

**American Geriatrics Society/ Physician Consortium for Performance Improvement®/
National Committee for Quality Assurance**

**Geriatrics
*Physician Performance Measurement Set***

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**Geriatrics
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Geriatrics
Revised Measure # 2: Advance Care Plan
Appropriate for all healthcare settings [except for the emergency department](#)

This measure may be used as an Accountability measure.

Clinical Performance Measure
<p>Numerator: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan</p> <p>Definition: Documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. This documentation in the medical record could also include as appropriate that the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.</p> <p>Denominator: All patients aged 65 years and older</p> <p>Denominator Exclusions: None</p> <p>Measure: Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan</p>
<p>The following clinical recommendation statements are quoted <u>verbatim</u> from the referenced clinical guidelines and represent the evidence base for the measure:</p> <p>The National Hospice and Palliative Care Organization provides the Caring Connection web site (www.caringinfo.org). This web site provides resources and information on end-of-life care, including a national repository of state by state advance directives.</p> <p><u>Advance directives</u> are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.</p> <p>Oral statements</p> <ul style="list-style-type: none">• Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.• Properly verified oral statements carry same ethical and legal weight as those recorded in writing. <p>Instructional advance directives (DNR orders, living wills)</p> <ul style="list-style-type: none">• Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.• May be revoked or altered at any time by the patient.• Clinicians who comply with such directives are provided legal immunity for such actions. <p>Durable power of attorney for health care or health care proxy</p> <ul style="list-style-type: none">• A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS¹)
<p>Rationale for the measure:</p> <p>It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. the Work Group has determined that the measure should remain as specified with no required time frame based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change, ^{2, 3, 4, 5, 6, 7, 8, 9} In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno 1997) than the risk that an established plan has become outdated that we should not define a specific time frame at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific time frame should be included. Data elements required for the measure can be captured and the measure is actionable by the physician.</p>

Data capture and calculations:

Calculation for Performance

For performance purposes, this measure is calculated by creating a fraction with the following components: Numerator, Denominator, and Denominator Exclusions.

Numerator (A) Includes:

- Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Denominator (PD) Includes:

- Patients who are 65 years and older

Performance Calculation

$$\frac{\text{A (\# of patients meeting numerator criteria)}}{\text{PD (\# of patients in denominator)}}$$

Components for this measure are defined as:

A	# of patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
PD	# of patients aged 65 years and older

Calculation for Reporting

For reporting purposes, this measure is calculated by creating a fraction with the following components: Reporting Numerator and Reporting Denominator

Reporting Numerator includes each of the following instances:

A. Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

D. Patients who do not have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan have a risk assessment for falls completed and there is no documented reason for not doing so

Reporting Denominator (RD) Includes:

- Patients aged 65 years and older

Reporting Calculation

$$\frac{\text{A(\# of patients meeting additional denominator criteria AND numerator criteria) + D(\# of patients NOT meeting numerator criteria)}}{\text{RD (\# of patients in denominator)}}$$

Components for this measure are defined as:

A	# of patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
D	# of patients who do not have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but

	patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
RD	# of patients aged 65 years and older

Measure Specifications – Revised Measure #2: Advance Care Plan

Measure specifications will be provided for multiple data sources.

A. Administrative claims data

Administrative claims data collection requires users to identify the eligible population (denominator) and numerator using codes recorded on claims or billing forms (electronic or paper). Users report a rate based on all patients in a given practice for whom data are available and who meet the eligible population/denominator criteria.

(Note: The specifications listed below are those needed for performance calculation.)

Denominator (Eligible Population): All patients aged 65 years and older

- E/M codes: 99201-99205, 99212-99215, 99218- 99223, 99231-99236, ~~99281-99285~~, 99291, 99304-99310, 99324-99328, 99334-99337, 99341-99345, 99347-99350, 99387, 99397, 99401-99404

Denominator Exclusion: None

Numerator: Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

- Report the CPT Category II codes designated for this numerator:
 - **1123F**: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record
 - **1124F**: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

B. Electronic Health Record System (*in development*)

C. Paper Medical Record (*in development*)

INFORMATION ON DEVELOPMENT METHODOLOGY FOR NON-RATED GUIDELINES – END OF LIFE CARE

American Geriatrics Society (AGS) Geriatrics at your fingertips Statement on Methodology⁵

Geriatrics at your fingertips does not attempt to explain in detail the rationale underlying the strategies presented. In many instances, these strategies have been derived from guidelines published by organizations such as the Agency for Healthcare Research and Quality, the American Geriatrics Society, the American Heart Association, and the American Diabetes Association. Many of the guidelines can be obtained from the National Guideline Clearinghouse (<http://www.guidelines.gov>). When no such guidelines exist, the strategies recommended herein represent the best opinions of the authors and the experts they have asked to review the chapters. In an effort to be comprehensive yet concise, references have been provided sparingly, but many others that are relevant are available from the organizations mentioned or in the most recent edition of the AGS *Geriatrics Review Syllabus*.

REFERENCES

¹ American Geriatrics Society (AGS). Geriatrics at your fingertips: Palliative and end-of-life care. In: Reuben DB, Herr KA, Pacala JT, Pollock BG, Potter JF, Semla TP, eds. Online edition: Geriatrics at your fingertips. 2006-2007; 8th edition. Available at: <http://www.geriatricsatyourfingertips.org>.