Advance Care Planning (ACP)

**Goal:** To increase the percentage of adults 66 years and older who had an annual discussion about preferences for resuscitation, life-sustaining treatment, and end of life care in the measurement year.

*Members in hospice are excluded from the eligible population*
*Services rendered during a Telehealth visit is acceptable for measure*

**Measurement Requirements:**

**Advanced Care Planning**

- Presence of advanced care plan in record **OR**
- Documentation of advanced care planning **discussion** and date performed **in 2023** **OR**
- Notation of previously executed advanced care plan

**To achieve this goal, Mercy Care Advantage:**

- PCP annual wellness visit letter detailing advance directive topics
- Annual Wellness Visit webinar with PCP’s
- Member brochure “Getting the most out of your Annual Visit” to improve member compliance and enhance PCP/member relationship
- Provider Newsletter article to improve compliance through provider awareness
- HEDIS Gaps in Care Reports available to providers through Mercy Care Plan website secure provider portal containing a comprehensive list of members needing care
- Member Health and Wellness Calendar to increase member awareness and importance of completing an advanced directive
- Assessment questions on advanced directives in Case Tracker Dynamo completed by the Case Management Staff
- COA supplemental mapping of HEDIS data collection

**Evidence of advanced care planning must include ONE of the following THREE:**

- The presence of an advanced care plan
  - Advanced Directive: Living Will, healthcare power of attorney, health care proxy
  - Actionable medical orders: written instructions initiating, continuing withholding, or withdrawing specific forms of life-sustaining treatment (e.g., Physicians Orders for Life sustaining Treatment (POLST), Five Wishes)
  - Living Will
  - Surrogate decision maker – A written document designating someone other than the member to make medical treatment choices (not just future treatment choices)

**OR**

- Documentation of an advanced care planning discussion with the provider and the date it was discussed in the measurement year
o Notation of a discussion or initiation of a discussion by a provider
o Oral statements such as conversations with relatives or friends about life-sustaining treatment and end-of-life care, or patient designation of an individual who can make decisions on behalf of the patient, documented in the medical record

OR

• Notation that the member previously executed an advanced care plan

Documentation that a member declined to discuss advance care planning is considered evidence that the provider initiated a discussion and meets criteria.

Documentation that a provider asked the member if an advance care plan is in place, and the member indicated that a plan is not in place is not considered a discussion or initiation of a discussion.

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