### Care for Older Adults (COA)

**Q: Which members are included in the sample?**

**A:** Adults 66 years and older who had *each* of the following in 2015:

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

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**Q: What codes are used?**

**A:** Please reference attached sample codes; reference Value Set Directory for additional codes

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**Q: What documentation is needed in the medical record?**

**A:**

- ✓ **Advanced Care Planning** – evidence must include either the presence of advanced care plan in the medical record or documentation of advance care planning discussion with the provider and the date when it was discussed.

- ✓ **Evidence of Medication Review** – must include medication list in the medical record, and evidence of a medication review and the date when it was performed or notation that the member is not taking any medication and the date when it was noted.

- ✓ **Evidence of Functional Status Assessment** – documentation must include evidence of functional status assessment and the date when it was performed.

- ✓ **Evidence of Pain Assessment** – documentation must include evidence of a pain assessment (may include positive or negative findings for pain) and the date when it was performed.
**Q: What type of medical record is acceptable?**

**A:**

**Advanced Care Planning:**
- ✓ Advance Directives
- ✓ Actionable medical orders
- ✓ Copy of Living Wills
- ✓ Copy of documentation of surrogate decision maker
- ✓ Evidence of oral statements noted in the medical record in 2015

**Medication Review:**
- ✓ Current medication list in 2015
- ✓ Notation of medication review in 2015
- ✓ Date and notation that the member is not taking any medication in 2015.

**Functional Status Assessment:**
- ✓ Progress notes, IHSS forms, HRA forms, AWE form
- ✓ Notation that Activities of Daily Living (ADL) were assessed or that at least 5 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 4 of the following were assessed: shopping for groceries, driving or using public transportation, using the telephone, meal preparation, housework, home repair, laundry, taking medications, handling finances.
- ✓ Result of assessment using a standardized functional status assessment tool
- ✓ Notation of cognitive status, ambulation status, sensory ability (hearing, vision and speech) and, other functional independence (e.g., exercise).

**Pain Assessment:**
- ✓ Progress notes – notation of a pain assessment (which may include positive or negative findings for pain)
- ✓ Result of assessment using a standardized pain assessment tool
- ✓ Numeric rating scales (verbal or written)
- ✓ Pain Thermometer
- ✓ Pictorial Pain Scales
- ✓ Visual analogue scale
- ✓ Brief Pain Inventory
- ✓ Chronic Pain Grade
- ✓ PROMIS Pain Intensity Scale
- ✓ Pain Assessment in Advanced Dementia (PAINAD) Scale
## Care for Older Adults (COA)

### Q: How to improve score for this HEDIS measure?

**A:**
- Use of complete and accurate Value Set Codes.
- Timely submission of claims and encounter data
- Ensure complete and appropriate documentation in medical record
- Timely submission of AWE Forms that are complete and accurate
### Advance Care Planning:

CPT Category II codes
- 1157F, 1158F

S0257

### Medication Review:

CPT Category II codes
- 1159F, 1160F

HCPCS code
- G8427

### Functional Status Assessment:

CPT Category II code
- 1170F

### Pain Assessment:

CPT Category II codes
- 1125F, 1126F