Using the ACP Care Plan to Meet MIPS Measures

Capturing a patient's care preferences and long-term health goals is a cornerstone of high-quality, patient-centered care. This process—known as Advance Care Planning (ACP)—ensures that medical decisions align with the patient's values, especially in situations where they may no longer be able to communicate their wishes.

Beyond its clinical importance, documenting ACP also supports compliance with the Merit-based Incentive Payment System (MIPS) Measure #047: Advance Care Plan and MIPS #PIMSH1 ACP in Metastatic Disease. These measures are high priority under the Quality Payment Program (QPP), designed to promote communication and care coordination.

This document provides information on the use of the ACP Care Plan in iKnowMed for MIPS initiatives. As always, having a significant ACP discussion is the best practice for patient care.

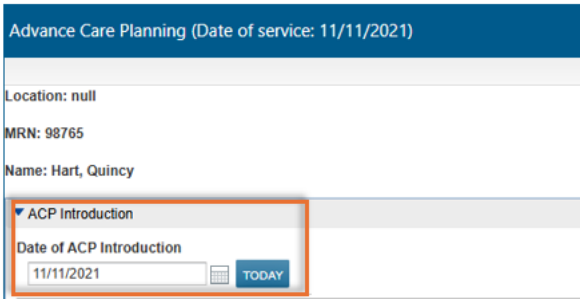
For **MIPS #47 Advance Care Planning, the documentation can occur at any time during the patient's care**.

For **MIPS #PIMSH1 Advance Care Planning in Metastatic Disease**, at least **1 qualifying activity must occur within the *6 months following the metastatic diagnosis***; no activities completed prior to the diagnosis will meet the measure.

ACP Introduction

Use the calendar widget to document the date of the ACP Care Plan creation. An ACP Care Plan is only created once and is edited or updated during the patient's treatment.

⊗ This is helpful documentation but *does not meet the measure requirements*.



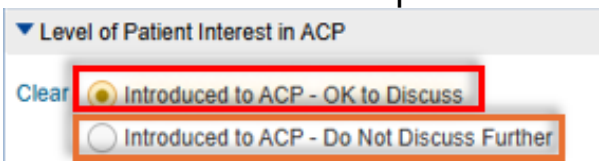
Level of Patient Interest in ACP

If the patient is open to learning more about Advance Directives, click the radio button next to **OK to Discuss**.

⊗ This will document the availability of further discussion *but does not meet the measure requirements.*

If the patient declines to discuss Advance Directives at this time, click the radio button next to **Do Not Discuss Further**. It is encouraged to readdress ACP discussions again in the future, especially if staging or treatment changes occur.

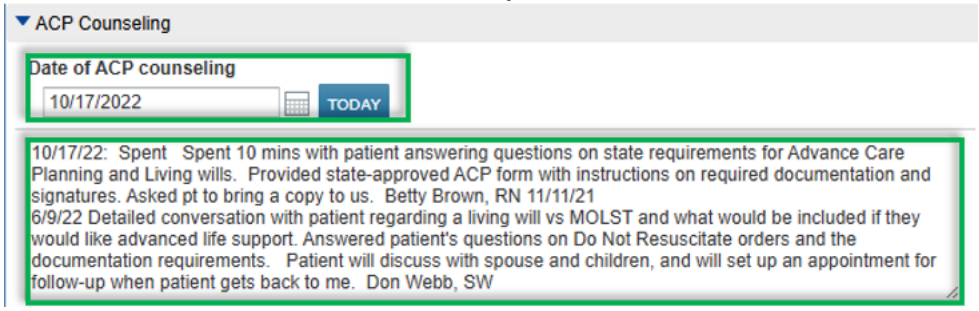
✓ This will exclude the patient from the measures.



ACP Counseling

If a significant conversation occurs but is not billable, **document an overview and the date of the discussion.**

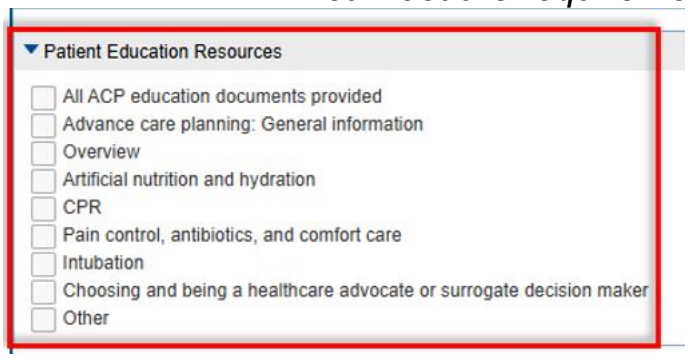
✓ This will meet the measure requirements.



Patient Education Resources

You may use this section to document any ACP education shared with the patient.

⊗ This section does *not meet the requirements for the measures.*

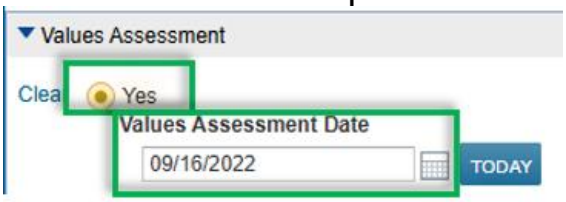


Values Assessment

If a values assessment is completed, click the radio button next to **Yes** and **use the calendar widget to document the assessment date.**

Answering the values questions in the Care Plan is **not required.** Any appropriate values assessment can be used. If using a values assessment tool outside of the one included in the ACP Care Plan, ensure that a copy is included in the medical record.

- ✓ This will meet the measure requirements.
- ✓ The assessment questions do not need to be completed



Future ACP Counseling

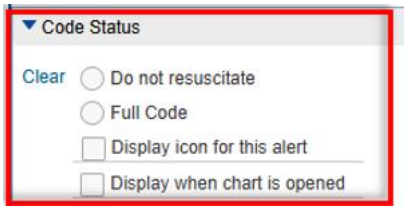
You may use this area to document future counseling.

- ⊗ This section does *not meet the requirements for the measures*.

Code Status

You may use this area to document future code status; however, this does *not* meet the measure requirements.

- ⊗ This section does *not meet the requirements for the measures.*



Advance Directive Documents

- ✓ If a copy of the Advance Directive is scanned into the medical record, click the radio button next to **Yes (attached to EHR)**, this will meet the requirements for the measures.

- ⊗ If you have requested a copy from the patient, you may document this by clicking the radio button next to the **Copy Requested**. This will serve as a

reminder but *does not meet the requirements for the measures.*

Surrogate Decision Maker

- ✓ If the patient has provided a Surrogate Decision Maker, check the button next to **Patient Designates a Surrogate Decision Maker and enter the name of the Surrogate Decision Maker**. This will meet the measure requirements. Note: adding relationship and phone number are best practices but are not required to meet the requirements for the measures.
- ✓ If the patient declines to provide a Surrogate, check the button next to **Patient Declines to Designate a Surrogate Decision Maker.** This will meet the requirements for the measures.