

*Attachment #5*

**REPORTING SPECIFICATIONS FOR ACOVE  
American Geriatrics Society Draft August, 2005**

<b>Quality Indicator and Code Descriptor</b>	<b>Denominator Specification</b>	<b>Numerator Specification</b>	<b>Testing experience#</b>	<b>Evidence<sup>1,2</sup> and Current Measures</b>
<p><b>Dementia 1-CH*</b>  <b>IF</b> a person age 75 or older is admitted to a hospital, <b>THEN</b> there should be documentation of a multidimensional assessment of cognitive ability.</p> <p>* Alpha-numeric refers to ACOVE system</p>	<p>All patients 75 years and older admitted to a hospital with length of stay of 48 hours or more.</p>	<p>Physician note documenting a multidimensional assessment of cognitive ability (including assessment of memory, orientation and attention) within 48 hours of hospital admission.</p>	<p>In ACOVE-1, 130 patients were eligible for this quality indicator and 52% passed.</p> <p>#Refers to ACOVE trials using chart review. Category II/G code methodology not tested</p>	<p>Observational studies show that physicians who screen for cognition are more likely to detect dementia than patients or caregivers are to complain of dementia symptoms.. Early treatment can delay the progression of dementia. Several guidelines advocate documentation of cognitive ability and/or assessment of functional status on admission to a nursing home, hospital, or physician practice.</p>

<p><b>00XF1: Multidimensional assessment of cognitive ability performed (must include assessment of memory, orientation and attention)</b></p>	<p>Hospital claims data defines population.</p>	<p>Physicians use QI reporting code. No code reported is interpreted as assessment not performed</p>		<p>ORYX measures not researched. ORYX is for hospital reporting, not physician reporting. If there is an ORYX measure and the hospital abstracts all admissions for this event, there could be a reporting method based upon facility reporting with the admitting physician being scored based upon hospital reporting.</p>
<p><b>Dementia 1-CO</b>  <b>IF</b> a person age 75 or older is new to a physician practice, <b>THEN</b> there should be documentation of an assessment of memory.</p>	<p>All patients 75 years and older seeing a primary care physician for a new outpatient visit.</p>	<p>Physician note documenting a multidimensional assessment of memory (including 3 item recall, documentation of formal mental status testing or notation about memory) within 3 months of new patient visit.</p>	<p>In ACOVE-2, 54 patients were eligible for this quality indicator and 11% passed.</p>	<p>Same as above.</p>
<p><b>00XF2: Assessment of memory performed</b></p>	<p>Denominator defined by reporting of CPT codes 99201-99205 or 99387. Patient is aged 75 or older.</p>	<p>Physicians use QI reporting code. No code reported is interpreted as assessment not performed</p>		<p>No current measure</p>
<p><b>Dementia 1-F</b>  <b>IF</b> a person age 75 or older is admitted to a hospital or is new to a physician practice, <b>THEN</b> there should be an assessment of functional status.</p>	<p>All patients 75 years and older admitted to a hospital with length of stay of 48 hours or more.</p>	<p>Physician note documenting an assessment of function (any assessment of activities of daily living or instrumental activities of daily living or notation about function) within 48 hours of hospital admission or within 3 months of the new outpatient visit.</p>	<p>In ACOVE-1, 130 patients were eligible for this quality indicator and 18% passed. In ACOVE-2 of 105 eligible patients, 55% passed.</p>	<p>Supported by observational studies and guidelines and consensus conferences.</p>

<p><b>00XF3: Basic or instrumental activities of daily living assessed</b></p>	<p>Denominator population includes inpatients defined by hospital admission claims and outpatient population defined by reporting of CPT codes 99201-99205 or 99387. Patient is aged 75 or older.</p>	<p>Physicians use QI reporting code. No code reported is interpreted as assessment not performed</p>		<p>No current measure</p>
<p><b>Depression 1</b>  <b>IF</b> a person age 75 or older presents with new onset of one of the following symptoms: sad mood, feeling down, insomnia or difficulties with sleep, apathy or loss of interest in pleasurable activities, complaints of memory loss, unexplained weight loss of greater than 5% in the past month or 10% over 1 year, or unexplained fatigue or low energy, <b>THEN</b> the patient should be asked about or treated for depression, or referred to a mental health professional within 2 weeks of presentation.</p>	<p>All patients 75 years and older who present at an outpatient visit with a new (in one year) diagnosis code of insomnia (ICD -9- CM codes to be specified), weight loss (ICD -9- CM codes to be specified) or fatigue (ICD -9- CM codes to be specified)</p>	<p>Patient should be asked about depression or treated for depression (), or referred to a mental health professional within 2 weeks of presentation</p>	<p>In ACOVE-1, 34 patients were eligible for this quality indicator and 26% passed. In ACOVE-2 of 209 eligible patients, 50% passed.</p>	<p>Supported by observational studies and guidelines and consensus conferences.   HEDIS has depression measures about therapy and frequency of follow up visits. The drug treatment measures have been problematic. This would add different elements.</p>
<p><b>00XF4: Symptoms of mood, sleep or memory disorder or weight loss or fatigue assessed, present, depression considered or depression treatment initiated.</b></p> <p><b>00XF5: Symptoms of mood, sleep or memory disorder or weight loss or fatigue assessed, not present.</b></p>	<p>000XF5 and 000XF6 could define the denominator and numerator. ICD9 diagnoses could be used to define the symptomatic population as an alternative. A list would need to be developed.</p>	<p>If ICD9s were used to define the denominator, one could also use both a code reporting consideration/treatment of depression or a list of drugs, certain CPT codes (the MH set or any E/M with a depression diagnosis) to define the numerator positives.</p>		

<p><b>Depression 3 and 4</b>  <b>IF</b> a person age 75 or older receives a diagnosis of a new depression episode, <b>THEN</b> the medical record should document (1) at least 3 of the 9 Diagnostic and Statistical Manual IV target symptoms for major depression within the first month of diagnosis and (2) that the patient was asked about suicidal ideation and psychotic thinking.</p>	<p>All patients 75 years and older who receive a new (in one year) diagnosis of depression (ICD -9- CM codes to be specified).</p>	<p><b>THEN</b> the physician should document in the medical record at least 3 of the 9 Diagnostic and Statistical Manual IV target symptoms for major depression and whether or not the patient has suicidal ideation and psychotic thinking.</p>	<p>In ACOVE-1, 13 patients were eligible for this quality indicator and no physician provided the necessary documentation. In ACOVE-2 of 60 eligible patients, 33% had documentation of target symptoms and 2% concerning suicidality.</p>	<p>No clinical trial evidence but recommended by numerous clinical guidelines.</p>
<p><b>00XF6: Symptoms of depression (must include at least 3 of 9 key DSM IV symptoms) and assessment of suicidal ideation and psychosis documented.</b></p> <p><b>OR</b></p> <p><b>00XF6: Symptoms of depression documented</b></p>	<p>Would use HEDIS for definition of “new” and “depression” and this would simply be another numerator in the current HEDIS set (of those 75+)</p>	<p>The shorter version seems the best G/category II code as others could use it and then in the explanatory appendix (Appendix H in CPT) it would say that for ACOVE: 3/9 of the following symptoms must be documented, and there was documentation of an assessment of SI and psychotic thinking. Symptoms assessed include mood, interests, weight, sleep, psychomotor activity, fatigue/energy, worthlessness/guilt, concentration/decisiveness and thoughts of suicide/death.</p>		<p>No current measure of documentation of assessment.</p>
<p><b>Depression 15</b>  <b>IF</b> a person age 75 or older has no meaningful symptom response after 6</p>	<p>All patients 75 years and older who receive a new (in one year) diagnosis of depression (ICD -9- CM</p>	<p>Within 8 weeks of the date of the new diagnosis, documentation of follow-up on the depression and change</p>	<p>In ACOVE-1, 9 patients were eligible for this quality indicator and 22%</p>	<p>Supported by observational studies and guidelines and consensus conferences.</p>

<p>weeks of treatment, <b>THEN</b> one of the following treatment options should be initiated by the 8th week of treatment: medication dose should be optimized or changed, or the patient should be referred to a psychiatrist (if initial treatment was medication); or medication should be initiated or referral to a psychiatrist should be offered (if initial treatment was psychotherapy alone).</p>	<p>codes to be specified).</p>	<p>in medication or treatment modality if no improvement.</p>	<p>passed. In ACOVE-2 of 49 eligible patients, 18% passed.</p>	
<p><b>00XF7: Response to treatment of depression assessed, positive response to therapy</b></p> <p><b>00XF8: Response to depression therapy assessed, non-responder, depression treatment modified (e.g. medication initiated or changed, referral to mental health professional)</b></p>	<p>HEDIS with age added. The true denominator in this measure includes only non-responders so a G/Cat II code is used to define non-responders and also report action. One of the two codes would be required to be reported. The number of weeks is determined administratively by dates reported.</p>	<p>One of the two codes would be required to be reported.</p>		<p>HEDIS addresses visit frequency only. This would be a new measure.</p>
<p><b>End of life 1</b> <b>ALL</b> persons age 75 or older should have in their outpatient charts (1) an advance directive indicating the patient's surrogate decision maker/life-sustaining treatment preferences, or (2) documentation of a discussion about who would be a surrogate decision maker or a search for a surrogate/preferences, or (3) indication that there is no identified surrogate/preference.</p>	<p>All patients 75 years and older seeing a primary care physician for a new outpatient visit.</p>	<p>Documentation of end of life counseling or an advance directive or a surrogate in the outpatient medical record within 3 months of the outpatient visit.</p>	<p>In ACOVE-1, 370 patients were eligible for this quality indicator and 4 passed.</p>	<p>Supported by observational studies and guidelines and consensus conferences. There is no current measure.</p>

<p><b>S0257 Counseling and discussion regarding advance directives or end of life care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate Evaluation and Management service)</b></p> <p><b>00XF9: Advanced directives or discussion of advanced directives or preferred surrogate decision maker documented</b></p>	<p>Denominator defined by reporting of CPT codes 99201-99205 or 99387. Patient is aged 75 or older.</p>	<p>The date that the G/Cat II code is reported would be used in administratively calculating within 3 months</p> <p>(There is already an S code, but given that S codes are not widely used it would be advised to add the G/Cat II code. It would also be part of a code set if created. Ideally the language would be the same or the S code would be deleted ultimately.)</p>		
<p><b>Falls 3H</b> <b>IF</b> a person age 75 or older reported 2 or more falls in the past year, or a single fall with injury requiring treatment, <b>THEN</b> there should be documentation of a basic fall history.</p>	<p>All patients 75 years and older with a visit to an outpatient primary care provider with a fall () or injury related to a fall ()</p>	<p>Documentation about of a basic fall history on the date of the fall code that includes: (1) circumstances of the fall, (2) medications used, (3) chronic conditions potentially related to fall and (4) mobility.</p>	<p>In ACOVE-1, 57 patients were eligible for this quality indicator and 49% passed. In ACOVE-2 of 95 eligible patients, 53% passed.</p>	<p>Three randomized controlled trials, and several observational studies demonstrated that post-fall evaluation can identify treatable causes of falls and reduce the risk of subsequent falls.</p>
<p><b>00XXF10: Fall history documented ( use for patient with 2 or more falls or a single fall with injury)</b></p> <p><b>00XF11: Fall inquiry taken, less than two falls and no fall with injury in past year</b></p>	<p>Visit codes with certain diagnoses and certain injury codes for any encounter to any provider may be an option to define the denominator. The G/Cat II code pair would be a method to define both the denominator and the numerator</p>	<p>One of the two codes would be required to be reported in the G/Cat II pair method.</p> <p>The Appendix would list the required elements or the descriptor would include text as follows: “must include circumstances of the fall, medications used, chronic conditions potentially related to fall and mobility”.</p>		<p>There is no current measure</p>
<p><b>Falls 3E</b> <b>IF</b> a person age 75 or older reported 2 or more falls in the past year, or a</p>	<p>All patients 75 years and older with a visit to an outpatient primary care</p>	<p>Documentation about of a basic fall exam on the date of the fall code that includes: (1)</p>	<p>In ACOVE-1, 57 patients were eligible for this quality</p>	<p>Same as above</p>

single fall with injury requiring treatment, <b>THEN</b> there should be documentation of a basic fall examination that resulted in specific diagnostic and therapeutic recommendations.	provider with a fall () or injury related to a fall ()	orthostatic blood pressure, (2) vision exam, (3) gait exam, (4) balance exam, and (5) neurological exam.	indicator and 3% passed. In ACOVE-2 of 95 eligible patients, 23% passed.	
<b>00XF12: Falls examination documented</b>	Visit codes with certain diagnoses and certain injury codes for any encounter to any provider may be an option to define the denominator. The G/Cat II code pair (00XF11 and 00XF12) would be a method to define both the denominator and the numerator	One of the two codes would be required to be reported in the G/Cat II code method.		There is no current measure
<b>Malnutrition 3</b> IF a person age 75 or older has documented involuntary weight loss or hypoalbuminemia (< 3.5 g/dL), THEN she or he should receive an evaluation for potentially reversible causes of poor nutritional intake.	All patients 75 years and older with a visit to an outpatient primary care provider with a diagnosis of weight loss (ICD-9-CM codes to be specified) or new albumin level <3.5	Documentation concerning at least 4 of the following or a cause of the weight loss: thyroid disease, gastrointestinal diseases, cancer, dental status, food security, food-related functional status, appetite and dietary intake, swallowing ability, disease-related dietary restrictions (e.g., low salt, low protein). Dietary consultation confers credit.	In ACOVE-1, 13 patients were eligible for this quality indicator and 77% passed. In ACOVE-2 of 32 eligible patients, 78% passed.	Supported by observational studies and guidelines and consensus conferences.
<b>00XF13: Albumin (serum) less than 3.5 g/dl</b> <b>00XF14: Involuntary weight loss present, evaluation documented</b>	Office visit codes with a weight loss V code could define the denominator and 000XF13 could supplement that. Another option is to use the pair method where all	In the paired methodology 00XF14 or 00XF15 would be required.  Credit could be given for any patient with any encounter to		No current measure

<b>00XF15: Involuntary weight loss not present</b>	persons have the presence/absence of the condition reported.	a dietitian.  List the minimum standards of the evaluation in an Appendix.		
<b>Malnutrition 4</b> <b>IF</b> a person age 75 or older has documented involuntary weight loss or hypoalbuminemia (< 3.5 g/dL), <b>THEN</b> he or she should receive an evaluation for potentially relevant comorbid conditions including: medications that might be associated with decreased appetite (e.g., digoxin, fluoxetine, anticholinergics) depressive symptoms, and cognitive impairment.	All patients 75 years and older with a visit to an outpatient primary care provider with a diagnosis of weight loss () or new albumin level <3.5	Documentation concerning medications, affect and cognition.	In ACOVE-1, 33 patients were eligible for this quality indicator and 52% passed. In ACOVE-2 of 56 eligible patients, 13% passed.	Supported by observational studies and guidelines and consensus conferences.
<b>See notes: no codes proposed</b>		We would review specifying medication, affect and cognition as required elements of the evaluation in 00XF14. If a technical expert panel indicated two measures were necessary, we would then revise 00XF14, create 00XF16 and clarify the specified elements.		
<b>Osteoporosis 3</b> <b>All</b> female person age 75 or older should be counseled about her risk for osteoporosis and the potential need for pharmacologic prevention of osteoporosis at a new primary care visit.	All patients 75 years and older seeing a primary care physician for a new outpatient visit ().	Documentation of counseling about osteoporosis risk and pharmacologic prevention in their outpatient medical record within 3 months of the new outpatient visit.	In ACOVE-2 of 369 eligible patients, 57% passed.	RCTs support primary prevention. Guidelines support counseling in clinical practice.
<b>00XF16: Counseling about</b>	Denominator defined by			Current HEDIS measure is for fracture

<b>osteoporosis risk and pharmacologic prevention documented</b>	reporting of CPT codes 99201-99205 or 99387. Patient is aged 75 or older			follow-up care
<b>Osteoporosis 8</b> IF a person age 75 or older is newly diagnosed with osteoporosis, THEN the patient should be offered treatment with bisphosphonates, SERMs, calcitonin or hormone replacement therapy within 3 months of diagnosis.	All patients 75 years and older who receive a new (in one year) diagnosis of osteoporosis or a hip or vertebral fracture ().	Documentation of offer of treatment with bisphosphonates, SERMs, calcitonin or hormone replacement therapy within 3 months of diagnosis.	In ACOVE-1, 10 patients were eligible for this quality indicator and 60% passed. In ACOVE-2 of 47 eligible patients, 81% passed.	RCTs support treatment of osteoporosis to decrease fractures. Guidelines support counseling in clinical practice.
<b>00XF17: Pharmacologic therapy for osteoporosis offered</b>	List of ICD9 codes to be developed	If prescription claims data indicates a drug is in use either the G/Cat II code or drug claims history would meet the element.		Current HEDIS measure applies to post fracture care only
<b>Urinary Incontinence 3</b> IF a person age 75 or older has new UI that persists for over 1 month or UI at the time of a new evaluation, THEN a targeted history should be obtained that documents each of the following: (1) characteristics of voiding, (2) ability to get to the toilet, (3) prior treatment for urinary incontinence, (4) importance of the problem to the patient, and (5) mental status.	All patients 75 years and older who receive a new (in one year) diagnosis of urinary incontinence ().	Documentation about of a basic incontinence history that includes: (1) characteristics of voiding, (2) ability to get to the toilet, (3) prior treatment for urinary incontinence, (4) importance of the problem to the patient, and (5) mental status.	In ACOVE-1, 32 patients were eligible for this quality indicator and 19% passed. In ACOVE-2 of 37 eligible patients, 46% passed.	Supported by observational studies and guidelines and consensus conferences. UI is HEDIS via CAHPS and therefore is not provider oriented.
<b>00XF18: Urinary Incontinence history documented (includes each of the following: characteristics of voiding, ability to get to the toilet, prior treatment for urinary incontinence, importance of the problem to the patient, and mental</b>	Option to use ICD9 or to use code pair method	If code pair method, then one of the two must be reported.  Could eliminate required elements from G/Cat II descriptor and add the list to an appendix		HEDIS UI measure is CAHPS and thus does not yield provider specific quantitative data

status), UI present for over one month				
<b>00XF19: Urinary Incontinence assessed, UI not present for over one month</b>				
<b>Urinary Incontinence 4</b> <b>IF</b> a person age 75 or older has new UI that persists for over 1 month or UI at the time of a new evaluation, <b>THEN</b> a targeted physical exam should be performed that documents (1) a rectal exam and (2) a genital system exam (including a pelvic exam for women).	All patients 75 years and older who receive a new (in one year) diagnosis of urinary incontinence ().	Documentation about of a basic incontinence targeted physical exam should be performed that documents (1) a rectal exam and (2) a genital system exam (including a pelvic exam for women).	In ACOVE-1, 32 patients were eligible for this quality indicator and 22% passed. In ACOVE-2 of 37 eligible patients, 51% passed.	Supported by observational studies and guidelines and consensus conferences.
<b>00XF19: Urinary Incontinence physical examination documented</b>	Option to use ICD9 or to use code pair method	There are some current preventive care G codes that could be used in lieu of the QI code(s). Also it may be appropriate to give credit if the patient has seen a urologist.  Put required exam elements in an appendix		HEDIS UI measure is CAHPS and thus does not yield provider specific quantitative data.
<b>Urinary Incontinence 7</b> <b>IF</b> a cognitively intact person age 75 or older who is capable of independent toileting has documented stress, urge, or mixed incontinence without evidence of hematuria or high post-void residual, <b>THEN</b> behavioral treatment should be offered.	All patients 75 years and older who receive a new (in one year) diagnosis of urinary incontinence ().	Documentation of offer of behavioral treatment or reason that this could not be offered.	In ACOVE-1, 31 patients were eligible for this quality indicator and 13% passed. In ACOVE-2 of 26 eligible patients, 15% passed.	RCTs support behavioral treatment as the first type of treatment.
<b>00XF20: Behavioral therapy for</b>	Option to use ICD9 or to use	Multiple conditionals		HEDIS UI measure is CAHPS and thus

urinary incontinence offered	code pair method	<p>addressed by use of the CPT Category II modifier, 1P. Report either 00XF20 or 00XF20-1P.</p> <p>Instructions would state: “use 1P if behavioral therapy not offered because patient has hematuria, high PVR, is incapable of independent toileting, has insufficient cognitive capacity to participate in behavioral therapy or is already receiving behavioral therapy”.</p>		does not yield provider specific quantitative data.
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1. The ACOVE-1 sample consists of 420 vulnerable elders enrolled in two managed care plans for whom quality of care data were collected from July 1998 through July 1999. Of these, 372 individuals had complete (inpatient, outpatient, nursing home, home care and mental health) medical records available for abstraction and 276 were interviewed. The quality indicators for ACOVE were developed in 1998-9 based on structured literature review and a formal expert group judgment process.<sup>1</sup> Of 236 quality indicators, 207 were implemented by chart abstraction or interview.<sup>2</sup> Because all patients were alive at the end of the chart abstraction period, few quality indicators of end-of-life care were triggered. Vulnerable elders are community-dwelling individuals 65 years and older who, based on a 13-item function-based survey, are classified as at moderate to high risk of death or functional decline over the next two years.<sup>3</sup> Overall condition scores are presented for ACOVE-1, but not for ACOVE-2 because condition-level scores are not comparable between studies due to change in composition of quality indicators within condition.

2. The ACOVE-2 sample consists of 644 community-dwelling individuals age 75 years and older who received medical care from two large medical groups in Southern California. These individuals screened positive for at least one of the following conditions: multiple falls, fall with injury or fear of falling; urinary incontinence bothersome enough to desire medical attention; or poor 3-item recall or proxy-reported cognitive impairment. For these patients, all outpatient medical records were collected, with the exception of ophthalmology, dermatology and allergy care. Because ACOVE-2 was a controlled trial, medical records were collected in two phases: a 13-month baseline collection (September 2000 through September 2001 at site 1 and December 2000 through December 2001 at site 2) and, after a 6-month ramp-up period, an intervention phase (April 2002 through April 2003 at site 1 and July 2002 through August 2003 at site 2). A quality of care interview was conducted with 566 patients (or their proxies) at the end of the intervention phase. The ACOVE Clinical Committee updated the ACOVE quality indicators for the ACOVE-2 data collection in 2001. In ACOVE-2, 93 quality indicators were evaluated by medical record review or interview; there was no evaluation of quality indicators that required inpatient, nursing home or ophthalmology records, nor indicators with small N's or very high pass rates in ACOVE-1. The baseline quality evaluation was based on only medical

records; the intervention phase evaluation incorporated information from the interview, includes the intervention effect for falls, incontinence and dementia, and excludes 3 care processes that were integrated into the intervention.