



# 2024 Workflow Workshop Webinar Series

MIPS CQM 47:  
Advanced Care Plan



# Agenda

## MIPS CQM 47: Advance Care Plan

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- Measure Overview

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- Measure Specifications

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- Recommended Workflow

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- Exclusion Workflow

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# 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

<u>Denominator</u>	<u>Numerator</u>
<ul style="list-style-type: none"><li>All patients aged 65 years and older</li></ul> <p><b>AND</b></p> <ul style="list-style-type: none"><li>Patient encounter during the performance period</li></ul>	<ul style="list-style-type: none"><li>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</li></ul>

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

The screenshot shows the 'Advance Directives' form with the following sections and fields:

- Patient Info Bar:** Includes tabs for Alerts, Allergies, Problems, Diagnoses, Medications, and Appointments. The 'Advance Directives' link is highlighted with a red box and number 1.
- Date reviewed:** A field with the date '03/20/2024' entered, highlighted with a red box and number 2.
- Directives on File:** A section with checkboxes for 'None' (checked) and 'Refused'. It includes sub-sections for Resuscitation, Place on life support, Intubation, Antibiotics, IV fluid and support, Tube feedings, and Blood/blood products. This section is highlighted with a red box and number 3.
- Save & Close:** A button at the bottom right of the form, highlighted with a red box and number 4.

# 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

**Advance Directives**

**1** Date reviewed: 03/20/2024 Time: 10:25 AM Discussed: 0 times Effective date of directive: / / Clear

**2** Documents: ☐ Living will ☐ Scanned advance directive document on file Verified by: ☐ Verified with patient and is current ☐ Verified with family only: Status: ☐ Reviewed ☐ Reviewed, detailed document Prefix: First name: Last name:

**3** Location of document: Relationship: Verified by medical records only

**Directives on File** ☒ None ☐ Refused Resuscitation: ☐ Attempt resuscitation/CPR ☐ Do not attempt resuscitation/DNR Place on life support: ☐ No ☐ Yes Intubation: ☐ No ☐ Yes Antibiotics: ☐ No ☐ Yes IV fluid and support: ☐ No ☐ Yes Tube feedings: ☐ No ☐ Yes Blood/blood products: ☐ No ☐ Yes

☐ Other directives:

**Durable Power of Attorney** Relationship: Last name: First: Address: ☐ Same as patient City: State: Zip: Home phone: ☐ Same as patient Work phone: Extension: Effective date of representation: Duration of representation: ☐ Indefinitely Comments:

**Healthcare Proxy** Relationship: Last name: First: Address: ☐ Same as patient City: State: Zip: Home phone: ☐ Same as patient Work phone: Extension: Effective date of representation: Duration of representation: ☐ Indefinitely Comments:

**4** Save & Close Cancel

Characters Left: 200

# Recommended Workflow

## Scenario 2: Document Counseling - Refusal

1. On Finalize template
2. Click on Counseling link

The screenshot displays the NextGen Healthcare interface for a patient visit. The top navigation bar includes tabs for Intake, Histories, SOAP, Finalize (highlighted with a red box and the number 1), and Checkout. Above the navigation bar, there are filters for Specialty (Rheumatology), Visit Type (Office Visit), and various clinical indicators (Risk Level, Care Team, Contagion Risk, HCC, TOB, HTN, DM, CAD, NOD, MAS, LCX, IPF, ILD, AST). Below the navigation bar, there are sections for Care Guidelines, Global Days, Clinical Trial, Default Provider (Unassigned), and Panel Control (Toggle, Cycle). A checkbox for 'Record contains substance use disorder information' is also visible. The main content area shows a list of sections: General, Today's Assessment, Provider Sign Off, and Evaluation and Management Coding. Below this, there are radio buttons for 'Straight forward' and 'Low complexity'. A 'Time (min)' field is present, with a label 'Total time personally spent today on patient care and documentation for this visit'. The 'Counseling Details' link is highlighted with a red box and the number 2.



# 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

The screenshot shows the 'Counseling Details' form. The 'Evaluation of counseling' field is highlighted with a red box, and the option 'refused' is selected. A dropdown menu is open, showing the following options: 'accepted the material', 'needs reinforcement', 'refused', 'returned the demonstration', 'verbalized an understanding', and 'was not receptive'. The 'refused' option is also highlighted with a red box. The form includes fields for 'Type of counseling', 'Method of counseling', 'Counselor', 'Date', and 'Time'. The 'Total counseling time (minutes)' is set to 6. The 'Comments' field is empty. The 'Educational materials' field is also empty.

Type of counseling:	Method of counseling:	Evaluation of counseling:
advance directives	verbal explanations	refused

Comments:

Educational materials:

Total counseling time (minutes): 6

Counselor: [blank] Date: /20/2024 Time: 6

Select your evaluation of counsel...

- accepted the material
- needs reinforcement
- refused
- returned the demonstration
- verbalized an understanding
- was not receptive

Close

# 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**

Specialty ▼ Rheumatology Visit Type ▼ Office Visit Risk Level Care Team Contagion Risk HCC TOB HTN DM CAD Default Provider: Unassigned

Intake **Histories** SOAP Finalize Checkout

Care Guidelines Global Days Clinical Trial History Review Panel Control: Toggle Cycle

Problem List 4

**Medical/Surgical/Interim** 2

☐ No relevant past medical/surgical history History Review: Detailed Reviewed, updated Reviewed, no changes Unobtainable:

**Medical History**

Disease/Disorder	Side	Onset	Comment

**Surgical/Treatment History** ☐ Reviewed

Management	Side	Date	Comment

Refresh Add Edit Remove **Interim History** 3 Add Edit Remove

"Interim History" - [New Record]

\*Encounter type: **hospice** Problem: Add to Problem List

Management: Date: //

Provider: Facility: Admit date: **3/15/2024** Admitted from:

Discharged to: Date: // Outcome/detail:

Discharge Diagnosis: Clear Clear Clear Clear

Comments:

4 **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**

"Interim History" - [New Record]

\*Encounter type:  Problem: ⓘ Add to Problem List

Management:  Date:

Provider:  Facility:  Admit date:  Admitted from:

Discharged to:  Date:  Outcome/detail:

Discharge Diagnosis:

Comments:

4 Save Close

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