



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0326

Corresponding Measures:

De.2. Measure Title: [Advance Care Plan](#)

Co.1.1. Measure Steward: [National Committee for Quality Assurance](#)

De.3. Brief Description of 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.

1b.1. Developer Rationale: This measure addresses advance care planning (ACP) as one facet of high quality care for older adults. ACP is intended to engage patients in proactive conversations and documentation about their care preferences should there be an event in which they cannot independently express their wishes and decisions ([Advance Care Plan Decisions, 2019](#)). It is widely agreed that ACP is a critical part of patient care, as it can lead to improved end of life care, increased trust in providers, decreased psychological distress, improved quality of life and can facilitate hope ([Rosenberg et al., 2020](#)). Patients with advance care plans have been found to experience improved quality of care at end of life ([Bischoff et al., 2013](#)). A systematic review found that among nursing home respondents, ACP can reduce hospitalizations between 9% and 26%, decrease costs and increase compliance with patients wishes ([Martin et al., 2016](#)).

However, many individuals are not having conversations regarding their care preferences in the event they are unable to make decisions. When asked, 70% of providers indicated that they only have ACP conversations with their patients experiencing advanced illness ([Bires et al., 2017](#)). Additionally, the benefits of ACP may only be realized if advance care plan documentation is created and the care team has access to, and follows, the patient's advance care plan. Evidence indicates that only between 35% – 38% of individuals have some form of an advance care plan ([Yadav et al, 2017](#); [Lendon et al., 2018](#)). Additionally, one study found that while 70% of patients were familiar with advance directives, only 35% had completed one.

The intent of this measure is to promote advance care planning discussions between older adults and their providers and documentation of that discussion in the patient's record.

[Advance Care Plan Decisions. \(2019\) Why Advance Care Planning is a Crucial Part of Population Health Strategy. Retrieved July 23, 2020, from https://acpdecisions.org/why-advance-care-planning-is-a-crucial-part-of-population-health-strategy/](#)

[Bires, J. L., Franklin, E. F., Nichols, H. M., & Cagle, J. G. \(2018\). Advance Care Planning Communication: Oncology Patients and Providers Voice their Perspectives. Journal of Cancer Education, 33\(5\), 1140–1147. https://doi.org/10.1007/s13187-017-1225-4](#)

[Bischoff, K. E., Sudore, R., Miao, Y., Boscardin, W. J., & Smith, A. K. \(2013\). Advance Care Planning and the Quality of End-of-Life Care in Older Adults. Journal of the American Geriatrics Society, 61\(2\), 209–214. https://doi.org/10.1111/jgs.12105](#)

[Lendon, J.P, Caffrey, C. & Lau, D. \(2018\). Advance directive documentation among adult day services centers and use among participants, by region and center characteristics?: National Study of Long-Term Care Providers, 2016. National Health Statistics Reports, 117. https://stacks.cdc.gov/view/cdc/58975](#)

[Martin, R. S., Hayes, B., Gregorevic, K., & Lim, W. K. \(2016\). The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review. Journal of the American Medical Directors Association, 17\(4\), 284–293. https://doi.org/10.1016/j.jamda.2015.12.017](#)

Rosenberg, A. R., Popp, B., Dizon, D. S., El-Jawahri, A., & Spence, R. (2020). Now, More Than Ever, Is the Time for Early and Frequent Advance Care Planning. *Journal of Clinical Oncology, JCO.20.01080*. <https://doi.org/10.1200/JCO.20.01080>

Yadav, K. N., Gabler, N. B., Cooney, E., Kent, S., Kim, J., Herbst, N., Mante, A., Halpern, S. D., & Courtright, K. R. (2017). Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care. *Health Affairs, 36(7)*, 1244–1251. <https://doi.org/10.1377/hlthaff.2017.0175>

S.4. Numerator Statement: 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.

S.6. Denominator Statement: All patients aged 65 years and older.

S.8. Denominator Exclusions: N/A

De.1. Measure Type: Process

S.17. Data Source: Claims

S.20. Level of Analysis: Clinician : Group/Practice

IF Endorsement Maintenance – Original Endorsement Date: Nov 05, 2007 **Most Recent Endorsement Date:** Jul 03, 2017

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? N/A

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[nqf_evidence_attachment_7.1.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

This measure addresses advance care planning (ACP) as one facet of high quality care for older adults. ACP is intended to engage patients in proactive conversations and documentation about their care preferences should there be an event in which they cannot independently express their wishes and decisions (Advance Care Plan Decisions, 2019).

It is widely agreed that ACP is a critical part of patient care, as it can lead to improved end of life care, increased trust in providers, decreased psychological distress, improved quality of life and can facilitate hope (Rosenberg et al., 2020). Patients with advance care plans have been found to experience improved quality of care at end of life (Bischoff et al., 2013). A systematic review found that among nursing home respondents, ACP can reduce hospitalizations between 9% and 26%, decrease costs and increase compliance with patients wishes (Martin et al., 2016).

However, many individuals are not having conversations regarding their care preferences in the event they are unable to make decisions. When asked, 70% of providers indicated that they only have ACP conversations with their patients experiencing advanced illness (Bires et al., 2017). Additionally, the benefits of ACP may only be realized if advance care plan documentation is created and the care team has access to, and follows, the patient’s advance care plan. Evidence indicates that only between 35% – 38% of individuals have some form of an advance care plan (Yadav et al, 2017; Lendon et al., 2018). Additionally, one study found that while 70% of patients were familiar with advance directives, only 35% had completed one.

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Advance Care Plan Decisions. (2019) Why Advance Care Planning is a Crucial Part of Population Health Strategy. Retrieved July 23, 2020, from <https://acpdecisions.org/why-advance-care-planning-is-a-crucial-part-of-population-health-strategy/>

Bires, J. L., Franklin, E. F., Nichols, H. M., & Cagle, J. G. (2018). Advance Care Planning Communication: Oncology Patients and Providers Voice their Perspectives. *Journal of Cancer Education*, 33(5), 1140–1147. <https://doi.org/10.1007/s13187-017-1225-4>

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Lendon, J.P, Caffrey, C. & Lau, D. (2018). Advance directive documentation among adult day services centers and use among participants, by region and center characteristics?: National Study of Long-Term Care Providers, 2016. *National Health Statistics Reports*, 117. <https://stacks.cdc.gov/view/cdc/58975>

Martin, R. S., Hayes, B., Gregorevic, K., & Lim, W. K. (2016). The Effects of Advance Care Planning Interventions on Nursing Home Residents: A Systematic Review. *Journal of the American Medical Directors Association*, 17(4), 284–293. <https://doi.org/10.1016/j.jamda.2015.12.017>

Rosenberg, A. R., Popp, B., Dizon, D. S., El-Jawahri, A., & Spence, R. (2020). Now, More Than Ever, Is the Time for Early and Frequent Advance Care Planning. *Journal of Clinical Oncology*, JCO.20.01080. <https://doi.org/10.1200/JCO.20.01080>

Yadav, K. N., Gabler, N. B., Cooney, E., Kent, S., Kim, J., Herbst, N., Mante, A., Halpern, S. D., & Courtright, K. R. (2017). Approximately One In Three US Adults Completes Any Type Of Advance Directive For End-Of-Life Care. *Health Affairs*, 36(7), 1244–1251. <https://doi.org/10.1377/hlthaff.2017.0175>

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Variation in Performance for groups/practices for the Advance Care Plan Measure, Calendar Year 2017 Data

Reporting level	N	Mean	std dev	Min	10th	25th	50th	75th	90th	Max	IQR	
Group/ practice	1,031	2,803	0.74	0	0.13	0.58	0.90	1	1	1	0.42	<0.001

N: Number of groups/practices reporting

IQR: Interquartile Range

p-value: p-value of independent samples t-test comparing groups/practices at the 25th percentile to groups/practices at the 75th percentile.

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1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

N/A

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities

included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

0326 is reported via the QPP MIPs program and does not include disparities results.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

In a study conducted by Kulkarni et al. (2011) among 369 multiethnic, multilingual participants, fewer than half (41%) reported that they discussed an advance care plan with their physician during a hospitalization. ACP rates are lower among older Blacks and Latinos, when compared to Whites (Carr, 2011). Estimates vary across samples, but most research studies found that when compared to their White counterparts, African Americans were less likely to participate in ACP and are more likely to informally discuss end of life care then formally document their wishes (Sanders et al, 2016). A study conducted by Harrison et al. in 2016 found that 2012 Medicare beneficiaries who were Latino, African American, were less educated, or lower income were less likely to have participated in ACP. In a study of beliefs about ACP in cancer patients at an urban, multispecialty cancer center, researchers found differences among both providers and patients in terms of their knowledge, preferences, and practices related to ACP. While 70% of patients were familiar with advance directives (100% of White patients and 45.5% of Black patients), only 35% of them reported having completed one (55.6% of White patients and 18.2% of Black patients, although not statistically significant) (Bires et al, 2017).

Bires, J. L., Franklin, E. F., Nichols, H. M., & Cagle, J. G. (2018). Advance Care Planning Communication: Oncology Patients and Providers Voice their Perspectives. *Journal of Cancer Education*, 33(5), 1140–1147. <https://doi.org/10.1007/s13187-017-1225-4>

Carr, D. (2011). Racial Differences in End-Of-Life Planning: Why Don't Blacks and Latinos Prepare for the Inevitable? *Omega*, 63, 1–20. <https://doi.org/10.2190/OM.63.1.a>

Harrison, K. L., Adrion, E. R., Ritchie, C. S., Sudore, R. L., & Smith, A. K. (2016). Low Completion and Disparities in Advance Care Planning Activities Among Older Medicare Beneficiaries. *JAMA Internal Medicine*, 176(12), 1872–1875. <https://doi.org/10.1001/jamainternmed.2016.6751>

Kulkarni, S.P., Karliner, L.S., Auerbach, A.D. & Perez-Stable, E.J. (2011). Physician Use of Advance Care Planning Discussions in a Diverse Hospitalized Population. *J Immigrant Minority Health* 13, 620–624. <https://doi.org/10.1007/s10903-010-9361-5>

Sanders, J.J., Robinson, M.T. & Block, S.D. (2016). Factors Impacting Advance Care Planning among African Americans: Results of a Systematic Integrated Review. *Journal of Palliative Medicine*, 19(2): p. 202 – 227.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly, Populations at Risk : Dual eligible beneficiaries

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

https://qpp.cms.gov/docs/QPP_quality_measure_specifications/Claims-Registry-Measures/2019_Measure_047_MedicarePartBClaims.pdf

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

No

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

N/A

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

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.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

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

Documentation that patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan may also include, as appropriate, the following: 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.

NUMERATOR NOTE: The CPT Category II codes used for this measure indicate: Advance Care Planning was discussed and documented. The act of using the Category II codes on a claim indicates the provider confirmed that the Advance Care Plan was in the medical record (that is, at the point in time the code was assigned, the Advance Care Plan in the medical record was valid) or that advance care planning was discussed. The codes are required annually to ensure that the provider either confirms annually that the plan in the medical record is still appropriate or starts a new discussion.

The provider does not need to review the Advance Care Plan annually with the patient to meet the numerator criteria, documentation of a previously developed advanced care plan that is still valid in the medical record meets numerator criteria.

Services typically provided under CPT codes 99497 and 99498 satisfy the requirement of Advance Care Planning discussed and documented minutes. If a patient received these types of services, submit CPT II 1123F or 1124F.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All patients aged 65 years and older.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Denominator Criteria (Eligible Cases):

Patients aged > 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

*Clinicians indicating the place of service as the emergency department will not be included in this measure.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

N/A

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

N/A

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

N/A

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (*Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.*)

Step 1: Determine the eligible population. The eligible population is all patients aged 65 years and older.

Step 2: Determine number of patients meeting the in Question S.7. above.

Step 3: Determine the number of patients who meet the numerator criteria as specified in Question S.5. above. The numerator includes all 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.

Step 4: Calculate the rate by dividing the total from Step 3 by the total from Step 2.

S.15. Sampling (*If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.*)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

S.16. Survey/Patient-reported data (*If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.*)

Specify calculation of response rates to be reported with performance measure results.

N/A

S.17. Data Source (*Check ONLY the sources for which the measure is SPECIFIED AND TESTED.*)

If other, please describe in S.18.

Claims

S.18. Data Source or Collection Instrument (*Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)*)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

None

S.19. Data Source or Collection Instrument (*available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1*)

No data collection instrument provided

S.20. Level of Analysis (*Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED*)

Clinician : Group/Practice

S.21. Care Setting (*Check ONLY the settings for which the measure is SPECIFIED AND TESTED*)

Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (*Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.*)

N/A

2. Validity – See attached Measure Testing Submission Form

[nqf_testing_attachment_7.1-637417211619924357.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

ALL data elements are in defined fields in a combination of electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

This measure uses the Clinical Quality Measure reporting method. Some components of this measure draw on structured fields, while others are available in narrative notes or other non-structured fields.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient

confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

This measure has been in use for 12 years (2008 to present) in the PQRI, PQRS and QPP/MIPS quality reporting program with no feedback received from the field citing difficulties reporting the measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

Broad public use and dissemination of this measure is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
	Public Reporting CMS Merit-Based Incentive Payment System (data reported publicly via Physician Compare) https://data.medicare.gov/data/physician-compare Payment Program CMS Merit-based Incentive Payment System (MIPS) https://qpp.cms.gov/mips/overview

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

CMS QUALITY PAYMENT PROGRAM: This measure is used in the Quality Payment Program (QPP) which is a quality and cost incentive program that uses payment adjustments to promote high quality and high value care delivery by eligible clinicians (EC). QPP provides performance-based payment adjustments to ECs, both negative and positive, for services furnished to Medicare Part B beneficiaries. EC performance is graded on quality measure performance, cost of care, engagement in clinical practice improvement activities, and use of Certified EHR Technology (CEHRT). Performance can be reported at the individual (clinician) or group (practice) level. In 2018, 874,515 ECs participated in MIPS, representing 98% of all eligible clinicians across the 50 states. 53% participated as a part of a group, 6% as individual clinicians, and 41% as a part of an Advanced Payment Model.

References:

Centers for Medicare and Medicaid Services (CMS). (2020). 2018 Quality Payment Program Reporting Experience. Baltimore, MD: Centers for Medicare and Medicaid Services. Retrieved from: <https://qpp.cms.gov/about/resource-library>

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

N/A - this measure is publicly reported through the Merit-Based Incentive Payment System (MIPS).

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

N/A

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

When clinicians and groups report their performance on this measure for MIPS, CMS provides them with feedback reports to inform performance improvement efforts. All individual and group performance data is reported publicly through Physician Compare, and annual benchmarks are publicly available to enable clinicians to understand how their performance compares to national benchmarks.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

Feedback reports are made available to clinicians in July following the measurement year (i.e. feedback reports for 2017 were available in July of 2018). Reports include performance rates as well as the associated payment adjustment to Medicare Part B payments. The full performance data set became available on Physician Compare in 2019. The Physician Compare data set includes measure performance scores for all individual clinicians and groups that reported measures to MIPS.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

NCQA assesses the measure annually as part of the CMS MIPS program, culminating in the Measures Finalization Meeting convened by CMS and its contractors. We have not received feedback from measured entities specific to this measure during that process.

4a2.2.2. Summarize the feedback obtained from those being measured.

We have not received feedback from those being measured via CMS or NCQA portals.

4a2.2.3. Summarize the feedback obtained from other users

We have not received any additional feedback on this measure.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

No feedback has been received that indicate the need for modification.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable

entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

2017 is the only year that publicly reported MIPS data currently is available on Physician Compare for this measure. Thus, we are unable to describe demonstrated performance improvement year over year.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

No unintended consequences were identified for this measure.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

Unexpected benefits could include better more transparent, provider-patient communication about advance care planning. Advance care planning is a critical part of patient care, as it can lead to improved end of life care, increased trust in providers, decreased psychological distress, improved quality of life and can facilitate hope (Rosenberg et al., 2020).

Rosenberg, A. R., Popp, B., Dizon, D. S., El-Jawahri, A., & Spence, R. (2020). Now, More Than Ever, Is the Time for Early and Frequent Advance Care Planning. *Journal of Clinical Oncology*, JCO.20.01080. <https://doi.org/10.1200/JCO.20.01080>

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

No

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

N/A

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

No appendix Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): National Committee for Quality Assurance

Co.2 Point of Contact: Bob, Rehm, nqf@ncqa.org, 202-955-1728-

Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance

Co.4 Point of Contact: Brittany, Wade, wade@ncqa.org, 202-530-0463-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

An expert panel was used to assess face validity of the measure. The panel consists of 33 members, whose specialties include internal medicine, geriatrics, anesthesia, orthopedic surgery, physical medicine & rehabilitation, neurology, palliative medicine, urology, geriatric psychiatry, emergency medicine, nephrology, radiation oncology, ophthalmology, medical epidemiology, methodology, hospital medicine, family medicine, and bioethics.

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Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2008

Ad.3 Month and Year of most recent revision: 02, 2008

Ad.4 What is your frequency for review/update of this measure? As needed based on revisions or updates to applicable clinical guidelines.

Ad.5 When is the next scheduled review/update for this measure? 12, 2021

Ad.6 Copyright statement: ©2020 by the National Committee for Quality Assurance

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