for a patient who is unable to make them (e.g., living will, health care power of attorney, health care proxy).
- **Actionable medical orders**. Written instructions regarding initiating, continuing, withholding or withdrawing specific forms of life-sustaining treatment (e.g., Physician Orders for Life Sustaining Treatment [POLST], Five Wishes).
- **Living will**. Legal document denoting preferences for life-sustaining treatment and end-of-life care.
- **Surrogate decision maker.** A written document designating someone other than the member to make medical treatment choices.

Examples of an advance care planning discussion

- **Notation in the medical record** of a discussion with a provider or initiation of a discussion by a provider during the measurement year.
  - Documentation that a member declined to discuss advance care planning is considered evidence that the provider initiated a discussion and meets criteria.
  - Documentation that a provider asked the member if an advance care plan was in place and the member indicated a plan was not in place is not considered a discussion or initiation of a discussion.
- **Oral statements.** Conversations with relatives or friends about life-sustaining treatment and end-of-life care, documented in the medical record. Patient designation of an individual who can make decisions on behalf of the patient. Evidence of oral statements must be noted in the medical record during the measurement year.

Medication Review

At least one medication review conducted by a prescribing practitioner or clinical pharmacist 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.

A medication list, signed and dated during the measurement year by the appropriate practitioner type (prescribing practitioner or clinical pharmacist), meets criteria (the practitioner's signature is considered evidence that the medications were reviewed).

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation must come from the same medical record and must include one of the following:

- A medication list in the medical record, ***and*** evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
- Notation that the member is not taking any medication and the date when it was noted.

A review of side effects for a single medication at the time of prescription alone is not sufficient. An outpatient visit is not required to meet criteria. Do not include medication lists or medication reviews performed in an acute inpatient setting.

Functional Status Assessment At least one functional status assessment during the measurement year, as documented through either administrative data or medical record review.

Administrative Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed.

Notations for a complete functional status assessment must include one of the following:

- Notation that Activities of Daily Living (ADL) were assessed or that at least five of the following were assessed: bathing, dressing, eating, transferring [e.g., getting in and out of chairs], using toilet, walking.
- Notation that Instrumental Activities of Daily Living (IADL) were assessed or at least four of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, cooking or meal preparation, housework, home repair, laundry, taking medications, handling finances.
- Result of assessment using a standardized functional status assessment tool, not limited to:
  - SF-36®.
  - Assessment of Living Skills and Resources (ALSAR).
  - Barthel ADL Index Physical Self-Maintenance (ADLS) Scale.
  - Bayer ADL (B-ADL) Scale.
  - Barthel Index.
  - Extended ADL (EADL) Scale.
  - Independent Living Scale (ILS).
  - Katz Index of Independence in ADL.
  - Kenny Self-Care Evaluation.
  - Klein-Bell ADL Scale.
  - Kohlman Evaluation of Living Skills (KELS).
  - Lawton & Brody's IADL scales.
  - Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales.

- ~~Notation that at least three of the following four components were assessed:~~
  - ~~Cognitive status.~~
  - ~~Ambulation status.~~
  - ~~Hearing, vision and speech (i.e., sensory ability).~~
  - ~~Other functional independence (e.g., exercise, ability to perform job).~~

A functional status assessment limited to an acute or single condition, event or body system (e.g., lower back, leg) does not meet criteria for a comprehensive functional status assessment. The components of the functional status assessment numerator may take place during separate visits within the measurement year. Do not include comprehensive functional status assessments performed in an acute inpatient setting.

~~***Note:*** *Notation alone that cranial nerves were assessed does not meet criteria for the sensory ability component. Documentation of assessment of cranial nerves corresponding specifically to hearing (cranial nerve VIII), vision (cranial nerve II) and speech (cranial nerve XII) with a result or finding meets criteria for this component.*~~

~~*Notation that the member spoke with the provider during a visit (e.g., documentation that states the member "reports," "denies," "stated" or "discussed") does not meet criteria for the speech (sensory ability) component. The intent is to find documentation that the provider performed a qualitative assessment of the member's speech functioning.*~~

Pain Assessment

At least one pain assessment during the measurement year, as documented through either administrative data or medical record review.

Administrative

Refer to *Administrative Specification* to identify positive numerator hits from administrative data.

Medical record

Documentation in the medical record must include evidence of a pain assessment and the date when it was performed.

Notations for a pain assessment must include one of the following:

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
- Result of assessment using a standardized pain assessment tool, not limited to:
  - Numeric rating scales (verbal or written).
  - Face, Legs, Activity, Cry Consolability (FLACC) scale.
  - Verbal descriptor scales (5–7 Word Scales, Present Pain Inventory).
  - Pain Thermometer.
  - Pictorial Pain Scales (Faces Pain Scale, Wong-Baker Pain Scale).
  - Visual analogue scale.
  - Brief Pain Inventory.
  - Chronic Pain Grade.
  - PROMIS Pain Intensity Scale.
  - Pain Assessment in Advanced Dementia (PAINAD) Scale.

Do not include pain assessments performed in an acute inpatient setting.

Note

- *Notation alone of a pain management plan does not meet criteria.*
- *Notation alone of a pain treatment plan does not meet criteria.*
- *Notation alone of screening for chest pain or documentation alone of chest pain does not meet criteria.*
- *Refer to Appendix 3 for the definition of* clinical pharmacist *and* prescribing practitioner.

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)	*Each of the 4 rates*	*Each of the 4 rates*
Eligible population	*Each of the 4 rates*	*Each of the 4 rates*
Number of numerator events by administrative data in eligible population (before exclusions)		*Each of the 4 rates*
Current year's administrative rate (before exclusions)		*Each of the 4 rates*
Minimum required sample size (MRSS)		*Each of the 4 rates*
Oversampling rate		*Each of the 4 rates*
Number of oversample records		*Each of the 4 rates*
Number of numerator events by administrative data in MRSS		*Each of the 4 rates*
Administrative rate on MRSS		*Each of the 4 rates*
Number of original sample records excluded because of valid data errors		*Each of the 4 rates*
Number of employee/dependent medical records excluded		*Each of the 4 rates*
Records added from the oversample list		*Each of the 4 rates*
Denominator		*Each of the 4 rates*
Numerator events by administrative data	*Each of the 4 rates*	*Each of the 4 rates*
Numerator events by medical records		*Each of the 4 rates*
Numerator events by supplemental data	*Each of the 4 rates*	*Each of the 4 rates*
Reported rate	*Each of the 4 rates*	*Each of the 4 rates*

