

# Improve Care for Older Adults (COA)

Use HEDIS® Guidelines to Help Keep Your Older Patients Healthy

## Advanced Care Planning

A discussion about preferences for resuscitation, life-sustaining treatment and end-of-life care.

**Documentation required:** Presence of advanced care plan in the medical record or documentation of the discussion with the date it was discussed.

**Acceptable medical record:**

- ✓ Actionable medical orders
- ✓ Surrogate decision maker
- ✓ Living will
- ✓ Advance directive

**Codes:** CPT 1157F (documentation) OR 1158F (discussion)

## Medication Review

A review of all of a member's medications (including prescriptions, OTCs and herbal/supplemental therapies) conducted by a prescribing practitioner or clinical pharmacist.

**Documentation required:** Medication list in the medical record with date when it was performed or note that the member is not taking any medications with date.

**Acceptable medical record:**

- ✓ Current medication list
- ✓ Notation of medication review
- ✓ OR date & notation that member is not taking any medication

**Codes:** CPT 1159F (med list) AND 1160F (meds reviewed)

## Functional Status Assessment

**Documentation required:** Evidence of a complete functional status assessment and the date it was performed.

**Acceptable medical record (include one of the following):**

- ✓ Notation that Activities of Daily Living (ADL) were assessed
- ✓ Results of assessment using a standardized functional assessment tool
- ✓ Notation that Instrumental Activities of Daily Living (IADL) were assessed
- ✓ Notation that at least three of the following four components were assessed: cognitive status, ambulation status, hearing/vision/speech, other functional independence.

**Codes:** CPT 1170F

## Pain Assessment

**Documentation required:** Evidence of a pain assessment and the date it was performed (may include positive or negative findings for pain).

**Acceptable medical record:** Results of a standardized pain assessment tool such as:

- ✓ Numeric rating scales
- ✓ FLACC scale
- ✓ Present Pain Inventory
- ✓ Pain Thermometer
- ✓ Pictorial Pain Scale
- ✓ Visual analogue Scale
- ✓ Brief Pain Inventory
- ✓ Chronic Pain Grade
- ✓ PROMIS Pain Intensity Scale
- ✓ Pain Assessment in Advanced Dementia (PAINAD) Scale

**Codes:** CPT 1125F (pain noted) OR 1126F (no pain noted)

Document the results of any screenings. Get credit for the work you've done! Pre-collection of this patient information is a valuable tool that meets the needs of your patient, while also satisfying HEDIS® measures.

Contact our Quality Advocate Team at 1(855) 339-4890 Mon - Fri from 8:30 am to 5:30 pm

## Improving Care for Older Adults: HEDIS® COA Form

Pre-collection of the following patient information meets the needs of your patient and satisfies your practice's HEDIS requirements

Member Name	Member ID	Member DOB
		____/____/____
PCP Name	Provider ID	Provider Phone No.

Advanced Care Planning: 1157F (documentation); 1158F (discussion)		
Does the member have advanced directives or processes in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If life planning is in place, indicate which of the following the member has:	<input type="checkbox"/> Living Will <input type="checkbox"/> Health Care Surrogate <input type="checkbox"/> Physician Orders for Life Sustaining Treatment <input type="checkbox"/> Durable Powers of Attorney for Health <input type="checkbox"/> None of these	
What is the code status of the member?	<input type="checkbox"/> DNR <input type="checkbox"/> Partial Code <input type="checkbox"/> Full Code	<input type="checkbox"/> Family or Member Undecided <input type="checkbox"/> Unknown
Was advanced care planning discussed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Follow-up needed?

Functional Status Assessment: 1170F		
In the following questions, indicate the level of ability of the member to self-care. IND=Independent, NA=Needs Assistance, FD=Fully Dependent		
<b>Shopping for groceries:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Driving or using public transport:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Using the phone or computer:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD
<b>Meal preparation:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Housework:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Taking medications:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD
<b>Handling finances:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Walking:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Dressing:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD
<b>Bathing:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Toileting:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD	<b>Eating:</b> <input type="checkbox"/> IND / <input type="checkbox"/> NA / <input type="checkbox"/> FD
In the following questions, indicate whether or not the member has any of the following:		
<b>Cognitive impairment?</b> <input type="checkbox"/> Yes / <input type="checkbox"/> No	<b>Speech impairment?</b> <input type="checkbox"/> Yes / <input type="checkbox"/> No	<b>Weaknesses of the extremities that interferes with self-care or mobility?</b> <input type="checkbox"/> Yes / <input type="checkbox"/> No
<b>Hearing impairment?</b> <input type="checkbox"/> Yes / <input type="checkbox"/> No	<b>Vision impairment?</b> <input type="checkbox"/> Yes / <input type="checkbox"/> No	<b>Has the member had any falls in the last 6 months?</b> <input type="checkbox"/> Yes / <input type="checkbox"/> No If yes, how many? _____

Pain Assessment: 1125F (pain noted) / 1126F (no pain noted)		
Does the member have chronic pain?	<input type="checkbox"/> Yes \ <input type="checkbox"/> No	On a scale from 0 to 10 (10 being max pain) what is the intensity of pain prior to treatment?
During the past 4 weeks, how much has the pain interfered with the member's normal work (outside and housework)?	<input type="checkbox"/> All of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Some of the time <input type="checkbox"/> None of the time	

Medication Review: 1159F (med list) AND 1060F (meds reviewed)						
Pharmacy Name:			Pharmacy Phone:			
Medication	Dose	Route	Frequency	Use	New?	Last Filled
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
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					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
Over the counter medications (use of anti-inflammatory or analgesic medications for symptom relief)						
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
					<input type="checkbox"/> Y / <input type="checkbox"/> N	__/__/__
Did the member fill meds under health plan? <input type="checkbox"/> Y / <input type="checkbox"/> N If no, explain:						
Medications were reviewed with the patient / primary caregiver and list is updated as of ____/____/_____						

Primary Care Physician's Name (print)	Primary Care Physician's Signature
Credentials: <input type="checkbox"/> MD / <input type="checkbox"/> DO / <input type="checkbox"/> NP / <input type="checkbox"/> PA	