Care of the Older Adult

Best Practices in Documentation for Optimal Member Outcomes & Provider Revenue

November 1, 2018

Health Partners Plans HPP

Agenda

- Objective
- NCQA Required Elements for Documentation
- Coding
- Resources
- Q&A

Objective

- Define HEDIS and the Care of the Older Adult (COA) measure
- Discuss the four required Components of Care for COA
- Discuss how appropriate documentation can lead to better health outcomes and improved provider revenue
- Learn how accurate coding and documentation go hand in hand

HEDIS

- Healthcare Effectiveness Data Information Sets (HEDIS)
- Developed by the National Committee for Quality Assurance (NCQA)
- Serves as a way of standardizing performance measurements for health plans.
- Find more information at http://www.ncqa.org/hedis-quality-measurement or http://www.ncqa.org/about-ncqa.

Who is the Older Adult?

- For purposes of the COA measure, the Older Adult is defined by NCQA as those members who are 66 years of age and older during the measurement year.
- The measure assesses the percentage of adults age 66 and older who are Dual Eligible Special Needs Plan (D-SNP) members.
- Patients on hospice are excluded.

COA is a key HEDIS measure!

How Important is COA?

- COA is the highest incentivized measure in our Quality Care Plus (QCP) program.
- QCP is a provider incentive program designed to reward practices for their performance in delivering quality services throughout the year.

Health Partners Plans HPP

Four Required Components of COA

1. Medication Review
2. Functional Status Assessment
3. Pain Assessment
4. Advanced Care Planning

Note: Advance Care Planning is an element featured in the national NCQA HEDIS measure but is not included in HPP's QCP Program.

Medication Review

- Defined as at least one medication review conducted by the prescribing practitioner or clinical pharmacist during the measurement year AND the presence of a medication list in the medical record.
- A medication list signed and dated by the appropriate prescribing provider meets criteria.

Medication Review

Documentation must come from the same medical record and include **ONE** of the following:

1. A medication list in the medical record and evidence of a medication review by a prescribing practitioner or clinical pharmacist, and the date it was performed.
2. Notation that the member *is not* taking any medication and the date noted. This will count for compliance.
3. Do not include documentation that medications are not tolerated. This is not an exclusion for the measure.

Medication Review Tip

TIP! While the medication review is not required to be performed during a patient visit, we recommend including the review in your in-person visits, so the patient better understands his or her medications. The medication review also provides an opportunity for education on medications that will contribute to increased adherence.

Functional Status Assessment

- Documentation of a complete functional assessment must include **ONE** of the following:
  1. Documentation that Activities of Daily Living (ADL) were assessed.
  2. Documentation that Instrumental Activities of Daily Living (IADL) were assessed.
  3. Results of functional assessment using a standardized tool.
  4. Documentation that cognitive status, ambulation status, sensory ability (vision, speech, hearing) and other functional independence (ability to exercise, perform job) were assessed.

Activities of Daily Living (ADLs)

Appropriate documentation of ADLs must address at least **FIVE** of the following:

1. Bathing
2. Dressing
3. Eating
4. Transferring in and out of chair
5. Using toilet
6. Walking
7. **Continence**

Health Partners Plans HPP

Instrumental Activities of Daily Living (IADLs)

Appropriate documentation of IADLs must assess at least **FOUR** of the following:

1. Shopping for groceries
2. Driving or using public transportation
3. Using the telephone
4. Meal preparation
5. Housework
6. Home repair
7. Laundry
8. Taking medications
9. Handling finances

Exclusions for Functional Assessments

Does not meet criteria:

- A functional assessment limited to an acute or single condition, event or body system (e.g., one cranial nerve, leg, back, etc.) does not meet criteria.
- Notations that cranial nerves were assessed does not meet criteria for sensory ability.
- Documentation that a member “reports”, “denies” or “stated” does not meet criteria for speech.

Does meet criteria:

- Documentation of cranial nerves corresponding specifically to hearing (VIII) vision (II) and speech (XII) with a result of finding does meet criteria.

Tools for Functional Assessment

Include but are not limited to:

- Assessment of Living Skills and Resources (ALSAR)
- Barthel SDA Index Physical Self-Maintenance Scale (ADLS)
- Bayer ADL Scale (B-ADL)
- Extended ADL Scale (EADL)
- Independent Living Scale (ILS)
- Klein-Bell ADL Scale
- Function Scale

Example of Standardized ADL Assessment Tool

KATZ INDEX OF INDEPENDENCE IN ACTIVITIES OF DAILY LIVING*

Activities *POINTS (1 OR 0)*	*Independence* *(1 POINT)* *NO supervision, direction, or personal assistance*	*Dependence* *(0 POINT)* *WITH supervision, direction, personal assistance, or total care*
BATHING Points: ____	(1 point) Bathes self completely or needs help in bathing only a single part of the body such as the back, genital area, or disabled extremity.	(0 points) Needs help with bathing more than one part of the body, getting in or out of bathtub or shower. Requires total bathing.
DRESSING Points: ____	(1 point) Gets clothes from closets and drawers and puts on clothes and outer garments complete with fasteners. May have help tying shoes.	(0 points) Needs help with dressing self or needs to be completely dressed.
TOILETING Points: ____	(1 point) Goes to toilet, gets on and off, arranges clothes, and cleans genital area without help.	(0 points) Needs help transferring to the toilet, cleaning self, or uses bedpan or commode.
TRANSFERRING Points: ____	(1 point) Moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.	(0 points) Needs help in moving from bed to chair or requires a complete transfer.
CONTINENCE Points: ____	(1 point) Exercises complete self-control over urination and defecation.	(0 points) Is partially or totally incontinent of bowel or bladder.
FEEDING Points: ____	(1 point) Gets food from plate into mouth without help. Preparation of food may be done by another person.	(0 points) Needs partial or total help with feeding or requires parenteral feeding.
TOTAL POINTS: ____	*6 = High (client independent)*	*0 = Low (client very dependent)*

* *Slightly adapted with permission from Gerontological Society of America. Katz, S., Down, T.D., Cash, H.R., et al. (1970). Progress in the development of the index of ADL.* The Gerontologist, 10, *20-30.*

Health Partners Plans HPP

Functional Status Assessment Tip

TIP! Review the standardized assessment tools and select the one that is most appropriate for your practice. Ensure that the documentation in your electronic medical record (EMR) captures all required elements of the standardized assessment tools thoroughly and accurately. Work with your EMR vendor to update or modify current questions to increase your compliance rate.

Pain Assessment

Documentation in the medical record must include evidence of a pain assessment and the date it was performed and include **ONE** of the following:

1. Documentation that the member was assessed for pain with positive or negative findings.
2. Result of assessment using a standardized pain assessment tool.

Examples of Standardized Pain Assessment Tools

- Numeric rating scales
- Face, Legs, Activity, Cry Consolability (FLACC) scale
- Pain Thermometer
- Faces Pain Scale (Wong-Baker Pain Scale)
- Brief Pain Inventory Scale
- Pain Assessment in Advanced Dementia (PAINAD) scale

Example of a Standardized Pain Assessment Tool

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	

Reference: Warden, V, Hurley AC, Volicer, V. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *J Am Med Dir Assoc, 4*:9-15. Developed at the New England Geriatric Research Education & Clinical Center, Bedford VAMC, MA.

Exclusions for Pain Assessments

- Notation of a pain management or pain treatment plan alone does not meet criteria.
- Notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria.

Improved Outcomes Related to Functional & Pain Assessments

Assessing activities of daily living and pain enables the practitioner to identify sensory and motor deficits to help:

- Prevent injury
- Identify obstacles to compliance with dietary and medication regimens
- Foster independence
- Identify the need for referrals for urinary incontinence, hearing or speech deficits, ambulatory difficulties
- Improve quality of life for older adults

Advanced Care Planning

- Defined as a discussion about preferences for resuscitation, life-sustaining treatment and end of life care by NCQA.
- Medical record must include documentation that a member who does not have an Advanced Care Directive was offered a discussion and/or information by the provider.
- A simple notation that a member does not have an Advanced Care Directive *does not* suffice as appropriate documentation.

Advanced Care Planning

Advanced Care Planning ***must*** include one of the following:

1. Advanced Care Directive
2. Actionable Medical Orders
3. Living Will
4. Surrogate Decision Maker

Health Partners Plans HPP

How Does Optimal Documentation of COA Impact the Provider?

- Improved patient care: clinicians obtain an integrated, holistic and clinically objective view of their patients.
- Optimal use of visits: addresses important gaps in care.
- Satisfaction of the COA measure in HPP's QCP program: helps providers earn up to $4 per member per month as long as all components are completed (medication review, functional status assessment and pain assessment).

General Recommendations for COA

- Complete the medication review, functional status assessment, pain assessment and advance care planning during the same visit. Do this on an annual basis for all eligible members.
- Utilize all touchpoints by your clinical team to complete these assessments (e.g., telephonic and face-to-face outreach).
- Utilize CPT II codes to document the results of your assessments. Although HPP recognizes that many providers do not utilize CPT II codes, leveraging these codes helps provide additional details for health outcomes measures and eases administrative burden by reducing medical record requests. For example, one large network practice worked with their billing team to get CPT II codes automatically added to claims, where applicable.

As always, your NAM is available to address any questions you may have. Thank you for your continued support in improving the health outcomes of our members.

HPP's QCP for COA

While the HEDIS COA measure entails four components, only three are included in HPP's QCP program. All three must be completed in order to be eligible for the incentive

- Medication Review
- Functional Status Assessment
- Pain Assessment

Health Partners Plans HPP

Utilizing CPT II Codes to Document Results of Assessments

HPP recognizes that many providers do not utilize CPT II codes. However, their use offers providers the following advantages:

- They provide additional details for health outcomes
- They help ease administrative burdens by reducing medical record requests

CPT II Codes Permitted by NCQA for COA

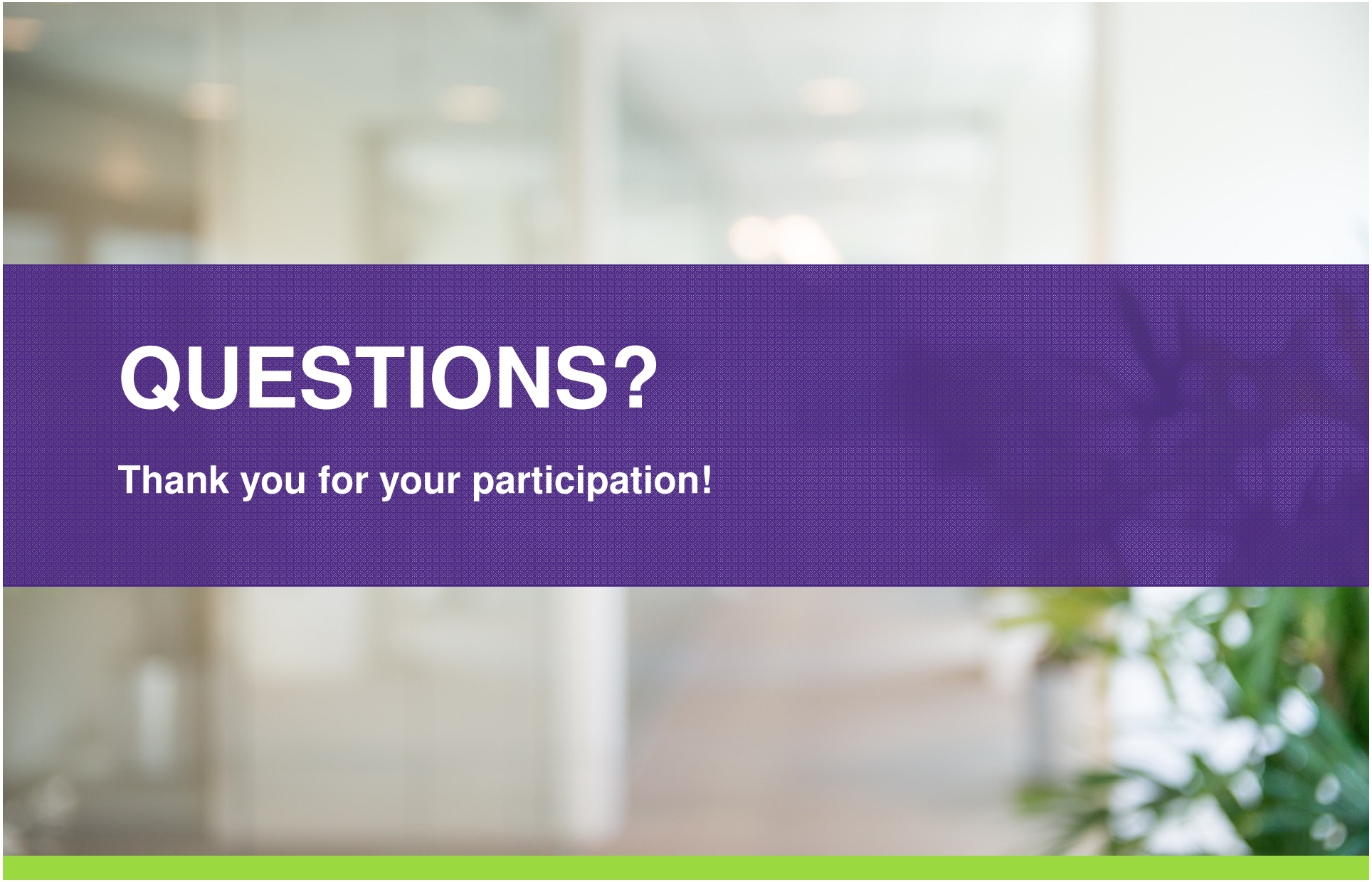
Functional Status Assessment: CPT/CPT II = 1170F

Medication List :CPT/CPT II =1159F, HCPCS=G8427

Medication Review: CPT/CPT II=90863, 99605-06, 1160F, ICD10=Z00.0, Z00.00, Z00.01

Pain Assessment: CPT/CPT II = 1125F, 1126F

Advance Care Planning: CPT/CPT II =99497, 1123F-24F, 1157F-58F, HCPCS = S0257



Health Partners Plans HPP