Advance Care Planning (ACP)

SUMMARY OF CHANGES TO HEDIS MY 2022

- This is a first-year measure.

Description

The percentage of adults 66–80 years of age with advanced illness, an indication of frailty or who are receiving palliative care, and adults 81 years of age and older who had advance care planning during the measurement year.

Definitions

Advance care planning — A discussion or documentation about preferences for resuscitation, life-sustaining treatment and end of life care.

Eligible Population

Product line — Medicare.

Ages — Members 66 and older as of December 31 of the measurement year.

Continuous enrollment — The measurement year.

Allowable gap — No more than one gap in continuous enrollment of up to 45 days during the measurement year.

Anchor date — December 31 of the measurement year.

Benefit — Medical.

Event/diagnosis — Follow the steps below to identify the eligible population.

Step 1 — Include members 66–80 years of age as of December 31 of the measurement year who meet any of the following criteria.

- *Advanced Illness:* Members who meet any of the following during the measurement year:
  - At least two outpatient visits (Outpatient Value Set), observation visits (Observation Value Set), ED visits (ED Value Set), telephone visits (Telephone Visits Value Set), e-visits or virtual check-ins (Online Assessments Value Set), nonacute inpatient encounters (Nonacute Inpatient Value Set) or nonacute inpatient discharges (instructions below; the diagnosis must be on the discharge claim) on different dates of service, with an advanced illness diagnosis (Advanced Illness Value Set). Visit type need not be the same for the two visits. To identify a nonacute inpatient discharge:
    1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).

2. Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
3. Identify the discharge date for the stay.

– At least one acute inpatient encounter (Acute Inpatient Value Set) with an advanced illness diagnosis (Advanced Illness Value Set).
– At least one acute inpatient discharge with an advanced illness diagnosis (Advanced Illness Value Set) on the discharge claim. To identify an acute inpatient discharge:
  1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
  2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
  3. Identify the discharge date for the stay.
– A dispensed dementia medication (Dementia Medications List).

- *Frailty:* Members who had a claim/encounter for frailty (Frailty Device Value Set; Frailty Diagnosis Value Set; Frailty Encounter Value Set; Frailty Symptom Value Set) during the measurement year.
- *Palliative Care*: Members who had a claim/encounter for palliative care (Palliative Care Assessment Value Set; Palliative Care Encounter Value Set; Palliative Care Intervention Value Set) during the measurement year.

Dementia Medications

Description	Prescription
Cholinesterase inhibitors	• Donepezil • Galantamine • Rivastigmine
Miscellaneous central nervous system agents	• Memantine
Dementia combinations	• Donepezil-memantine

Step 2 Include all members 81 years of age and older, as of December 31 of the measurement year.

Required exclusion Members in hospice or using hospice services anytime during the measurement year. Refer to *General Guideline 17: Members in Hospice.*

Administrative Specification

Denominator The eligible population.

Numerator Evidence of advance care planning during the measurement year (Advance Care Planning Value Set).

Data Elements for Reporting

Organizations that submit HEDIS data to NCQA must provide the following data elements.

Table ACP-3: Data Elements for Advance Care Planning

Metric	Data Element	Reporting Instructions
AdvanceCarePlanning	EligiblePopulation	Report once
	ExclusionAdminRequired	Report once
	NumeratorByAdmin	Report once
	NumeratorBySupplemental	Report once
	Rate	(Percent)