2024 Workflow Workshop Webinar Series

MIPS CQM 47:
Advanced Care Plan

Agenda

MIPS CQM 47: Advance Care Plan

- Measure Overview
- Measure Specifications
- Recommended Workflow
- Exclusion Workflow

MIPS CQM 47: Advanced Care Plan

Measure Overview

Advanced Care Plan	
Description	Percentage of patients aged 65 years or 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.
Exclusion	Hospice/Inpatient services received by patient any time during the measurement period
Points Available	Up to 10

Note: This measure is to be documented at least **once** per performance year

Measure Specifications

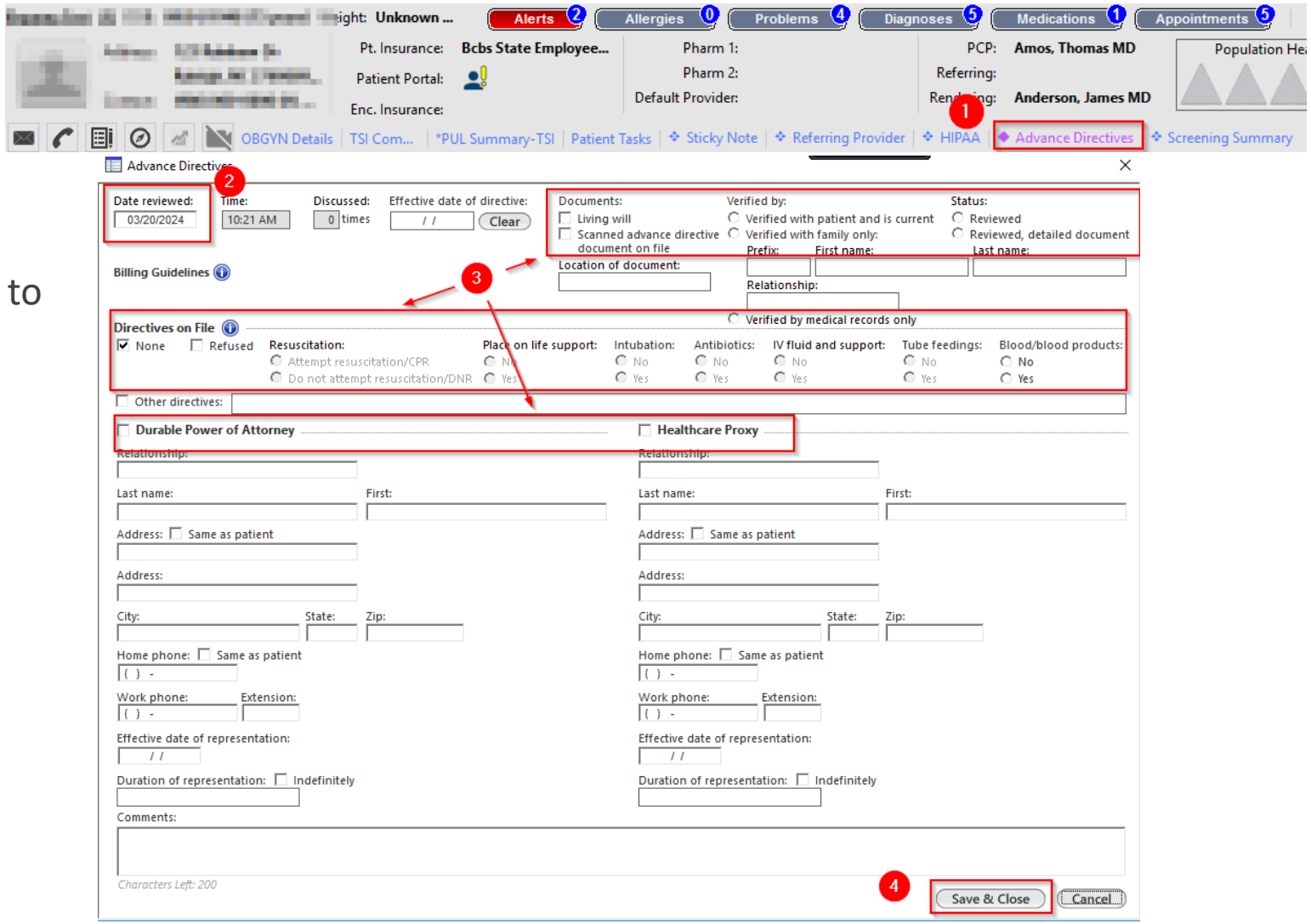
Denominator	Numerator
• All patients aged 65 years and older **AND** • Patient encounter during the performance period	• Patients who have an advance care plan or surrogate decision maker documented in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

Special Note: For a complete list of qualifying encounters, please reference the measure papers

Recommended Workflow

Scenario 1: Document Advanced Care Plan Details

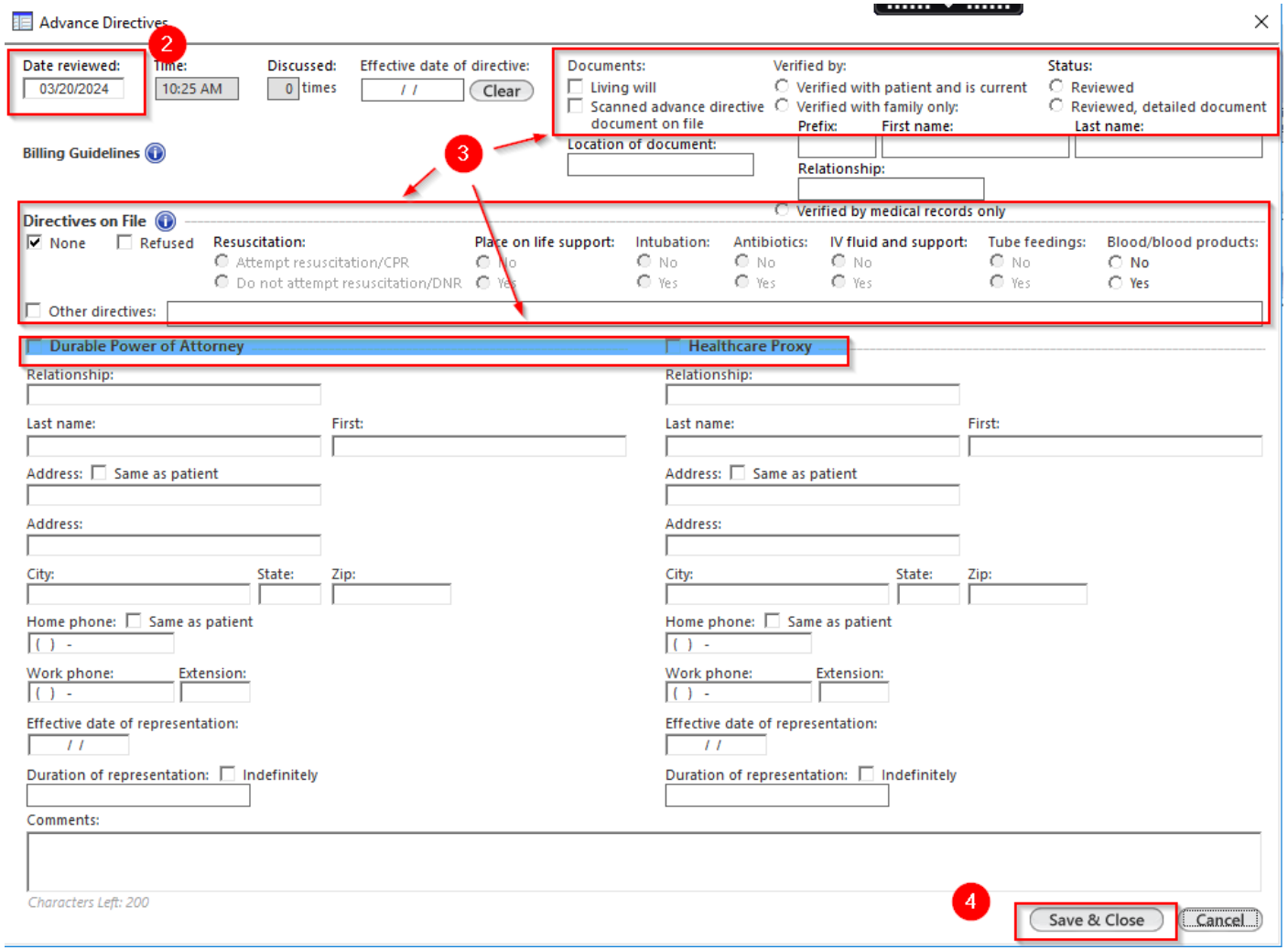
1. From the *Intake* template, select **Advance Directives** active text link on the Patient Info Bar to open the *Advance Directives* popup
2. Enter the Date Reviewed in the **Date** field
3. Select Any Advanced Directives options as outlined (all areas are not required)
4. Click **Save & Close** button



Recommended Workflow

Scenario 1: Document Advanced Care Plan Details

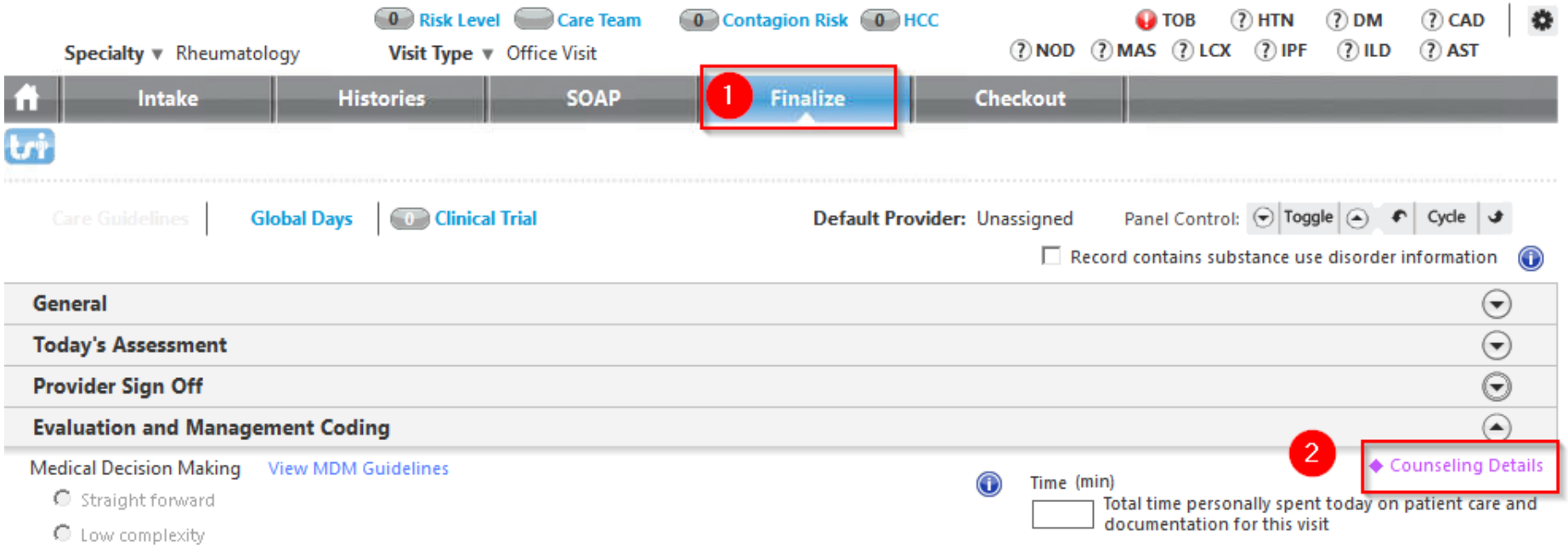
- **QP Tip:**
  - Since many patients will not have an actual advanced directive document available, the easiest workflow is to **document the Durable Power of Attorney OR Healthcare Proxy** (a legal document that allows someone to make healthcare decisions for you)
- This information can be collected as part of standard intake forms



Recommended Workflow

Scenario 2: Document Counseling - Refusal

1. On Finalize template
2. Click on Counseling link

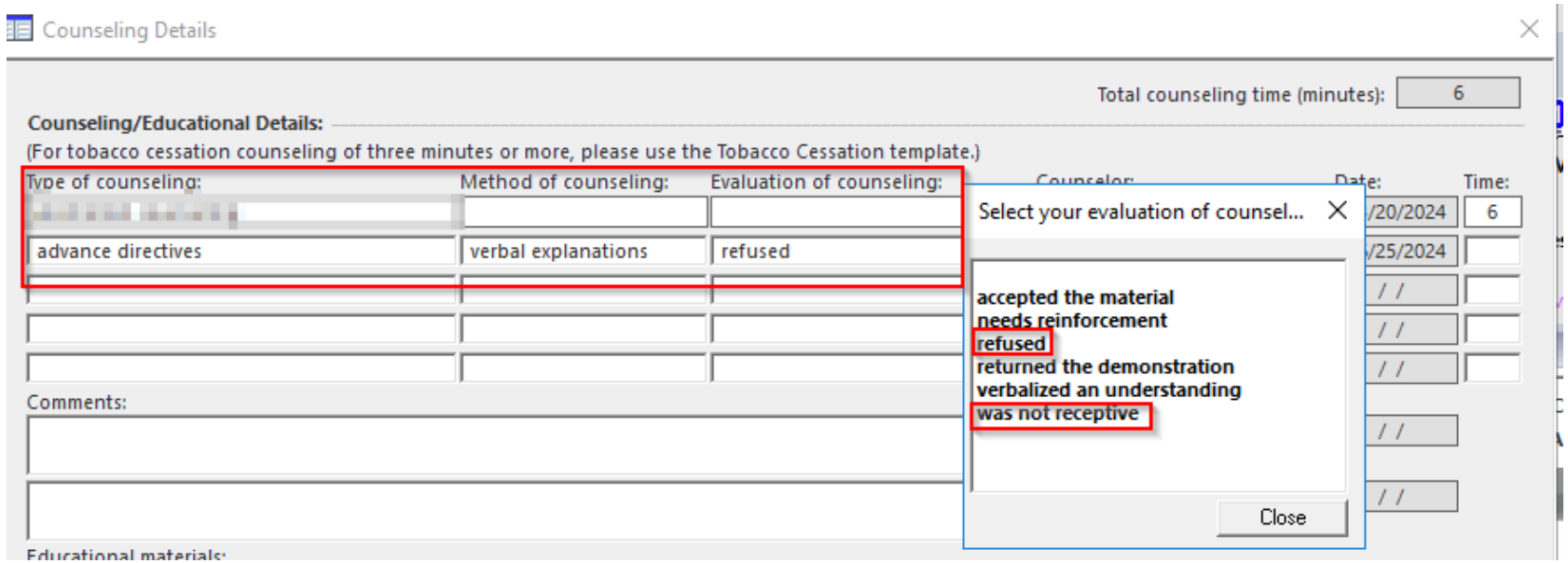


Recommended Workflow

Scenario 2: Document Counseling - Refusal

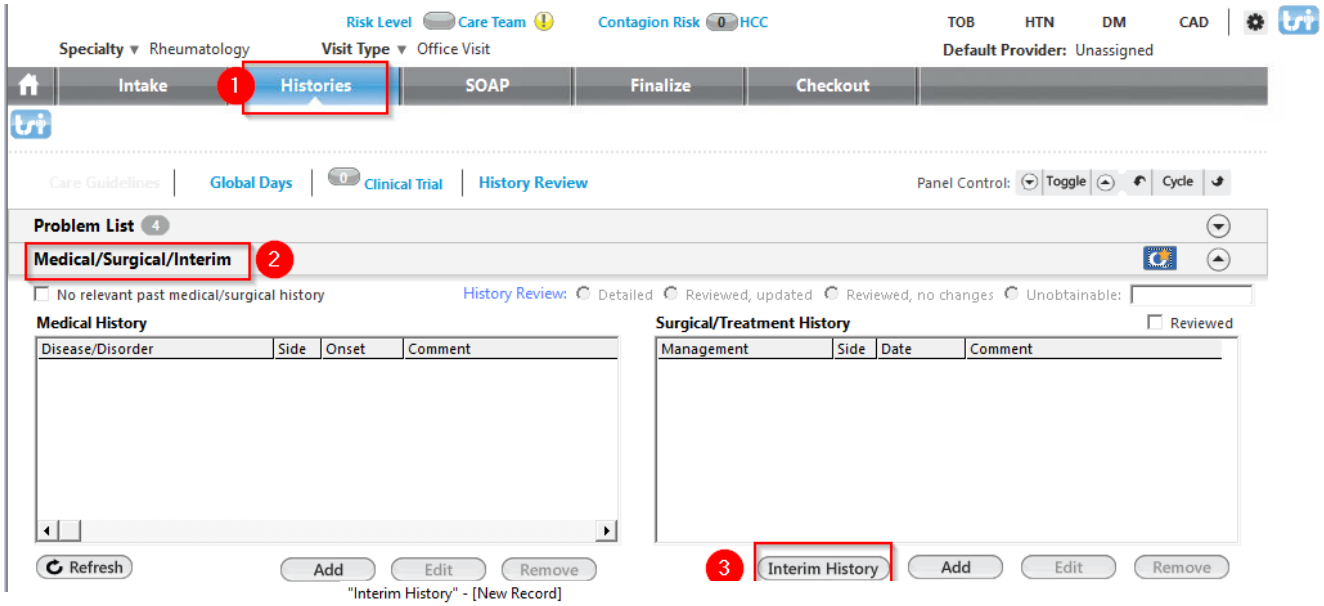
3. Select **patient refused** or **was not receptive** on the **Evaluation of counseling** evaluation field to document patient refused or not receptive

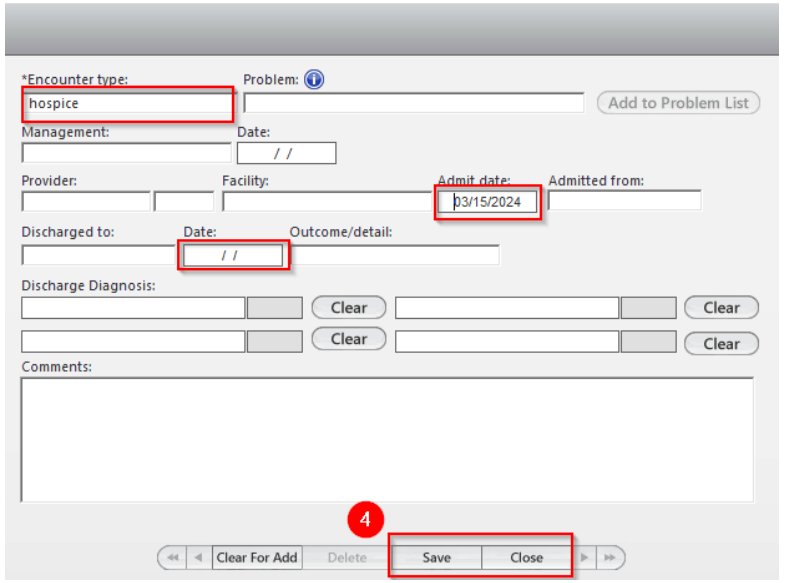
4. Click **Save & Close** button



Exclusions Workflow: Option 1

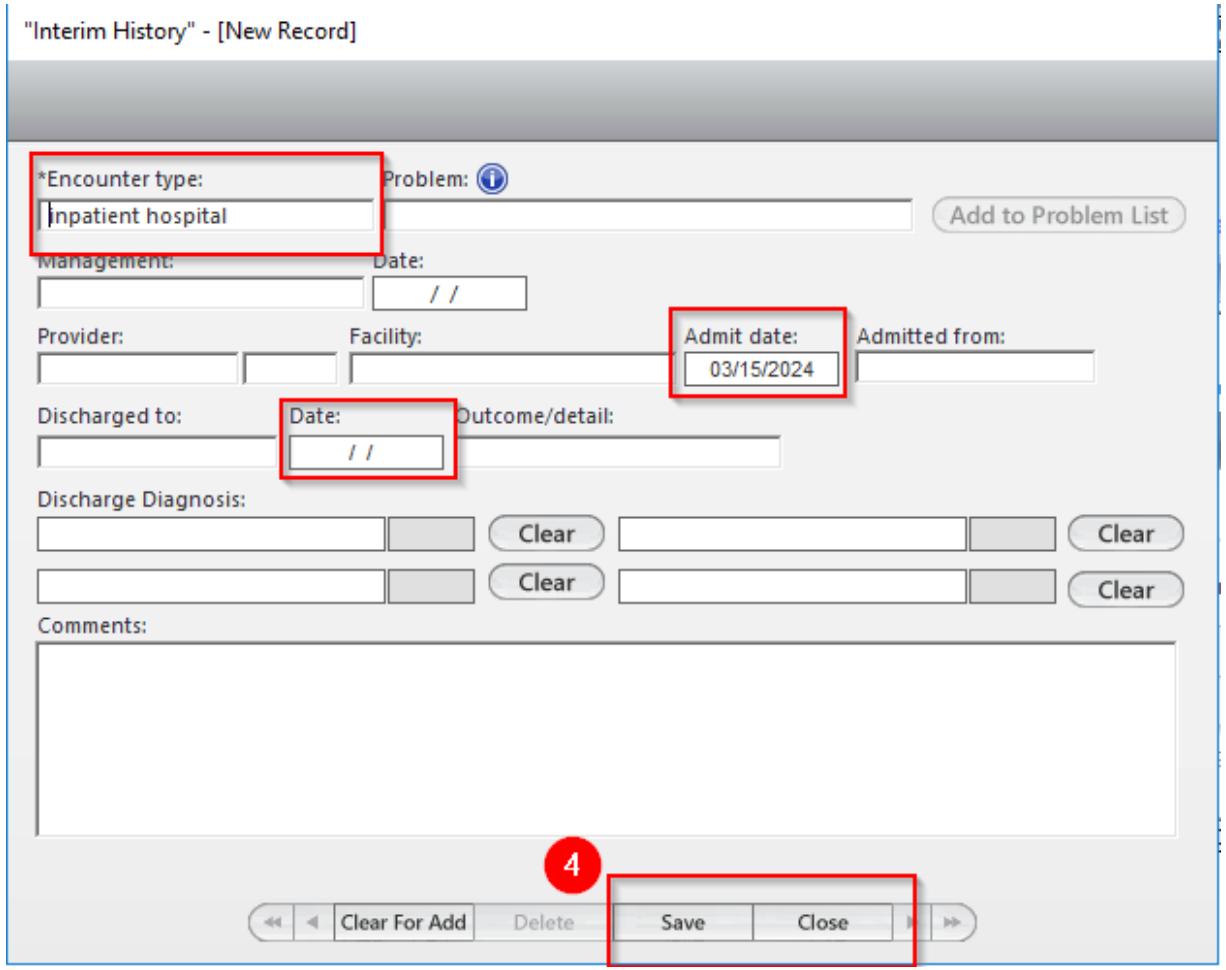
1. From the Histories template, select the Interim History link on the Medical/Surgical/Interim panel
2. Select hospice as the encounter type
3. Enter the Admit date, or the Discharge date
4. Click **Save & Close**





Exclusions Workflow: Option 2

1. From the Histories template, select the Interim History link on the Medical/Surgical/Interim panel
2. Select inpatient as the encounter type
3. Enter the Admit date, or the Discharge date
4. Click **Save & Close**



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