Care of Older Adults (COA)

Overview

Adults 66 years and older during their visit to the primary care provider, preferably during annual wellness visit had their medications reviewed, functional status assessment and pain assessment completed during the current year

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WHY IS IT IMPORTANT

- COA measure helps to determine the level of care patients need and ensure that the needed care is received to optimize their quality of life
- Screening of elderly adults is an effective way to identify functional decline, to recognize the complexity of their medication regime and if chronic or acute pain is present that can impact their ability to manage their health condition at home

Understanding the Measure

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- How is someone identified for the measure:
  - Members 66 years of age and older who are screened for functional assessment, pain assessment and medication review in the current year
- How is it measured:
  - Identify members that had:
    - Completed medication review by a prescribing provider
    - Complete functional assessment
    - Completed pain assessment

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TALKING POINTS WITH PROVIDER GROUPS

- Discuss with provider groups that COA is about an assessment of their patients' functional status to evaluate their ability to perform certain tasks that are necessary for daily living and the level of assistance needed to accomplish those tasks, presence of pain or no pain that can impact their mobility and reviewing their current medications that cause mental changes or adverse effects that can result in dizziness or pseudo dementia
- Remind provider groups that they must assess their patients for all 3 components for patients to be compliant for COA measure
- Discuss how the results of the COA can impact their patient's level of care and ability to manage their health condition(s)
- Discuss the different types of standardized tests

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PROVIDER GROUP'S KEYS TO SUCCESS

- Encourage provider groups to complete patients' annual wellness visit on each calendar year, to assess their patients' functional assessment, presence of pain and complete medication review
  - Medication Review- inform provider groups the following:
    - An outpatient visit is not required to complete medication review
    - Only one medication review is required during the current year
    - It must be conducted by a prescribing practitioner or clinical pharmacist
    - The presence of a medication list must be in the medical record
    - Documentation in the medical record the member is not taking any medication is acceptable for medication review
  - Functional Status Assessment- inform the provider groups the following:
    - Documentation in the medical record must include evidence of a complete functional status assessment and the date when it was performed in the current year
    - Inform provider groups that there are available Functional Status Assessment or FSA tool. For example, Katz Index of Independence in ADL or Katz ADL, Functional Status Questionnaire, Extended ADL (EADL) Scale
    - The components of the functional status assessment numerator may take place during separate visits within the current year. Components may be combined from different dates of service in the current year to meet the criteria for functional status assessment
    - A specific setting is not required for Functional Status Assessment. Services provided during a telephone visit, virtual check-in, or e-visit meet criteria
    - Notation for a complete functional status assessment must include ONE of the following:
      - At least FIVE of the following activities of daily living or ADLs were assessed - bathing, dressing, eating, getting in and out of bed or chair, using the toilet, walking
      - At least Four of the following instrumental activities of daily living or IADLs were assessed - shopping for groceries, cooking or meal prep, laundry, driving or using public transportation, housework, taking medications, using the telephone, home repair, handling finances
  - Pain Assessment – inform the provider groups the following:
    - There are available standardized pain assessment tool. For examples - Numeric rating scales (verbal or written), Pain thermometer, Pictorial
    - Inform provider groups that only one pain assessment is needed in the current year
    - Documentation in the medical record that member was assessed for pain (may include positive or negative findings for pain)

Resources

- HEDIS Quick Reference Guide (page 15)
- Adult Pocket Guide
- CPT II Codes Flyer