

COA - CARE OF OLDER ADULTS



PURPOSE OF THE MEASURE

The percentage of adults 66 years of age and older who had each of the following during the measurement year (2026):

- Medication Review
- Functional Status Assessment
- Pain Assessment

***Functional Status Assessment and Pain Assessment may be completed during a telephone visit, e-visit, or virtual check-in.**



MEDICATION REVIEW

A medication review is defined as a review of all a member's medications, including prescription medications, over-the-counter (OTC) medications, and herbal or supplemental therapies, conducted by a prescribing practitioner or clinical pharmacist during the measurement year (2026) and the presence of a medication list in the medical record.

A medication list is described as a list of the member's medications in the medical record. The list may include medication names only or may include medication names, dosages and frequency, and may include prescription medications, over-the-counter (OTC) medications and herbal or supplemental therapies.

The medication review must be performed during the measurement year (2026).

- Documentation must come from the same medical record and must include one of the following:
 - ✓ A medication list in the medical record, and evidence of medication review by a prescribing practitioner (e.g., MD, Physician Assistant, Nurse Practitioner) or clinical pharmacist and the date it was performed.
 - ✓ Notation that a member is not taking any medications and the date in which it was noted

MEDICATION REVIEW

Acceptable Documentation for medication review:

- A medication list signed and dated in 2026 by the appropriate practitioner type meets criteria. The practitioner's signature is considered evidence that the medications were reviewed.
 - ❖ Do not use the date medications were added, started or stopped. It must be the date the doctor signed off to review the medications.
- A signed progress note in 2026 that has an embedded medication list is considered acceptable, even if it does not state medications were reviewed. It must be signed by an appropriate provider. The signature is considered evidence of the medication review.
- If a signed medication review is found in a progress note which is documented as being with an appropriate provider, the progress note itself is not required to be signed. There must be proof in the medical record it was a visit with an appropriate provider (name/credentials).
- A stand-alone medication list is acceptable for the medication list portion, but there must be further review in the form of a progress note with information about the member's medications.
- Medication Administration Records (MARs) from nursing homes or skilled nursing facilities are acceptable for medication list portion but need to have a review found with them.
- An outpatient visit is not required to meet criteria. The doctor may sign that he reviewed the stand-alone medication list without evidence of an outpatient visit.

MEDICATION REVIEW

Do not use:

- A review of side effects for a single medication at the time of prescription
- A stand-alone medication list that has dates when medications were started, stopped, refilled by the provider alone (must have evidence of review)
- The medication section on a Minimum Data Set (MDS) form even if a list is available
- Medication lists or reviews performed in an acute inpatient setting

ACCEPTABLE MEDICATION REVIEW EXAMPLES

The example below shows a medication list. If this was in a 2026 progress note signed by an acceptable provider, the provider signature counts as the medication review. Enter the date of the progress note.

Current Outpatient Prescriptions:

FREESTYLE LITE METER monitoring kit	
fluconazole (DIFLUCAN) 150 mg tablet	
FARXIGA 10 mg tab	TAKE 1 TABLET BY MOUTH EVERY DAY
ESTRACE 0.01 % (0.1 mg/gram) vaginal cream	
FREESTYLE LANCETS 28 gauge misc	
acyclovir (ZOVIRAX) 5 % ointment	Apply 1 application to affected area five times daily, to affected area as directed.
conjugated estrogens (PREMARIN) vaginal cream	To be used vaginally as directed.
lidocaine (XYLOCAINE) 5 % ointment	
amlODIPine (NORVASC) 10 mg tablet	
lidocaine 5 % gel	Apply 1 application to affected area twice daily.
amlODIPine (NORVASC) 5 mg tablet	Take 1 tablet by mouth once daily.
Lancets lancets	Use as instructed
blood sugar diagnostic (FREESTYLE LITE STRIPS) test strip	Checks blood sugar three times a day
metFORMIN (GLUCOPHAGE) 1,000 mg tablet	Take 1 tablet by mouth daily with breakfast.
gabapentin (NEURONTIN) 100 mg capsule	
Blood Pressure Monitor kit	1 Each once daily.
losartan (COZAAR) 50 mg tablet	Take 1 tablet by mouth once daily.
acyclovir (ZOVIRAX) 200 mg capsule	
TRUEPLUS LANCETS 30 gauge misc	
cholecalciferol (VITAMIN D-3) 2,000 unit tablet	Take 1 tablet by mouth once daily.

ACCEPTABLE MEDICATION REVIEW EXAMPLES

ASSESSMENT/PLAN:

1. Essential hypertension - ICD9: 401.9, ICD10: I10 (primary diagnosis)

- suboptimal control
- Continue current medication(s)
- Encouraged dietary sodium restriction/DASH diet
- Follow up in 1 month for BP recheck.
- Goal of BP <130/80

2. Controlled type 2 diabetes mellitus without complication, without long-term current use of insulin (HCC) - ICD9: 250.00, ICD10: E11.9
uncontrolled

- Continue current medications increase metformin to 1000 mg q am and 500 mg q hs
- A1C 7.4!

This example shows an Assessment/Plan that says, "Continue current medications," and "Increase Metformin." Those statements count as the review of the medications. If this progress note had a medication list in it, this would be acceptable for the medication review.

ACCEPTABLE MEDICATION REVIEW EXAM

Medication Name	sig Description	Start Date	Stop Date	Refilled	Rx Elsewhere
Wellbutrin XL 100 mg 24 hr tablet	take 1 tablet by oral route for tablet, extended release	/			Y
propranolol 10 mg tablet	take 1 Tablet by oral route 3 times every day	/			Y
Suboxone 8 mg-2 mg buprenorphine film	place 1 film by sublingual route every day allow to dissolve	/			Y

Medication Reconciliation

Medications reconciled today

FUNCTIONAL STATUS ASSESSMENT

Documentation in the medical record must include evidence of a complete functional status assessment and the date on which it was performed.

Any one of the below will count:

- Notation that Activities of Daily Living (ADL) were assessed OR that at least five of the following were assessed during the measurement year (2026):
 - Bathing
 - Dressing
 - Eating
 - Transferring (e.g., getting in and out of chairs)
 - Using toilet
 - Walking
- The components may come from more than one visit in the measurement year (2026).
- •Notation of functional independence does count for ADL assessment

FUNCTIONAL STATUS ASSESSMENT

Examples of Functional Status Assessment (continued):

- Notation that Instrumental Activities of Daily Living (IADL) were assessed OR at least four of the following were assessed during the measurement year (2026):
 - Shopping for groceries
 - Driving or using public transportation
 - Using the telephone
 - Stating that the member did a telephone interview is not acceptable.
 - Cooking or meal preparation
 - Housework
 - Home repair
 - Laundry
 - Taking medications
 - Stating that the member is "taking medications as prescribed" is acceptable.
 - Handling finances
- The components may come from more than one visit in the measurement year (2026)

FUNCTIONAL STATUS ASSESSMENT

Examples of Functional Status Assessment (continued):

- ✓ SF-36'
- ✓ Assessment of Living Skills and Resources
- ✓ (ALSAR)
- ✓ Barthel ADL Index Physical Self-Maintenance
- ✓ Scale (ADLS)
- ✓ Bayer ADL Scale (B-ADL)
- ✓ Barthel Index
- ✓ Edmonton Frail Scale
- ✓ Extended ADL Scale (EADL)
- ✓ Groningen Frailty Index
- ✓ Independent Living Scale (ILS)

Result of assessment using a standardized functional status assessment tool, not limited to the following list:

- ✓ Katz Index of Independence in ADL
- ✓ Kenny Self-Care Evaluation
- ✓ Klein-Bell ADL Scale
- ✓ Kohlman Evaluation of Living Skills (KELS)
- ✓ Lawton & Brody's IADL Scales
- ✓ Patient Reported Outcome Measurement
- ✓ Information System (PROMIS) Global or
- ✓ Physical Function Scales

FUNCTIONAL STATUS ASSESSMENT THAT MEETS CRITERIA

- Notation that activities of daily living or instrumental activities of daily living were assessed.
- At is acceptable to have ADLs or IADLs that occur on different dates of service during separate visits with the same or different providers (within the same or different medical groups/practices) as long as all the required components (i.e at least 5 of the listed ADLs) occurred during the MY 2026.
 - ❖ A medical record documenting ADL's: Independent or IADL's Independent would be compliant for the Functional Status Assessment because it specifically stated that the ADLs and IADLs were assessed.
 - ❖ A note stating a member "needs assistance with activities of daily living" is acceptable because it shows that the ADLs were assessed.
 - ❖ A note stating that the member is total care. needs assistance the ADLs is acceptable.
- Functional status assessments rendered during a telephone visit, e-visit, or virtual check-in does not meet criteria for the measure

KEY NOTES

- ❖ The functional status assessment can be done by any provider type. This includes RN or LPN assessments in a skilled nursing facilities or homecare settings, and internal case management records.
- ❖ If "ADL" or "IADL" is not specifically stated in the documentation search the medical records for the ADL/IADL components. The documentation must be specific enough to indicate the required number of components were assessed (i.e. at least 5 of the listed ADL or 4 IADL listed)
- ❖ Addressing a member's hygiene needs" can be substituted for the "bathing" component of functional status

If a Katz screening is documented (as seen below), only enter on the screening tool line and choose Katz. You would not enter this for ADLs or the components. Only enter each screening for one component. The screening below it is a Lawton-Brody screening. Since we have a screening tool already entered, it could be entered as the IADL component. Or vice versa (enter Lawton-Brody and then enter ADLs for the Katz).

If assessments were found on separate visits, or separate listings, then you could enter all on the separate lines. This is from one assessment, so enter each screening one time, not on all components.

FUNCTIONAL STATUS ASSESSMENT

FUNCTIONAL STATUS ASSESSMENT

Functional Status Assessment is assessing the member's ability to do activities, not the member's means to do activities.

For example, managing finances can mean any of the following:

- Can the member write the checks out?
- Can the member drive to the place to pay bills?
- Can the member use the internet to pay bills?
- Can the member handle banking?

This does not mean does the member has insufficient funds.

For example, transportation means:

- Can the member drive?
- Can the member get on a bus and get to place(s) they need to go?

It does not mean does the member have a car or a lack of one.

The examples to the right are not assessing their functional ability, but rather their means to get things done. These examples would not count for transportation or managing finances.

Financial Resource Strain: Low Risk

- Difficulty of Paying Living Expenses: Not very hard

Food Insecurity: No Food Insecurity

- Worried About Running Out of Food in the Last Year: Never true
- Ran Out of Food in the Last Year: Never true

Transportation Needs: No Transportation Needs

- Lack of Transportation (Medical): No
- Lack of Transportation (Non-Medical): No

Physical Activity: Inactive

- Days of Exercise per Week: 0 days
- Minutes of Exercise per Session: 0 min

Stress: Stress Concern Present

ACCEPTABLE FUNCTIONAL STATUS ASSESSMENT EXAMPLES

ACTIVITIES OF DAILY LIVING

BATHING - Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.	Dependent
DRESSING - Needs help with dressing self or needs to be completely dressed.	Dependent
TOILETING - Needs help transferring to the toilet, cleaning self, or uses bedpan or commode.	Dependent
TRANSFERRING - Needs help in moving from bed to chair or requires a complete transfer.	Dependent
CONTINENCE - Is partially or totally incontinent of bowel or bladder.	Dependent
FEEDING - Needs partial or total help with feeding or requires parenteral feeding.	Dependent
Total Score	0
In the last week, have you needed help to perform any of your usual activities like getting dressed, bathing, grooming, eating, using the toilet, walking or getting in or out of your chair or bed?	Yes

- Answer : Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight
- Question : Dressing Upper Body - How dresses and undresses (street clothes, underwear) above the waist, including prostheses, orthotics, fasteners, pullovers, etc.
- Answer : Independent, setup help only - Article or device provided or placed within reach, no physical assistance or supervision in any episode
- Question : Dressing Lower Body - How dresses and undresses (street clothes, underwear) from the waist down including prostheses, orthotics, belts, pants, skirts, shoes, fasteners, etc.
- Answer : Independent, setup help only - Article or device provided or placed within reach, no physical assistance or supervision in any episode
- Question : Walking - How walks between locations on same floor indoors
- Answer : Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight
- Question : Locomotion - how moves between locations on same floor (walking or wheeling). If in wheelchair, self-sufficiency once in chair
- Answer : Limited assistance - Guided maneuvering of limbs, physical guidance without taking weight
- Question : Transfer toilet - How moves on and off toilet or commode
- Answer : Independent, setup help only - Article or device provided or placed within reach, no physical assistance or supervision in any episode
- Question : Toilet use - How uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjust clothes EXCLUDE TRANSFER ON AND OFF TOILET
- Answer : Independent, setup help only - Article or device provided or placed within reach, no physical assistance or supervision in any episode
- Question : Bed mobility - How moves to and from lying position, turns side to side, and positions body while in bed
- Answer : Independent, setup help only - Article or device provided or placed within reach, no physical assistance or supervision in any episode
- Question : Eating - How eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral

UNACCEPTABLE FUNCTIONAL STATUS ASSESSMENT EXAMPLE

Example:

This is an example of a functional status assessment that is limited to an acute condition (s/p total knee replacement). There are several items listed by the provider:

- ✓ Uses walker to ambulate
- ✓ Needs assistance with meal prep, bathing, dressing, shopping, laundry, housekeeping.
- ✓ Able to transfer and use the bathroom on her own because of her walker

These cannot be counted as they all relate to the acute condition (total knee surgery).

History of Present Illness:

1. forms

Pt is s/p R Total knee replacement surgery

She uses a walker to ambulate

She continues to have moderate to severe pain in her R knee

She is in physical therapy

Her Orthopedic surgeon is also planning to operate on her Left knee in the future

Pt currently lives with her daughter who is her caretaker **since surgery**

Pt needs assistance with meal prep, bathing, dressing, shopping, laundry, housekeeping

She is able to transfer and use the bathroom on her own because of her walker, but she has to do so carefully and slowly



PAIN SCREENING

Evidence of a pain screening/assessment may include any of the following in 2026:

- Documentation that the patient was assessed for pain (which may include positive or negative findings for pain).
- Results of assessment using a standardized pain screening tool, not limited to the below:
 - ✓ Numeric rating scales (verbal or written)
 - ✓ Face, Legs, Activity, Cry Consolability (FLACC) scale
 - ✓ Verbal descriptor scales (5-7 Word Scales, Present Pain Inventory)
 - ✓ Pain thermometer
 - ✓ Pictorial pain scales (Faces Pain Scale, Wong-Baker Pain Scale)
 - ✓ Visual analogue scale
 - ✓ Brief Pain Inventory
 - ✓ Chronic Pain Grade
 - ✓ PROMIS Pain Intensity Scale
 - ✓ Pain Assessment in Advanced Dementia (PAINAD) Scale

PAIN SCREENING

Acceptable Documentation for Pain:

- A negative or positive pain assessment is acceptable.
- Pain can be acute or chronic.
- The pain may be related to the reason for the visit (e.g., patient fell down the steps today and her leg is in pain).
- Aches, -algias, and tenderness are acceptable. In general, any description of any type of pain on the part of the member satisfies this element.

Do Not Use:

- A notation of a pain management plan alone
- A notation of a pain treatment plan alone
- Notation of screening for chest pain or documentation of chest pain alone — the presence of chest pain does not satisfy this element. This is the only type of documented pain which does not do so.
- Pain assessments performed in an acute inpatient setting

ACCEPTABLE PAIN SCREENING EXAMPLES

Example 1:

- This example shows a pain screening with a pain scale, as well as other documentation of pain. This is acceptable if found in 2024.

PAIN	
Pain Scale	3
Quality of pain	Cramping
Pattern of pain	Intermittent
Pain Location	Right leg
Intervention	No
Other findings	Not applicable

Example 2:

- This example shows a ROS that states the member has chronic pain in her knees and hips. Any type of pain assessment is acceptable, except chest pain. This is acceptable to enter if found in 2024.

Chronic Pain: Yes, describe
Knees, hips/arthritis

Example 3:

- This example shows a member in for follow-up after surgery. She is still having pain in her knee. This is acceptable even though it is related to the reason for the visit.

History of Present Illness:

1. forms

Pt is s/p R Total knee replacement surgery
She uses a walker to ambulate
She continues to have moderate to severe pain in her R knee

Example:

This example shows an assessment of chest pain in the review of systems. This is not acceptable for pain screening. Chest pain is the only unacceptable pain assessment.

REVIEW OF SYSTEMS		
System	Neg/Pos	Details
Constitutional	Negative	Chills, fever and malaise.
Respiratory	Negative	Cough and dyspnea.
Cardio	Negative	Chest pain.

UNACCEPTABLE PAIN SCREENING EXAMPLES

UNACCEPTABLE PAIN SCREENING EXAMPLES

Example:

This is an example of a pain assessment performed in an inpatient setting. This is unacceptable for pain screening.

ADMISSION NOTE	
M.D.:	Pager:
Date:	Time:
Chief Complaint: twitching	Primary MD:
	Emergency Contact:
	Code Status:
History of Present Illness: This is a 51 year old woman with a history of lupus, lupus nephritis, and cadaveric renal transplant in 2000 who now presents with 2 weeks of worsening twitching. The patient describes starting neurontin for headaches approximately 3 weeks ago. She subsequently noted first subtle twitching of an extremity or her face. The movements have progressed to include difficulty speaking, dysarthria ("I couldn't say what I was thinking") and difficulty walking. The patient has also noticed worsening fatigue, a change in her skin ("It's ashy") and worsening edema (including LE and peri-orbital). On Friday the patient called the transplant nurse who recommended she come to the Emergency room. There, she was seen by neuro, who felt most of her symptoms were most likely related to worsening renal failure with gabapentin. They also noted b/l ptosis and findings suggestive of a peripheral neuropathy. The patient reports no improvement in symptoms since arrival.	Review of Systems: ☐ positive ☐ negative Constitutional: -ABO- Fever, Chills, Night Sweats, Fatigue Weight Loss, Weight Gain, Heat Intolerance, Cold Intolerance Neuro: Headache, Seizures, Syncope, Lightheaded, Vertigo, Dizziness, Tremor, Weakness, Numbness, Tingling HEENT: Vision change, Diplopia, Cataracts

EXCLUSIONS

- Member died during 2026
- Members who use hospice services or elect to use a hospice benefit anytime during the measurement year (2026), regardless of when services performed
- Palliative care is not considered the same as hospice care.