BlueCross BlueShield of Illinois

HEDIS® Measure

Care for Older Adults Guidelines

Care for Older Adults (COA) is included in the Blue Cross and Blue Shield of Illinois (BCBSIL) Quality Improvement (QI) program for Blue Cross Community MMAI (Medicare-Medicaid Plan)[SM] members.

The **MMAI Healthcare Effectiveness Data and Information Set (HEDIS) COA** guidelines are for adults age 66 years and older. They are to have the following items assessed and documented in their medial record on or before December 31 of the measurement year.

1. **Advanced Care Planning:** Discussion or documentation about a member's preferences for resuscitation, life-sustaining treatment and end of life care.
2. **Functional Status Assessment:** Review or assessment of a member's functional status and their ability to perform activities of daily living.
3. **Pain Assessment:** Documentation in the medical record of a member's total body pain status or use a standardized pain assessment tool to assess their pain level.
4. **Medication Review:** Review of member's medication performed by a prescribing practitioner or clinical pharmacist during the year, to include prescription medications, over the counter (OTC) medications and herbal or supplemental therapies.

COA Assessment Tools/Options

Advanced Care Planning

Documentation in the member's medical record of at least one end of life discussion on or before December 31 of the measurement year.

Chart contains a copy of the advance care plan. Examples of an advance care plan include:

- **Advance directive:** Documentation or instructions in the medical record about who can make medical decisions for a patient and who is unable to make them (e.g., living will, 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 indicating a member's wishes regarding life-sustaining treatment and end-of-life care.
- **Surrogate decision maker:** A written document designating someone other than the member to make future medical treatment choices.

Chart contains documentation of an advance care planning discussion to include:

Notation in the medical record of a discussion or the initiation of a discussion that shows that the provider discussed with the member, their preferences about resuscitation, life-sustaining treatment and end-of-life care during the measurement year.

- A note stating the member declined to discuss advance care planning is considered evidence that the provider initiated a discussion and meets criteria.
  - A provider asks a member if an advanced care plan is in place and the member says no, **is not considered** a discussion or initiation of a discussion.
- Oral statements documented in the medical record during the measurement year:
  - Conversations with relatives or friends about life-sustaining treatment and end-of-life care.
  - Patient designates an individual who can make decisions on behalf of the patient.

Functional Status Assessment

Documentation in the member's medical record of at least one comprehensive functional status assessment on or before December 31 of the measurement year. Assessment is done by using one of the four assessment types:

- Activities of Daily Living (ADL)
- Instrumental Activities of Daily Living (IADL)
- Functional status assessment tools (with results) posted in the medical record

1. Notation of ADL at least five areas were assessed and results documented in the member's medical record during the measurement year: *(need at least five areas assessed)*

- Bathing
- Dressing
- Eating
- Using toilet
- Walking
- Transferring (e.g. getting in and out of chairs)

2. Notation of IADL assessed for at least four areas with results documented in the medical record on or before December 31 of the measurement year: *(need at least four areas assessed)*

- Shopping for groceries
- Using the telephone
- Cooking or meal preparation
- Driving or using public transportation
- Housework
- Home repair
- Laundry
- Taking medications
- Handling finances

3. Functional Status Assessment Tools utilized to assess members ADLs with results documented in the member's medical record on or before December 31 of the measurement year:

- SF-36®
- Barthel Index
- Bayer ADL (B-ADL) Scale
- Extended ADL (EADL) Scale
- Independent Living Scale (ILS)
- Assessment of Living Skills and Resources (ALSAR)
- Barthel ADL Index Physical Self-Maintenance (ADLS) Scale
- Patient Reported Outcome Measurement Information System (PROMIS) Global or Physical Function Scales
- 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
- Edmonton Frail Scale
- Groningen Frailty Index

Documentation that DOES NOT meet the measure for functional status assessment

- 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.

PAIN ASSESSMENT

Documentation in the member's medical record of at least one overall pain assessment on or before December 31 of the measurement year.

Notation of a Pain Assessment must include documentation that the member was assessed for total body pain, which may be a positive or negative finding for pain

Standardized Pain Assessment Tool: Result of an assessment using a standardize pain assessment tool, such as:

- Numeric rating scales (verbal or written)
- Brief pain inventory
- Pain thermometer
- Chronic pain grade
- Visual analogue scale
- PROMIS pain intensity scale
- Pictorial pain scales (Faces pain scale, Wong-Baker pain scale)
- Pain Assessment in Advanced Dementia (PAINAD) scale
- Face, Legs, Activity, Cry Consolability (FLACC) scale
- Verbal descriptor scales (5-7 word scales, present pain inventory)

Documentation that **DOES NOT** meet the measure for pain assessment, include:

- Documentation of pain focusing on a single area, e.g., hip pain, knee pain, back pain, etc.
- Pain assessment performed in an acute inpatient setting cannot be used

MEDICATION RECONCILIATION

Documentation in the member's medical record of at least one medication review on or before December 31 of the measurement year. The member does not have to be present.

A review of all medications that a member is taking, including prescription medications, OTC medications and herbal or supplemental therapies completed by a prescribing practitioner or clinical pharmacist.

- A medication list in the outpatient records that is reviewed, signed and dated during the measurement year by a prescribing practitioner or clinical pharmacist.
- 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.

Documentation that DOES NOT MEET the measure

- A review of side effects for a single medication at the time of prescription alone is not sufficient.
- List of medication reviewed in an acute inpatient setting.

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