Summary of Technical Expert Panel (TEP): Advance Care Planning Measure

September 2025

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Background

The Centers for Medicare & Medicaid Services (CMS) has contracted with Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation (CORE) for the development of a process measure that assesses and promotes provider communication and documentation of end-of-life (EOL) goals of care discussions with their patients. The CORE contract name is Development, Reevaluation, and Implementation of Outcome/Efficiency Measures for Hospital and Eligible Clinicians, Hospital Option Period 1, contract number HHSM-75FCMC18D0042, Task Order HHSM-75FCMC24F0042. As part of its measure development and maintenance process, CORE convenes groups of stakeholders and experts who contribute direction and thoughtful input during the measure development cycle. The Advance Care Planning (ACP) Measure is designed to capture discussions of EOL care goals and their documentation across diverse populations of hospitalized patients.

The primary goal of this technical expert panel (TEP) is to bring together clinicians, patients, and caregivers to provide critical input on the development of the ACP Measure. This approach is consistent with CMS's approach for iterative improvement of quality measures and quality programs.

The CORE measure development team is comprised of clinicians, measure development experts, and experts in quality measurement. The TEP currently includes 11 individuals, ranging from experts in palliative care, patient safety and quality, clinicians, and patient/family/caregivers.

This report summarizes the feedback and recommendations provided by the TEP during three TEP meetings: the first meeting held on January 24, 2024, the second meeting held on June 10, 2024, and the third meeting held on June 30, 2025.

Measure Team

The CORE ACP Team is led by Ms. Leianna Dolce, and overseen by Project Director, Dr. Katie Balestracci and Division Lead, Ms. Monika Grzeniewski. See Table 1 below for the full list of CORE team members on the measure development team.

Table 1: CORE ACP Team

Name	Role
Kathleen Balestracci, PhD, MSW	Project Director
Monika Grzeniewski, MPH	Division Lead
Leianna Dolce, BS, PMP	Project Lead
Nicole Voll, MPH, PMP	Testing Lead
Beth Triche, PhD	Testing Director
Katherine O'Hare, MSW	Data Assets Lead
Faseeha Altaf, MPH	Data Assets Division Lead
Shefali Grant, MPH	Project Manager
Prince Omotosho, BS	Research Support

Name	Role
Zhen Tan, MS	Analyst
Shu-Xia Li, PhD	Analytic Director
Lisa Suter, MD	Senior Director

Technical Expert Panel

In alignment with the CMS Measures Management System, and under the guidance of CMS, CORE previously held a 30-day public call for nominations in 2023 and convened a TEP for the development of the ACP Measure. The role of the TEP is to provide recommendations and feedback on specific aspects of the measure development details presented to them.

CORE solicited potential TEP members via emails sent to individuals and organizations representing thought leaders in EOL care, email blasts sent by the CMS Office of Communication, and through a posting on CMS's website. After reviewing TEP nominations, CORE initially confirmed a TEP of the 15 members. Since the first TEP meeting, four TEP members have declined to continue participation. The full list of currently participating TEP members is below in Table 2.

Table 2: ACP TEP Membership

Participant and Credentials	Organization, State	Conflict of Interest Disclosure
Catherine Auriemma, MD, MSHP	University of Pennsylvania Perelman School of Medicine, Philadelphia, PA	None Identified
Rory Farrand, MS, MA, MSN, APRN-BC	National Hospice and Palliative Care Organization, Finleyville, PA	None Identified
Erik K. Fromme, MD, MCR, FAAHPM	Serious Illness Care Program, Ariadne Labs, Newton, MA	Intellectual COI: SICP program has vested interest in this measure development
Beryl Kenney	PFE Partner, Pflugerville, TX	None Identified
Shabina Khan	PFE Partner, Libertyville, IL	None Identified
Leigh Ann Kingsbury, MPA	Principal, InLeadS Consulting, New Bern, NC	None Identified
Roger Lacoy	PFE Partner, Des Moines, IA	None Identified
Lydia Mills, MSW, LCSW, LICSW	The US Oncology Network, Hemet, CA	None Identified
MaryBeth Nance	PFE Partner, Delta, PA	None Identified

Participant and Credentials	Organization, State	Conflict of Interest Disclosure
Karl Steinberg, MD, CMD, HMDC, HEC-C	AMDA-The Society for Post-Acute and Long-Term Care Medicine, Oceanside, CA	None Identified
L. Scott Sussman, MD, FHM, FACP, FAAHPM	Yale New Haven Hospital, New Haven, CT	None Identified

Specific Responsibilities of the TEP members

Specific responsibilities of TEP members include:

- Complete and submit all nomination materials, including the TEP Nomination Form, letter of interest, disclosure of conflicts of interests, and curriculum vitae;
- Review background materials provided by CORE prior to each TEP meeting;
- Attend and actively participate in the TEP in-person meeting and/or teleconference meeting(s);
- Provide input and feedback to CORE on key clinical, methodological, and other decisions;
- Provide feedback to CORE on key policy or other non-technical issues;
- Review the TEP summary report prior to public release; and
- Be available to discuss recommendations and perspectives following group TEP meetings and public release of the TEP summary report.

CORE provides an agenda and background materials before every meeting for TEP members to review. TEP members are expected to attend a majority of meetings, and to review and comment on materials for the meetings they cannot attend. CORE then summarizes member comments and recommendations in a report that will be publicly posted on CMS's website.

TEP Meetings

TEP meetings follow a structured format consisting of the presentation of updates on measure development, key issues and areas for feedback identified during measure development, and CORE's proposed approaches to addressing the issues, followed by an open discussion of these issues by the TEP members.

CORE held its first TEP meeting on January 24, 2024, the second TEP meeting on June 10, 2024, and the third meeting on June 30, 2025.

For details of the TEP call schedule, please see Appendix A.

TEP Meeting #1 Overview

Prior to the TEP meeting, CORE provided TEP members with detailed meeting materials outlining the Patient EOL Goal Setting measure background and proposed approach, and questions to serve as the focus for discussion. The goal of this TEP meeting was to solicit feedback from the TEP on the proposed methodologic approach for capturing EOL goals-of-care (GOC) processes for hospitalized patients and measure cohort specifications. During the meeting, based on the TEP member input, an additional question and discussion session was added to capture additional feedback on the measurement approach.

The following bullets represent a **high-level summary** of what was discussed during the TEP meeting and TEP feedback by email following the meeting. For a detailed meeting summary, please see the full minutes of the meeting in Appendix B. For details of the email discussion following the TEP meeting, please see Appendix C.

Project Overview and Approach

CORE presented the measure background and reviewed key terminology included in the discussion.

- CORE noted that the goal of this measure is to ensure that hospitalized patients and their caregivers have the opportunity to express and specify their preferences for EOL medical care through ACP.
    - CORE identified two key steps to the ACP process: discussion with the patient, and documentation of the patient's preferences for EOL medical care and surrogate decision makers through advance directives (AD) or other ACP documents.
- CORE explained that the measure focus is ADs and other important ACP documents for hospitalized patients, recognizing the importance of patients' wishes being documented and readily available to their healthcare providers. This is an important starting point for a measure that is intended to become broader and more comprehensive over time. This measure will not identify patients' individual personal decisions regarding EOL care, dictate how EOL conversations should be conducted, or influence patients' decision-making or preferences for EOL treatment. CMS recognizes and respects patients' privacy.
- CORE proposes a measure numerator that will assess for the presence of ADs or other important ACP documents, specifically:
    - AD (living will, power of attorney for healthcare) OR
    - Portable medical orders (Medical Orders for Scope of Treatment [MOST], Medical Orders for Life-Sustaining Treatment [MOLST], Physician Orders for Life Sustaining Treatment [POLST]).
- CORE proposes that the measure cohort will be patients aged 65 years and older who are admitted for hospitalization.

Measuring Advance Care Planning

CORE presented the proposed approach to capturing ACP:

- CORE described the proposal to focus the measure on assessment for the presence of ADs or other ACP documents, specifically a living will or power of attorney for healthcare (ADs) or portable medical orders (MOST, MOLST, POLST).
- CORE posed the following discussion question to the TEP: **Is there anything you would add or change to this approach to capturing documentation?**

TEP Feedback:

- All TEP members agreed on the importance of EOL goal setting to empower patients and caregivers to ensure their preferences are met and prevent needless suffering at the EOL.
- TEP members noted that documents and documentation are different things, and there was widespread support among the TEP that the documentation was most important.
- The TEP voiced strong concern about the measure numerator's focus on ACP documents and potential for negative unintended consequences. Specific feedback included:

  - ADs are a proxy for ACP conversations, but they can also be a barrier to discussions when providers have a ‘one and done’ mentality and avoid readdressing patient wishes. Patients’ wishes are contextual and a one-time document can miss the evolution in people’s thinking, making it difficult for clinicians to use the documents in decision-making.
  - Some patients know they have an AD, but they do not remember what it says. ADs are rarely effective in ensuring patients get the care they want because a patient’s perspective on what is acceptable can and does change, and the AD may not reflect that change. Family members may dispute the validity of what is outlined in documents, based on more recent conversations.
  - ADs do not require discussion with a healthcare provider and are often not informed by the patients’ clinical context, especially when they have been created with attorneys that are outside the clinical setting. Clinicians often have reason to doubt the utility of ADs because they may reflect outdated or incomplete treatment preferences.
  - The measure’s focus on documents may encourage inappropriate use of these documents in the wrong patient populations, such as the use of portable medical orders in healthy adults.
  - Patients with poor trust toward the healthcare system may perceive the focus on formal ACP documents as an attempt to limit their care. When there is low trust in the healthcare system, ADs do not work well because patients feel they have to say they would want all interventions in any situation to make sure they are not on the receiving end of discrimination.
- Several TEP members expressed feasibility concerns about ACP documents:
  - ADs are difficult to execute in the hospital setting due to witness restrictions (e.g., require notarization, hospital employees cannot witness), and there are challenges with having patients return the signed and witnessed documents following discharge.
  - For documents that are returned following discharge, there may not be processes in place to prioritize adding these documents to the electronic health record (EHR) following the patient’s discharge.
  - In the hospital EHR environment, it can be hard to determine the presence of documents as they can be scanned and labeled in different ways.
  - In practice, the question about AD is not presented in a meaningful way, generally being asked by admitting RNs, which can come across to patients as an ambiguous afterthought, during a time in which patients often feel nervous, anxious, or scared. Additionally, patients with limited proficiency in English, or patients who use support for communication (e.g., someone with non-verbal Autism) may be unable to answer the questions in a way that accurately reflects their wishes.
  - ACP is an interdisciplinary process and involves contributions from many care team members, including chaplains, social workers, nurses, and case managers. Portable medical orders limit interdisciplinary participation in ACP as only medical professionals can sign them.
  - Not all ADs are equal, expressing specific concern about using legal documents with high reading levels that are difficult for both patients and clinicians to interpret, and recommended investigation into documents that are designed to be patient-centered and appropriate for people with diverse backgrounds. Disability-focused organizations suggest documents in plain language.

- TEP members acknowledged challenges with constructing a prospective national measure given uncertainty around the duration of the life, wide variation across (and sometimes regionally within) states in documentation requirements, lack of portability across states, and which events may trigger when the documents go into effect.
- TEP members noted the need for people who live with critical illnesses and disabilities, who may chronically rely on intensive medical treatment modalities like ventilation, to communicate and document what healthcare services they do and do not want.
- TEP members strongly recommended including documentation of ACP discussions in the measure numerator. TEP members believed that this would have the benefit of incentivizing EHR vendors to develop standard ACP documentation modules within the EHR, hospitals to adopt these ACP modules, and clinicians to document ACP discussions more consistently and in centralized locations within the EHR.
    - Many TEP members felt that incentivizing interoperable EHR systems for capturing ACP discussions and incentivizing providers to document discussions in a centralized location had to potential to be transformative and drive system change.
- TEP members emphasized the importance of providing clinicians with the skills to have meaningful, robust ACP conversations with patients and families and the importance of the relationship between the patient, the professional/clinician having the ACP conversation, and the healthcare proxy the patient selects to be their surrogate when they cannot make their own decisions.

Documentation of End-of-Life Discussions

CORE requested feedback from the TEP on capturing documentation of EOL discussions:

- CORE posed the following discussion question to the TEP**: What is your ideal approach for capturing documentation of EOL discussions?**

TEP Feedback:

- TEP members stressed the importance of capturing documentation of ACP discussions as the best way to accomplish this measure's intent. TEP members offered practical solutions to the challenge of finding documentation of these conversations in the EHR. Specific feedback included:
    - Consideration of The Joint Commission process measure “Treatment Processes and Goals of Care.”
    - Inclusion of the time-based ACP Current Procedural Terminology (CPT) codes in the measure, as a signal ACP discussion has occurred.
    - Capturing use of structured ACP documentation fields that are offered by some EHRs.
    - Potential for Artificial Intelligence (AI) and Natural Language Processing (NLP) to allow more sophisticated search functionality of EHR notes to locate evidence of ACP discussions.
- Some TEP members suggested focusing on the presence of an assigned Health Care Proxy or Health Care Power of Attorney as a simple and practical way to ensure patients’ preferences are honored.

Measure Cohort

CORE presented the proposed approach to defining the measure cohort:

- CORE described the proposal to apply the measure to patients aged 65 years and older.

- CORE posed the following discussion question to the TEP: The proposed measure cohort is patients aged 65 years and older who are admitted for hospitalization. **What patient populations or criteria, if any, should be considered as exclusions?**

TEP Feedback:

- Some TEP members recommended narrowing the denominator to patients with serious illness or those expected to die within one year if focusing on documents.
- Other TEP members noted that ACP is designed for all adults at "any age or stage of health," including those who are young and healthy. Thus, they recommended that the measure be applied to all adults aged 18 and older.

Consideration of Psychiatric Advance Directives

CORE asked the TEP whether to include psychiatric AD in the measure numerator:

- Following the TEP meeting, CORE emailed the following question to the TEP: **Should psychiatric AD be included in the measure numerator? Why or why not?**

TEP Feedback:

- Five TEP members responded, and most believed they should not be considered as they do not reflect preferences for EOL and they may not be available in all states. One TEP member suggested if psychiatric AD were included, it should be treated as a separate category.

Next Steps

- CORE will share the TEP Summary Report with the TEP for review. TEP members will be asked to provide any suggested edits, as necessary.
- TEP members will be asked to complete a brief survey on your experience in this meeting.
- TEP members are encouraged to reach out via email if they have questions or further input.
- CORE will provide CMS with a summary of TEP input for consideration.

Conclusion

The TEP voiced strong concern about the proposed measure numerator being too narrowly focused on ACP documents and the potential for negative unintended consequences. TEP members were concerned that the focus on documents would not incentivize providers to have nuanced, personalized, and iterative ACP discussions with patients. TEP members strongly recommended including documentation of discussions in the measure numerator as they believed that this would have the benefit of incentivizing standardized documentation within the EHR. TEP members noted that EOL goal setting is relevant to patients of any age, and that a measure about such discussions would be applicable to any patient over the age of 18.

TEP Meeting #2 Overview

Prior to the second TEP meeting, CORE provided TEP members with the meeting presentation.

The following bullets represent a **high-level summary** of what was discussed during the TEP meeting. For a detailed meeting summary, please see the full minutes of the meeting in Appendix D.

Background and Approach

CORE reviewed the measure background.

- CORE explained that the purpose of the meeting was to provide the TEP with an overview of updates made on the revised ACP measure specifications based on TEP feedback received during the first TEP meeting (January 24th, 2024), and to obtain TEP input on the measure importance and face validity.
- CORE shared background on measure purpose and importance and summarized the TEP's previous valuable feedback about the initial measurement approach and their concrete recommendations for changing the initial measure specifications.
- CORE reviewed the changes to the ACP measure concept specifications:
    - The revised measure numerator is patients who have an ACP document, or documentation of an ACP discussion in the medical record by the time of discharge**.** The numerator may be satisfied by one of the following:
        - ACP document, as evidenced by:
            - Health care agent (Health Care Proxy or Medical Power of Attorney for Health Care)
            - AD or Living Will
            - Portable medical orders
                - MOST, MOLST, POLST, or Do Not Resuscitate (DNR) Order form
        - Other documentation that an ACP discussion occurred during hospitalization prior to discharge, as evidenced by the ACP note or the ACP CPT® codes 99497 or 99498.
    - The revised measure denominator:
        - Patients aged 18-years and older who are discharged from an inpatient hospitalization within the measurement period.

Expanded Measure Cohort and Update Numerator Definition

CORE posed the following discussion question to the TEP: Do you agree that this measure, as a first step, can positively impact the provision of advance care planning?

TEP Feedback:

- All TEP members expressed appreciation to the CORE team for incorporating TEP feedback into the ACP measure specifications and agreed that this measure as a first step can positively impact the provision of ACP. Overall, the TEP members were supportive of the expanded cohort that includes all patients aged 18 and older. Several TEP members expressed concerns about including ACP for patients who are not chronically or seriously ill. Specific feedback included concerns about cohort being overly broad for EOL planning, and a concern about implementation challenges if not controlling for serious illness.
- TEP members supported an update to the numerator with the inclusion of Health Care Agent as a separate numerator option to ensure measure applicability to the broader population's needs.

Documentation of ACP Discussions

CORE discussed the proposed documentation to be included in the measure numerator (and other updates to the measure).

TEP Feedback:

- Overall, the TEP members affirmed the updates to the measure specifications and appreciated that the measure changes reflected their recommendation to add ACP discussions to the measure numerator.
- TEP members noted some concerns about ACP documentation such as outdated ACP documents, ACP documents that are difficult to locate, and prioritization of documents in the event multiple documents exist.
- TEP members expressed reservations that the ACP CPT codes may be over-utilized or used inappropriately. They suggested additional alternative CPT II tracking codes to consider (1123F, 1124F, 1157F, 1158F, S0257).
- TEP members acknowledged the challenges and discussed strategies to operationalize the identification of ACP conversations and the best approach to data capture. Implementation of the ACP measure could incentivize consistent ACP documentation and data across healthcare systems to ensure information is easier to find and act on for the next treating clinician and give patients opportunities for meaningful engagement in ACP discussions.
- TEP members voiced concern about potential disability bias and the importance of respecting individuals' perceptions of quality of life (QOL), as well as patients' right to opt-out of ACP discussion.

Measure Importance and Face Validity

CORE presented the questions about measure importance and face validity:

- CORE invited the TEP's input on measure importance and face validity of the measure. TEP members were asked to respond to the following questions during the meeting or via survey for the members who could not attend:
    - Measure Importance: **The ACP Measure is meaningful and/or produces information that is valuable to patients and caregivers in making their care decisions.**
        - Of the 13 TEP members that responded, 54% (7) strongly agreed and 46% (6) agreed.
    - Face Validity: **The ACP Measure could differentiate good from poor quality care among hospitals.**
        - Of the 13 TEP members that responded, 62% (8) agreed and 38% (5) disagreed.
- The TEP shared feedback about the revised ACP measure's importance and face validity, with all TEP members confirming the measure importance and mixed feedback on the face validity due to the difficulty in determining quality of ACP discussions.

Additional TEP Recommendations for Improving the ACP Measure

CORE posed the following discussion question to the TEP: What might you like to see included in a future version of the measure?

TEP Feedback:

- TEP members strongly encouraged a measure that allows for multiple healthcare team members, including social workers and clergy, to be able to initiate and engage in the ACP discussions, and articulated concerns about the variation across states' legal environments (e.g., scope of practice/authorization to discuss the risks and benefits of therapeutic interventions) impacting clinical team participation in ACP conversations.

- TEP members suggested future iterations of the measure capture whether a single clinician or an interdisciplinary clinical team participated in the discussion, whether the clinical team/clinician reviewed an existing order, if care was provided in concordance/discordance with the patient's wishes, and an approach to promote more nuanced and high-quality ACP conversations.
    - TEP members recommended the future iterations of the measure include more specificity related to capturing the quality of ACP counseling provided by hospitals. Many TEP members acknowledged the challenges with measuring the subjective concept of quality of ACP conversations. They suggested accommodating for variation of provider and patient perceptions of QOL by incorporating a patient-reported, outcome-based performance measure (PRO-PM) to capture the patient's perspective.
- TEP members emphasized the importance of provider training in having high quality EOL discussions with patients and interpreting orders, as clinicians may not feel skilled or comfortable with these discussions or interpreting existing orders.

Next Steps

- CORE will share the TEP Summary Report with the TEP for review in late July. TEP members will be asked to provide any suggested edits, as necessary.
- TEP members will be asked to complete a brief survey on your experience in this meeting.
- TEP members are encouraged to reach out via email if they have questions or further input anytime to CMSAdvanceCarePlanning@yale.edu
- CORE will provide CMS with a summary of TEP input for consideration.

TEP Meeting #3 Overview

Prior to the TEP meeting, CORE provided TEP members with the meeting presentation and updated TEP Charter. The goal of this TEP meeting was to solicit feedback from the TEP on measure testing results and importance and face validity of the measure.

The following bullets represent a **high-level summary** of what was discussed during the TEP meeting and TEP feedback by email following the meeting. For a detailed meeting summary, please see the full minutes of the meeting in Appendix E.

Measure Overview

CORE presented a high-level review of the project goal, specifications, and impact of TEP input on measure specifications.

- CORE reviewed that the goal of the electronic clinical quality measure (eCQM) is to capture advance care planning documents and discussions in order to promote person-centered care in which patients, or their caregivers, have an opportunity to specify the patient's preferences for medical treatment at, or in preparation for, the end-of-life (EOL).
- CORE noted that previous TEP input shaped the current measure specifications. The measure denominator is the number of patients 18 years and older with an inpatient hospital discharge in the measurement period and the numerator is the number of these patients with evidence of an ACP document or discussion, resulting in a proportion score where a higher percentage score is better. The numerator can be satisfied by any of the four categories:
    - Health Care Agent, including Health Care Proxy or Medical Power of Attorney for Health Care;

    - Presence of advance directive or a living will;
    - Portable medical orders, including Medical Order for Scope of Treatment (MOST), and Medical Order for Life Sustaining Treatment (MOLST), Physician Order for Life Sustaining Treatment (POLST) and Do Not Resuscitate (DNR) Order form or billing code and;
    - Evidence of an ACP discussion.

TEP Feedback:

- A TEP member expressed worry that sometimes a DNR code status may be carried over from prior encounters or used as a placeholder, therefore potentially not representing the patient's most up to date wishes. Another TEP member noted that the DNR code applicable to the measure was a Z code which is only applied if it is part of Evaluation and Management (E/M) Coding and their Current Procedural Terminology (CPT) coding, which CORE confirmed.
- In response to a question about whether an ACP discussion must have a resulting decision for inclusion, CORE noted that the ACP discussion itself if sufficient. A TEP member commented that no decision is a decision – full code and full treatment.

Measure Testing Results

CORE reviewed the status of and results from measure testing which assesses usability and use, importance, feasibility, data element validity, measure score, and measure score reliability.

- CORE reviewed that measure testing has been completed with three testing partners representing 43 hospital sites across three regions of the country, with data from Epic EHRs, for 338,473 patients during the calendar year 2023.
- CORE reviewed that measure feasibility determined that ACP data elements are available, accurate, captured in standard terminologies, and captured during routine workflows.
    - The only data element the testing partners did not find to be available or fully accurate was the discussion of "Goals, preferences, and priorities for medical treatment." CORE noted that this is a single code, listed individually for feasibility testing due to its distinct code type, whereas the other data element categories assessed for feasibility had many coding options.
    - Testing partners indicated that many of the data elements are already routinely collected during inpatient care, but that there's also room for growth.
- CORE shared results for data element validity from one testing partner representing six acute care hospitals. During validity testing, data elements were checked against the patient EHR to confirm that documentation was present. The findings revealed a high level of agreement between most data elements and the chart review, from 92% to 100%.
    - The data element "Advance directive" did not score as highly due to the term being clinically interchangeable with other types of ACP documents, such as healthcare agent. CORE noted that this is not considered a threat to measure validity. For the 15 instances in which documents were incorrectly coded as "advance directive," the document was confirmed as belonging to one of the other acceptable numerator categories, thus no patient was missed in the numerator.
- CORE presented measure performance score results highlighting a wide range of scores, from 13.3% to 84.3% across the 43 testing sites, showcasing both room for improvement for many facilities, but also sites that did extremely well.
    - The median hospital measure score was 34.7%, and the mean was 40% (SD 16.7%).

    - CORE noted that higher hospital scores in testing aligned with testing sites that have dedicated palliative care teams in place.
- CORE presented measure score reliability results, using signal-to-noise reliability: a median of 0.9991, a mean of 0.9987, with a range of 0.9939 to 0.9998 was calculated. CORE noted that this exceeds the Partnership for Quality Measurement (PQM) recommended 0.6 minimum score for consensus-based entity (CBE) endorsement.

TEP Feedback:

- A TEP member that there are many state-specific names for portable medical orders (POLST-type forms) and encouraged that the final measure includes them all.
- A TEP member noted concern over the consistent “no” response in testing for the “Goals, preferences, and priorities for medical treatment” code in feasibility testing and over not having significant representation for clear goals, preferences and priorities, despite having lots of identified healthcare agents, within data element validity.
    - CORE clarified that the “Goals, preferences, and priorities for medical treatment” data element was a singular data element separated out in feasibility testing for logistical reasons, but shared disappointment that no testing partner had a specific structured field for this element specifically and hopes for use of a structured field in the future in order to prevent important preferences being buried in the clinical notes.
    - Another TEP member added that it is hard to imagine any conversation that results in a DNR order not to encompass some level of goals, preferences and priorities. Those discussions may be with the patients themselves or with a surrogate but if they are ill enough to be in the hospitals and have a conversation that results in DNR or comfort care, it is sufficient. They shared they do not see a point in seeing a goals, preferences and priorities conversation in detail.
- A TEP member noted some testing partners with facilities scoring higher than others, and asked if additional contacts with the health system per patient in the year are likely to result in increased documentation and therefore greater ability to capture. They also asked if Care Everywhere or, generally, the sharing of information across health systems was being considered, as all of the testing partners were using Epic.
    - CORE noted that the testing partner with higher scores has a dedicated palliative care program.
    - CORE noted that EPIC has an ACP module, but they were different across Epic EHR systems. The team will continue to do outreach to non-Epic sites for continued feasibility testing to make sure data capture is also feasible in other healthcare systems.
    - CORE responded that patients may get their care at the same hospital frequently, making it easier to have that documentation in place, but hopes that the measure to incentivize that even if a patient is visiting a new facility, that facility is making sure that they know the patients’ wishes.

Discussion

CORE led a discussion on the measure results.

- CORE requested feedback on the measure results providing the following prompts:
    - Do you have any questions on any of the results presented;
    - Do any findings surprise you;

    - Are you concerned about any results or aspect of the measure; and
    - Do you believe this measure will provide useful data to hospitals?

TEP Feedback:

- TEP members overall expressed that the measure is important and will be meaningful to hospitals.
- Two TEP members supporting the measure noted concerns:
    - A TEP member noted that the measure would provide valuable information to hospitals, and hoped that it would provide motivation to find better ways to document goals, preferences and wishes in a way that is more easily accessible and ideally to have the content in a way that clinicians at the bedside are able to access more readily. They noted the higher performer in the health system putting resources towards palliative care and hope the measure does not become a proxy for existing resources.
    - One TEP member stated that they think this will be a meaningful measure, will help move the needle in the direction of having more meaningful discussions, and will allow people to get treatments they want and prevent ones they don't want. They noted that their only concern is that this has potential to be gamed, but by at least putting this out there, hopefully meaningful conversations will occur.
- A TEP member shared concerns noting ACP can be an ongoing discussion and not just one-time decisions.
    - CORE responded that it is important to be mindful of patient and provider burden and continuing to raise conversations that a patient feels was already completed and answered via older documentation. She added that ACP is certainly fluid and ongoing and the team ensured those discussions are a portion of the numerator that can be captured.

Face Validity and Next Steps

This third TEP meeting highlighted promising testing results and concluded with TEP members continuing to agree with the importance and usefulness of the measure. CORE discussed the face validity survey to be sent out, summarized additional next steps, and closed the meeting.

Appendix A. TEP Call Schedule

TEP Meeting #1

January 24th 2024, 12:30–3:00 pm EST (Zoom teleconference)

TEP Meeting #2

June 10th 2024, 2:00–4:00 pm EST (Zoom teleconference)

TEP Meeting #3

June 30th 2025, 2:00–3:30 pm EST (Zoom teleconference)

Appendix B. Detailed Summary of TEP #1 Meeting

Patient End-of-Life (EOL) Goal Setting Measure Technical Expert Panel (TEP) Meeting #1 Minutes
Wednesday, January 24, 2023, 12:30–3:00 PM ET

Participants

- **Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation (YNHHSC/CORE):** Kathleen Balestracci, Melinda Bateman, Darinka Djordjevic, Sheila Eckenrode, Shefali Grant, Monika Grzeniewski, Roisin Healy, Hazar Khidir, Stephanie Lambert (X4 Health), Prince Omotosho, Patricia Nogelo, Lisa Suter, Mariel Thottam, Ariel Williams

- **Technical Expert Panel (TEP) Participants:** Catherine (Katie) Auriemma, Rory Farrand, Erik K. Fromme, Rebecca Gagne-Henderson, Beryl Kenney, Shabina Khan, Leigh Ann Kingsbury, Roger Lacoy, Lydia Mills, MaryBeth Nance, Nina O'Connor, Stephanie Parver, Karl Steinberg, Scott Sussman

- **Centers for Medicare & Medicaid Services (CMS):** Melissa Hager, Ron Kline, Raquel Myers, Ngozi Uzokwe

Executive Summary

- The purpose of the first Patient End-of-Life (EOL) Goal Setting Measure TEP meeting was for the CORE team to share with the TEP the Patient Goal Setting measure overview and approach.
    - CORE noted the goal of the measure is to promote person-centered EOL care where patients, or their caregivers, have an opportunity to specify their preferences for medical treatment at the EOL.
    - CORE proposed a measure that will assess for the presence of advance directives (AD) OR other important advance care planning (ACP) documents.

TEP Action Items

- Reviewing and sending any suggested edits to the meeting summary;
- Completing a brief survey about their experience during this meeting; and
- Reaching out via email if they have any questions and watching their email for future project updates.

CORE Action Items

- Following up by email with the TEP regarding the third discussion question in the slide deck for input following today's meeting;
- Sharing a summary of today's meeting for TEP review in mid-February; and
- Considering TEP feedback during the measure development process.

Detailed Discussion Summary

Welcome & Introductions

- Ms. Mariel Thottam welcomed the TEP members, introduced herself as a CORE Stakeholder Engagement Lead, provided instructions about the meeting controls for closed captioning, provided participation guidelines and ground rules for the discussion, shared details about the specific CMS funding source supporting this work, and reminded members about the confidentiality of meeting materials and discussion.

- Ms. Thottam reviewed the meeting agenda and introduced the other CORE Stakeholder Engagement team members at the meeting, Dr. Patricia Nogelo, Ms. Roisin Healy, and Ms. Ariel Williams.
- Dr. Hazar Khidir introduced herself as board certified emergency physician, a Yale School of Medicine faculty member, and the measure lead for the CORE Patient Goal Setting measure; she introduced additional CORE Patient Goal Setting team members.
- Dr. Khidir welcomed attendees from CMS.
- Dr. Khidir noted the project team's appreciation for the TEP members' participation, given the personal and professional expertise they have and their willingness to provide input about the proposed measure.
- Ms. Thottam facilitated TEP member introductions and reviewed the TEP Role and Charter, noting the purpose of the TEP is to gain stakeholder input on measure development and increase transparency. She reviewed the TEP member responsibilities and confirmed the TEP's approval of the TEP charter.

Project Overview and Approach

- Dr. Khidir noted CORE is currently developing a Patient EOL Goal Setting measure, and the goal of the measure is to promote person-centered EOL care where patients, or their caregivers, have an opportunity to specify their preferences for medical treatment at the EOL.
    - She noted that for the purpose of this measure, the discussion would focus on AD and ACP.
- Dr Khidir defined ACP and discussed the ACP continuum, which is dynamic and shaped by changes in health status, patient readiness to discuss EOL medical treatment, or evolution in goals for quality of life.
    - It is not a one-time activity and can change across the span of a person's life.
    - In the healthcare setting, ACP can occur before or at the time of a life-threatening illness.
    - Dr. Khidir noted there are two key steps to the process of ACP.
- The first involves discussions about a person's goals, wishes, and preferences for medical treatment, as well as identifying a trusted person to make decisions if the person can no longer make their own decisions.
- The second step is to document the patient's preferences for EOL medical treatment through AD.
    - Dr. Khidir explained that the focus of the measure under development will be on the second step, capturing documentation of AD.
- Dr. Khidir noted AD are defined as legal documents that capture patients' preferences for EOL care decisions and consist of a living will and designation of a power of attorney for health care.
    - Dr. Khidir noted additional ACP documents called portable medical orders that are used by patients and healthcare providers to capture EOL treatment decisions for seriously ill or frail individuals, including: Medical Orders for Scope of Treatment (MOST), Medical Orders for Life Sustaining Treatment (MOLST), and Physician Orders for Life Sustaining Treatment (POLST).
- Dr. Khidir described CORE's approach for the Patient EOL Goal Setting measure:

    - The proposed numerator assesses the presence of ACP documents including AD (living will, power of attorney for health care) or portable medical orders (MOST, MOLST, POLST).
    - CMS is focused on documentation because they want to make sure that patients and their families have the chance to have their wishes captured and documented in their medical records and so it is available to their care team.
    - CMS respects patients’ privacy and this measure does not aim to identify patients’ personal decisions regarding EOL care.
    - CMS knows that these discussions are very nuanced and can and should vary according to patients’ needs and does not aim to dictate how EOL conversations are conducted, or what specific EOL decisions are captured.
- Several TEP members noted concern that this measure is overly focused on legal documents and does not consider other ways of documenting ACP conversations and stated "Power of Attorney for Health Care" has many different names in different states.
    - A TEP member noted agreement about the focus on legal documents and stated that we already have issues with a "check the box" mentality around goals of care (GOC)/ACP.
    - A TEP member noted it is Medical Power of Attorney (MPOA) in Texas and that there is a lot of confusion between Power of Attorney (POA) for financial needs versus MPOA and noted when people travel between states that not all documents are honored everywhere.
    - A TEP member noted certain states have “triggers” for when these documents go into effect.
    - A TEP member noted concern about documents being vague.
    - A TEP member noted it would be helpful to understand how CMS intends to determine whether the document is present in the electronic health record (EHR) as they are often scanned and labeled in different ways.
- A TEP member noted concern about the proposed measure’s narrow focus on people at EOL, as a lot of people live with critical illnesses and want others to know their wishes for their health care and from the healthcare system. They noted it is also critical to clarify that the person who makes decisions on their behalf is selected by the patient, and that patients have autonomy to choose who their power of attorney will be rather than defaulting to surrogates.
    - Dr. Khidir agreed the intent is to advance person-centered care including patients choosing their alternate decision maker.
- A TEP member noted the wide range of documents meeting the criteria and asked if there was any consideration of other documents that might constitute an acceptable AD. They noted concern that the legal documents being discussed are at a reading level way above what an average person can interpret, and they can even be difficult for clinicians to interpret, particularly when they are devoid of any context. They wondered if there is a plan for identifying and investigating practice documents that are designed specifically to be patient-centered in their language and appropriate for people of diverse backgrounds, as an alternative to the legalese used for estate planning.
    - Dr. Khidir noted she agreed with the importance of using person-centered language that is easily digestible by patients and noted the upcoming discussion in the meeting about the types of documents for inclusion.

  - A TEP member noted Prepare For Your Care (prepareforyourcare.org) is written in pretty easy-to-read language, as is National Hospice and Palliative Care Organization's (NHPCO's) Caring Info (caringinfo.org).
  - A TEP member noted decision aids for providers that are written in user-friendly language https://coalitionccc.org/CCCC/CCCC/Resources/Decision-Aids-for-Healthcare-Providers.aspx#:~:text=Decision%20Aids%2C%20available%20for%20adults,language%20with%20evidence%2Dbased%20information.
- A TEP member expressed concern that there was a leap from documentation to documents, as the focus on documentation could be transformative and the focus on documents would represent a step back 20 years. They asked about where this measure would be applied (e.g., inpatient vs. outpatient setting, hospital vs. long-term care, all Medicare beneficiaries).
  - Another TEP member agreed and stated the definition of the denominator would be essential.
  - Ms. Monika Grzeniewski clarified for the TEP that the measure is initially intended for the inpatient setting, attributed to acute care hospitals.
  - Another TEP member noted the difficulty in executing AD in the hospital setting due to requirements for witnesses.
- Ms. Thottam reviewed the goals of the TEP meeting and that there would be discussion about three focused discussion questions.

Discussion Session #1: Measuring Advance Care Planning

- Dr. Khidir presented the proposed measure that will assess for the presence of AD or other ACP documents, specifically:
  - AD (living will, power of attorney for health care); and
  - Portable medical orders (MOST, MOLST, POLST).
- Dr. Khidir noted the discussion question for the first TEP round robin session:

Question 1: Is there anything you would add or change to this approach to capturing documentation?

- A TEP member noted first, that at best, AD and portable medical orders are a proxy for an ACP process having occurred and at worst, they are a barrier to quality conversations with patients and family members with serious illness. Sometimes presence of an AD is seen as a reason not to have a nuanced conversation with loved ones and clinicians. When those AD are not in person-centered language and completed with consultation of someone's medical team and family, they may not incorporate the clinical context and they may never be readdressed. In addition, not all AD are equal, such that some of them help direct people through the process of ACP and others do not.
  - The TEP member shared a link to a study they were alluding to in their comments: https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2791668
  - Ms. Thottam noted several chat responses in agreement with these comments.
  - Another TEP member asked if the TEP member had data about how often clinicians do not follow AD because they do not know how to interpret them. They stated there are huge fears in certain communities that signing a MOLST/POLST means "no care," not just "care I do not want."
    - A TEP member responded that they did not have data but noted there is an updated study coming out of the Oregon Health & Sciences University (OHSU)

        and University of Washington (UW) that looked at care discordant to what was documented within POLST and why it occurred. Dr. Kelly Vranas from OHSU presented some of the preliminary findings at grand rounds a few months ago.
    - A TEP member noted recent studies, done by a major critic of POLST, illustrate the problems clinicians have following POLST. Sometimes it is because they disagree and sometimes it is not clear how to apply the orders.
    - Another TEP member noted AD are useful for helping patients and families think and talk about how they want to be cared for, but they are only rarely effective in ensuring that patients get the care they want, because a person's definition for what is acceptable can and often does change.
        - Another TEP member echoed this point, noting that although triage or nurses on the floor broach the topic of AD initially when it is not in the EHR, that is where chaplains come into the equation, and it is why they are focused on community education, so the documents are at least initiated before an emergent situation or chronic illness advances.
    - A TEP member stated that this approach to the measure, if implemented as planned, will have very negative unintended consequences.
- A TEP member noted the work happening at Ariadne Labs, suggesting it is the conversation that is critical, and the documents should be the end result of that because not everyone is ready for a MOLST, POLST, or living will. Some patients want to keep their conversation with the physician private and do not want to tell their loved ones. The point is the conversation happened and we work on improving our skills and having these meaningful, robust conversations that are longer than five or ten minutes, and sometimes take hours with the patient.
- A TEP member noted agreement with the previous speakers and shared that most existing EOL measures are retrospective and look at the last six years of life and whether they have documentation of an EOL conversation, and for a prospective measure you cannot do EOL as it is not a population that is identifiable to anybody, or that anyone wants to be identified as part of.
- A TEP member noted that historically AD have been vague and not useful in healthcare centers, and just as often as they are looked at, they are ignored because of being vague and because they do not capture what other members of the interdisciplinary team are doing. There is a limitation in who can sign these orders, because a social worker or chaplain is not capable of discussing risks and benefits, and that goes for lawyers as well. One reason AD are being ignored is because they are difficult and so there might be some way we can document these conversations that have been conducted between a clinician who is able to describe risks and benefits of treatment and foregoing treatment.
    - Dr. Khidir noted the TEP's feedback has been helpful and valuable. She noted the scope of the measure CMS is interested in is a starting point for achieving a much broader and comprehensive measure that looks at documentation of discussions as well. She noted that CORE will take this feedback to CMS for further consideration.
- A TEP member stated that as a chaplain for both hospice and hospitals, a lot of their discussions involve the patient and their families when they do not have an AD in place. In some hospitals they are not allowed by the hospital to serve as a witness. They also noted that when they talk about AD in underserved communities, one of the reasons for outreach is to educate and to explain the kind of vagueness of what an AD is. They did not think POLST was used in Texas, and

out of hospital do-not-resuscitate order (DNR) is used, which is not as comprehensive as other documents. In Texas, the law is that if somebody does not have an out of hospital DNR to govern lack of resuscitation when someone is in transit from one facility to another, then someone will be resuscitated. Texas law states someone will be resuscitated unless they have an approved medical bracelet or necklace.

  - Another TEP member noted north Texas uses POLST and south Texas does not; they were not sure about central Texas. They stated there is a difference between documenting people's wishes and honoring them. This measure is targeting the former and not the latter.
    - Another TEP member noted it is not the place for the clinician to disagree with POLST.
    - The TEP member noted that it is complicated because sometimes POLST are completed without the patient's knowledge, and sometimes family members insist that the patient wants something other than what is in the POLST. People complete the POLST thinking about "if I'm dying" but then might present with a clearly reversible condition. They stated it is also worth noting there is solid public research showing two-thirds of people are not interested in ACP for a variety of reasons, but lack of trust and lack of empowerment are central.
    - A TEP member noted they worry about when it comes down to the "letter of the law" as opposed to the "spirit of the law," the content is critical and that should be the focus. They asked whether all AD, especially the ones that are filled out by attorneys, document people's nuanced wishes and worried it may be more of a "check the box." They noted many patients tell them they do not remember what their living will says, but they know they have one.
  - Another TEP member noted an important thing about AD is that they name the surrogate/agent/proxy and provided a link for the Texas POLST form: https://static1.squarespace.com/static/5eaf204ef965f00825c4347a/t/63ab3f1674ce2a23dca5af11/1672167190974/TX+POLST+Form+adopted+1-2022.pdf
    - A TEP member noted agreement and stated if the measure focus is documents (as opposed to documentation) it might be better to focus entirely on naming a health care durable power of attorney.
  - A TEP member provided a link regarding the End-of-Life Care Form from the Texas Medical Association: https://www.texmed.org/Template.aspx?id=4859
- A TEP member added support for the earlier conversation about the focus on documents versus documentation. For people who live with disability and/or people with dementia and receive "supports and services" (typically through Medicaid waivers), where ACP is done systemically (through the lens of the system), it is typically done by a case or care manager. Sometimes people in this role are nurses and other times they are social workers who come to the task with a good clinical grounding, but they do not come to these conversations with a comfort level with these conversations. It is not just a lack of clinical understanding of ACP. Statistically, somewhere between 60-65% of Americans do not have AD for themselves, and then in the disability system we are asking for professionals who do not have an AD for themselves to complete one with someone else, and the result is we absolutely see the "check-the-box" approach that was mentioned earlier. A person's service plan includes a question for whether

the person has an AD that is a yes/no. If the box is checked yes, you move on and if it says no, you do not know where to go next; for this reason, it is also not informed decision making when we focus solely on the document. They expressed support for conversation, the nuances of conversation, and the nature of a relationship. While we know ACP frequently does not help somebody get what they want, and it is the relationship with somebody who can act as their advocate when that person can no longer self-advocate that matters.

- A TEP member noted agreement with what others have said and wondered about who is capturing the information and where they are putting it because patients at the hospital are not necessarily asked if they have an AD. They suggested time-based codes to capture the conversation in the EHR documentation. They also wondered if clinicians access the information on AD. Addressing AD is something to be done with compassion; you cannot just go in the room and say we need to know if you have an AD or living will and then walk out.
- A TEP member noted it would be helpful to have information on the best- and worst-case scenarios when you are making the decision about having surgery and making sure that document is in place. They had an experience where this did not happen. Even if you have a primary care physician (PCP) that has a document in their systems, it should be discussed again when talking about having major surgery. When you are going to have anesthesia, that timing may be too late because you are anxious anyway.
- A TEP member noted that quality of communication and documentation of that communication is so important. However, it may be beyond what we can control in these circumstances. In Connecticut, there was mandated education for MOLST, but it was unsuccessful, and few people in Connecticut have a MOLST because of the education requirement and trying to control the quality of communication. They did not see how you can do that on a national level.
- A TEP member stated they agreed with everything that was said so far, especially the importance of the conversation with patients. They noted the common difficulty of getting the documents back from the patient once that discussion happened, and they were concerned about providers successfully meeting a measure numerator because it is hard to get the documents back and they often need to include a witness signature, or it needs to be notarized. Most states do not allow someone on the healthcare team to sign it. Getting a physical copy of the document returned is challenging for the provider, and once a document does come back it may not always be a priority. Their other concern was about there already being some quality measures out there around ACP and they wondered if this measure was intended to replace them, as it seems like there is a lot of overlap. Regarding the EHR documentation of AD, providers can pull it up if someone scans the documents into the EHR, but the number of times the documents are actually scanned into the record is very low. The conversations are happening because they can see it in the EHR documentation.
- A TEP member noted that assessing if these documents exist is not a question of whether or not the patient has X, Y, or Z document. The questions are not presented in a meaningful way. In practice, the TEP member has seen admitting registered nurses (RNs) asking the question and suggested that it comes across as an ambiguous afterthought, leading patients feel nervous, anxious, or scared. This is a barrier because patients feel like they are being told that they will have a poor outcome today or tomorrow. The suggested assessment for the existence of documents might be broadened in situations where it is asked more readily than at the point of care so that it is not such an overwhelming question if a patient does not have one already.

- A TEP member agreed with the group about the limitations of documents and thought of ACP as a process. A one-time document sometimes misses the evolution in people's thinking and for clinicians that is a reason they are very hard to apply to decision making. Patients' wishes are contextual, depending on prognosis and whether someone would want a treatment or not. Documents do not easily reflect that. In the communities where there is low trust in the healthcare system and in trusting they will receive fair and equitable health care; AD do not work well because patients feel they have to say they would want everything in any situation to make sure they are not on the receiving end of disparities of care. There are a lot of limitations to AD—it can depend on the illness presenting itself, and they can be a struggle to fill out. The TEP member noted the need for a measure that is capturable, measurable, and scalable. They wondered if adding ACP Current Procedural Terminology (CPT) codes to the numerator would be helpful. These are time-based codes that capture a conversation occurred between a clinician and a patient about their wishes and goals, and it is documented in the EHR, which is ultimately the behavior we are trying to achieve. It might be able to broaden the numerator beyond only the documents.
- A TEP member noted agreement with many prior commenters that it is definitely a process, and the Joint Commission (TJC) actually has a process measure for the quality-of-care program called "Treatment Purposes and Goals-of-Care" where POLST and MOLST are eligible sources of information, but it can also reflect a conversation with the patient or family and on specific desired/not desired interventions. It is not checking for a specific document, and rather it is assessing if treatments and preferences have been discussed. They wondered if for this measure would look for a document to be scanned or for a summarization in the EHR (e.g., no cardio-pulmonary resuscitation [CPR]) and whether the record could be queried or if it would require the record to be reviewed to assess for the presence of these documents.
    - A different TEP member noted that increasingly EHRs are creating places for this documentation. Although it is currently hard to get clinicians to do it, if CMS starts measuring documentation, then clinicians might start to do it and then other clinicians might actually be able to find it, which would be transformative. They stated a measure based on documentation is okay, but that a measure of documents was a "hard no."
    - A different TEP member agreed that CMS incentivizing conversations would cause hospitals to push EHRs to improve the ease with which conversations can be found. They stated Epic has come a long way with its ACP module.
    - A different TEP member stated even if the patient verbally designated a person to make decisions on their behalf during a healthcare episode (which in some states takes precedence over a written AD) that should be considered as meeting this measure. They noted concern that some clinicians will just take the easy path and complete a POLST instead but suggested it may be less of an issue in the hospital.
- A TEP member noted the unintended consequence is this reinforces what we have been trying to get away from for years, and even decades, giving a healthy 65-year-old a POLST form when all they want is default treatment. They stated it is important that if somebody just wants default treatment, like CPR, intubation, shocks, they do not need a POLST form or an AD because clinicians assume this default treatment. Incentivizing the completion of a form just means there are a lot of forms that do more harm than good when someone completes the POLST and then their condition later changes. Now there is a conflict that is hugely destructive

where a family member says the patient would not have wanted a feeding tube or CPR and what the provider has on file is the signed document that reflects the patient wants all that medical technology can offer. When we talk about the denominator, limiting the population to those expected to die in the next year or two would make focusing on these documents more acceptable. There would still be challenges with factors others have mentioned, like witnessing requirements. It is easy to do a POLST if you have a doctor, a patient, and a family member. It is actually more complex, because in most places it requires a witness. Maybe as time goes by, remote notarization could be done in the healthcare setting.

  - A different TEP member stated you cannot make an AD-based measure valuable. It can only cause harm. The TJC measure sounds right to them and would mostly have the desired effect. The suggested conversations that cannot be found should not count and for the denominator they suggested focusing on patients with serious illness.
- A TEP member wondered whether living wills which seem to have a lot of challenges are something we can move away from. Regarding the power of attorney, a discussion with the patient makes it more likely to represent what matters to the patient. They wondered if we needed something objective that would allow us to be more likely to capture the spirit of what matters to the patient versus the letter of the law. Documents created by an attorney might not capture the nuances of what matters most to a patient in their dynamic health course.
- A TEP member noted it is hard to find those conversations because they are not always in the right place in the EHR and are buried in clinician notes. If CMS starts measuring this, it will have the effect that the EHRs increasingly are building a place for this kind of documentation, but it is like pulling teeth to get clinicians to put the documentation in the right place and they have all kinds of excuses for why they cannot do it, or they are just not aware of it. If CMS starts counting the documentation, clinicians will start putting it in the right place and other clinicians will be able to find it when the sick patient comes to the hospital. That is what they meant by transformative, that a measure like this could drive the process to work better but you need to measure the right thing.

Discussion Session #2: Documentation of End-of-Life Discussions

- Dr. Lisa Suter thanked the TEP for an incredible discussion so far. She noted that there were some underlying motivations behind this measure, that CMS has a strong desire to improve this process and they see EOL discussions as something that needs to be corrected and improved. It is a priority for CMS to address this, and oftentimes what happens with measures as they are developed for a specific application is that they evolve over time. They may also start at measuring what we can and then evolve as technology or clinical practice changes, and over time a measure can evolve to be a more nuanced.
  - She stated the CORE team heard in the first discussion session that the concept of measuring the presence of documents has limitations, including the fact that we are not getting to the quality of EOL discussions.
  - She noted the initial discussions between CORE and CMS were to move forward with a less ambitious measure to try to move “the needle.” She proposed a couple of options for the next discussion sessions:
    - Continue to talk about how to make an AD-focused measure as valuable as possible, by narrowing who is measured to the most relevant population,

        recognizing that all measures are imperfect, and we want to create a measure that has the fewest unintended consequences.
        - Consider stepping away from the proposed foundational measure focused on AD and focus on a more ambitious and transformational measure that the TEP is eager for, but that may not be immediately feasible for the many reasons that have been raised here, including challenges of locating documentation in the medical record and variation in how these discussions are currently documented.
    - She invited CMS to comment.
- Dr. Ron Kline noted he is the Chief Medical Director of the Quality Measurement and Value-based Incentives Group (QMVIG) at CMS. He is a pediatric oncologist by training with 20 years in practice and he has been advocating for this measure because he sees many unfortunate things happen where people have no idea about what their loved one would want. He suggested not letting perfect be the enemy of the good. At the end of the day, the question the TEP needs to answer for CMS is whether what is being proposed, though imperfect, is a step forward. If that is the case, we can work on making it better. He noted the importance of considering clinician burden while making this as good and nuanced as we possibly can.
    - He noted that focusing on either documentation or documents is fine. Focusing on documentation would be harder to do, and there will be more administrative burden associated with collecting documentation of conversations. He noted that adjusting the measure to capture documentation would be acceptable so long as we have a mechanism for knowing what a person wanted for their care. A clinician and a patient sitting down and having a conversation is probably the best thing that can happen, and he accepts documentation in addition to documents, recognizing there will be some push-back and complaints about administrative burden.
        - A TEP member noted incremental change is still a change.
        - A TEP member stated there is 20 years of research and experience showing that AD do not accomplish what CMS wants to do. They strongly supported counting documentation and not documents.
- Dr. Suter noted, based on Dr. Kline's feedback, that the CORE team would proceed in the current discussion session to focus on including the right documentation in the measure, and then would shift to discussion of the measure cohort.
    - A TEP member noted the option to tweak the measure to include things other than POLST or AD. These conversations occur all the time and they do not require a legal form. To bill the ACP CPT code 99497 does not require a specific legal form to be completed.
        - Dr. Kline noted billing the CPT code without any result may just become a check-box exercise.
        - Another TEP member asked whether it might work to count the billing code with a contemporaneous document. It would make the numerator much smaller but would perhaps better capture what we are aiming for. They suggested the appropriate measure may not be on the patient level, but rather at the health system- or hospital-level. They suggested asking "is there a

        centralized location for ACP documentation” and “how are you ensuring your patients’ goals/wishes are present there.”
            - Several TEP members expressed support for documentation rather than a document.
        - A different TEP member suggested the reason CMS said they want to count ‘documentation’ is because while ACP is at its heart a conversation, there is real concern that people who have the conversation may not be there when patients get too sick to speak for themselves, and they stated this is ‘right thinking.’ The suggested just counting documentation that occurs in the designated place in the EHR and thought that soon artificial intelligence (AI) will be able to comb the medical record to identify the correct information.
            - Another TEP member noted the increased interested in improving EHR interoperability, something supported by the transition to Fast Healthcare Interoperability Resources (FHIR) measures and reflecting the work done by the Office of the National Coordinator for Health Information Technology (ONC).
    - A TEP member noted if these conversations occur in outpatient settings, inpatient doctors may not have visibility into them when the person is admitted.
    - Another TEP member agreed that both AD and POLST paradigm order forms are really outpatient documents and only marginally relevant to real-time conversations in the hospital.
    - Another TEP member noted if they are documented in the same place for inpatient and outpatient then we could see the important discussions that happened in the ambulatory space.
    - A TEP member suggested a national POLST.
        - A TEP member noted that with the current political climate and the differences among state programs and laws, the likelihood of passing legislation to make that happen is vanishingly slim for the foreseeable future. They provided a link: https://polst.org/national-form/.
        - A TEP member noted it would be great if all these forms (e.g., medical power of attorney, living will) could be standardized. They noted that we are a mobile society and getting these forms completed after the appropriate discussions is hard enough, let alone keeping track of directives from multiple states.

Question 2: What is your ideal approach for capturing documentation of EOL discussions?

- A TEP member noted that for scalability, we need to have a harmonized process that is human resources agnostic and can be used in the course of regular work, such as a potential template or using natural language processing (NLP) to get these conversations that are already taking place out of the record. POLST is for outside the hospital, and it is not really a hospital order set in the first place.
- A TEP member noted POLST is for outside the hospital. For people who are going home, it is great to send them home with a POLST, especially if they want to limit their treatment. Since this is an inpatient denominator, we are talking about, they would recommend getting the focus off the POLST. Everyone has code status order sets in the hospital and those reflect that there

was some sort of ACP in most cases. They stated if there is documentation that a person has designated an agent to speak for them if they are incapacitated that is valuable and not that hard to pull from the record. Regarding documentation of an actual conversation, considering the way technology is going, and that there are some research studies that demonstrate they can pull out that a conversation occurred. (they referenced Jerry Powell's podcasts). If someone spent 16 or more minutes on this conversation, presumably they are billing CPT 99497, which is another data point that can be considered. They thought there was potential the code may be overutilized and abused, and conversations that took one minute may also be billed. These are some things CMS could be looking at. They noted if an AD cannot really be done in the hospital, it is unclear how it is helpful for demonstrating something has happened in real time. They supported taking a broader approach.

- A TEP member noted agreement with the previous speakers and thought there is something to be said for the new ways of capturing that there is documentation of patients' preferences and being less stringent about what it looks like. But again, that can result in box checking. It really can be a one-minute conversation and making the measure more relative to documentation versus documents is a middle ground that would reflect the quality of care better.
- A TEP member noted, with a lot of agreement from other members, that what we are really trying to get to is a state where the conversation is documented in a certain place in the EHR that is accessible to be seen across encounters and between clinicians. One of the struggles is if it is described in an admission note or an office visit note it cannot impact care because the emergency department (ED) cannot see it. This is where there is an amazing opportunity for CMS to drive system change. They are excited about the potential for a measure that encourages systems to put that conversation in the right spot in Epic. There is an ACP module that not everyone uses, and other health systems have different EHRs. If the metric drives people to put that conversation in the right place, so when the patient goes between settings you can see it, that would change patient care and improve outcomes.
    - The TEP member noted a secondary benefit of documenting it in those specific places in the EHR is that it meets the billing requirements for coding. While imperfect, they were more comfortable using the codes as a surrogate than the document because they reflect a substantive conversation occurred with a patient that met a time threshold. They would like CMS to think about the measure as a way to reward clinicians for putting the conversation in a place that is visible to everyone and where it can influence care. They have done this at the health system-level, using a dashboard for clinicians to show whether they put ACP activity where other people could see it. initially, the rates were extremely low, and clinicians pushed back in the ways Dr. Kline described (e.g., it is so much work, it is too hard), and then once they started to see we were not going to move and that was going to be the measure, they could see the benefit of being able to find the conversation when the patient came back. We improved the rates and made a lot of progress, which was way more impactful for patients coming through different settings than the documents.
- A TEP member agreed with collecting more than just presence of a document and noted existing measures built on the CPT coding.

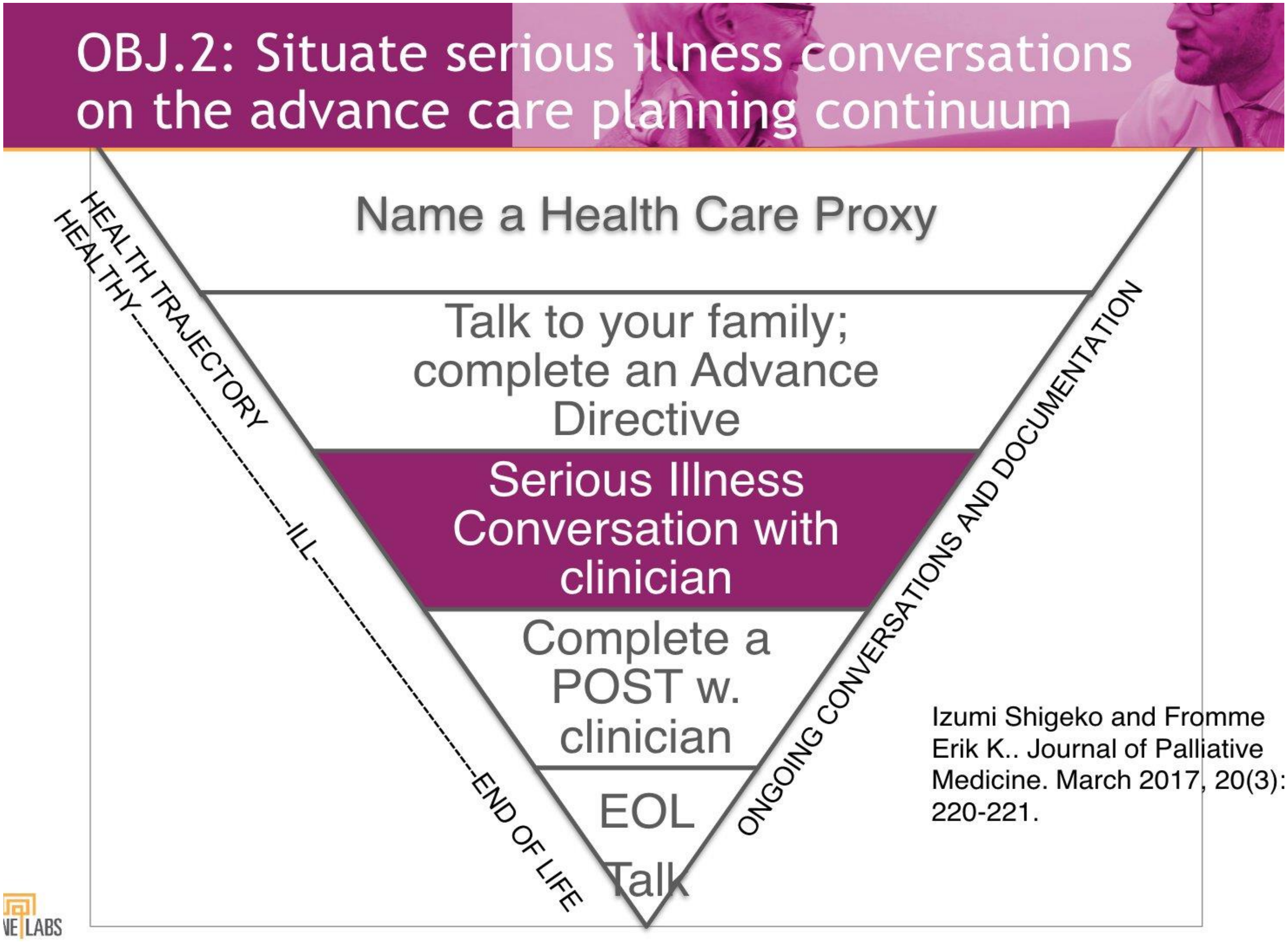
- A TEP member noted agreement with a prior TEP response regarding the importance of having the notes visible across clinicians. They stated there is a need to destigmatize EOL discussions, so it is just something that you do regularly.
- A TEP member liked the notion of a middle space, and the thing that concerned them was that research tells us most physicians believe that people with disabilities have a lesser quality of life than people without disabilities. There is a risk in emphasizing reduced burden for clinicians that jeopardizes people who need specialized communication and engagement. The nuanced discussion they can have with their sister is different than the one with a client that has spinal muscular atrophy. They thought it is a cautionary tale, and we need to proceed with awareness of the implicit bias that exists. There are a lot of people with disabilities for whom the way they eat is a feeding tube and the way they breathe is with respiratory support. They are not considered extraordinary measures in their lives and there is risk of them being injured because of implicit bias.
    - Several TEP members agreed.
- Dr. Kline noted CMS wants AD to be relevant, not just for the identified hospitalization, but also for long-term use.
    - A TEP member noted it may be helpful to clarify what AD are and are not and referred to Figure 1.
    - Another TEP member thanked Dr. Kline for sharing the clarification about wanting this to live beyond the current hospital episode, and they noted although it is a great idea, it is hard to operationalize an AD in the hospital because of the witness requirements. POLST orders are more easily achieved at the bedside and are appropriate for people with limited life expectancy who want to limit treatment, but it is not appropriate for a lot of hospitalized patients. They shared a link to a resource discussing the intended population for POLST: https://polst.org/wp-content/uploads/2020/03/2019.01.14-POLST-Intended-Population.pdf. They hope we can use this brain trust and the CMS team to figure out a way to expand what can count toward this measure, with an eye to incentivizing health systems and EHR vendors to include a place to easily document GOC conversations and treatment preferences.
        - Another TEP member noted that if our community clinicians could be notified by the EHR when patients have been hospitalized they could follow up when the patient is discharged. Too often, we do not find out unless we ask directly. They noted appreciation for CMS's attention to this and their desire to find a solution.
        - Another TEP member agreed it was a worthy goal and noted concern that a hospitalization may not be conducive to completion of a high-quality AD. The measure may incentivize superficial completion with would be worse than not having an AD.
        - Dr. Kline noted if there were an AD in place prior to the hospitalization, it would count.
        - Another TEP member stated hospitalization is often a key inflection point for a person with serious illness or receiving a new diagnosis. Preferences stated in prior AD completed in a different clinical context are frequently not relevant.
            - A TEP member agreed and noted the importance of discussing whether what the patient said a year ago is still accurate.

- A TEP member stated when their daughter had surgery, they had been going to the doctor for three years leading up to the surgery and the discussion should have taken place during that time, and the document put in place along with the blood work, lab work, and all of the other documents. Another way would be to have a discussion with your PCP that manages your health care that is notarized. The discussion never took place with their PCP. If the discussion doesn't happen before a medical event, there may not be time to have documents notarized. You need clarification beforehand when the person is alive and can speak on their own behalf about what they want.
- A TEP member noted sensitivity to the cultural implications that even talking about having the discussion can have on a family, and the importance of having the discussion before an emergency arises, such as a heart attack or surgery, because those are emotional times for the person and their family. They have seen families torn apart, and fissures occur that people will not come back from due to disagreements because the discussions did not happen, or the person had multiple discussions with different family members at different times. Some people decide in the heat of the moment and then carry around guilt about it for many years, questioning whether they made the right decision. They had a health scare last year and had their AD available on their phone which is a great place to save documents, medication lists, and physician information. The health team said they did not need it but later they did and fortunately their medical power of attorney knew what they wanted. They think about people who do not know they have this option and others who had a discussion ten years ago, as a lot can change in ten years including your opinion. They thought it was most important that people have discussions in the first place, and accounting for cultural considerations. People may not want to talk about it, and they may just want to let their family decide and those things need to be considered.
  - The TEP member noted how important it is to get wills done and funeral plans in place. Sadly, many omit the importance of having discussions about what they do and do not want before a crisis occurs. It is important for people to revisit their choices at least once a year and when their health changes, and their timeliest decisions can be honored.
  - Another TEP member noted preferences change based on context and AD do not contain that.
  - A TEP member responded that this story is the reason we know that the document is not the be-all-end-all, and having a relationship with someone who knows your wishes, values, and what you consider quality of life for yourself is most important.
  - Another TEP member noted patients want honesty and truth-telling from their clinicians. However, we know many clinicians are not even able to identify when patients are approaching EOL, and we need to ensure that clinicians are both able to identify patients who are in decline and feel comfortable having these discussions by offering training.
- A TEP member suggested the population denominator is narrow because patients trust their PCP, and they would be making these decisions in the heat of a crisis. There is a possibility of coupling the documentation and a document. They suggested one approach could be for CMS to require continuing medical education (CME) in GOC discussions. Having some sort of repository where discussions that are coded for billing for a documentation of GOC discussion can be

coupled with whatever documentation that was completed. It does not need to be a POLST as that is intended for people with serious illness that we anticipate might die in the next couple of years. There could be another document that the physician or any provider could complete and put into a repository. They did not think it was a good idea to just keep it for hospitalized patients. It is much better to have a provider that knows the patient and can discuss the risks and benefits.

- A TEP member stated they believe there is transformative potential for this measure, and they shared an image (Figure 1 below) they stated might be helpful for talking about potential denominators, because they thought maybe unintentionally, we were talking about different denominators. The point of the image is that ACP is a process, as has been discussed, and that there may be different denominators for different ACP stages. For example, at the top of the triangle it is widest because anyone who is 18 or older could reasonably name a healthcare proxy/surrogate, and the next step down from that is talking to your family and perhaps completing an AD, which they are calling an early-GOC conversation that is a conversation about goals and priorities, which you could say is good for any patient. They think there is a particular leverage point around serious or multiple chronic illnesses beyond which some patients may be candidates for a POLST form. The issue that has been alluded to is that those tend to be best when somebody wants to set some limits on their treatment as if you just want the standard treatment then the form is not going to help you. At the very bottom is the EOL talk, which is a GOC discussion that occurs late. The triangle narrows because the denominator of patients for whom these conversations is appropriate differs depending on the stage they are in their life, the stage of their illness, and what is important to them. They just wanted to make the point that there is a shifting denominator that needs further exploration for this measure.
    - Another TEP member noted people are uncomfortable talking about EOL, and most people struggle to make decisions on hypotheticals. Identifying a proxy is a much easier conversation. It is also very applicable for people whose capacity for healthcare decision making is questioned. The bar for identifying a proxy is very different from the bar for capacity to make a complex healthcare decision.
- A TEP member stated there is not a measure or a modifier code we put on claims that indicates someone is within the last six months of life and they thought that needs to be identified. They also commented about relevancy across settings because of course conversations someone has when they are in a crisis in the hospital setting look different than when they feel better outside the hospital. A lot of these measures end up being tested in an inpatient setting and then get pushed to outpatient or ambulatory settings, and they would love to ensure we do not use the wrong measures when we are talking about those people. Everyone wants to have these conversations with a clinician they know and trust, and theoretically the gatekeeper should be the PCP. The reality is the PCP is not having these conversations, and it is up to palliative care clinicians in the hospital who are consulted to have these conversations when the patient is in crisis. Hopefully, if they get discharged to a community setting, maybe there is a palliative care consult or a follow-up discussion but too often it is a conversation that happens in sort of a vacuum and then it is hard to carry it forward. They suggested better training (e.g., Vital Talk courses) for clinicians to identify when a patient is in decline and to have those skillful discussions. There are a million ways we can support clinicians and PCPs, and not just rely on specialty palliative care clinicians.

Figure 1: Ariadne Labs Advance Care Planning Continuum



OBJ.2: Situate serious illness conversations on the advance care planning continuum

Name a Health Care Proxy

Talk to your family; complete an Advance Directive

Serious Illness Conversation with clinician

Complete a POST w. clinician

EOL Talk

HEALTH TRAJECTORY

HEALTHY-----------ILL-----------END OF LIFE

ONGOING CONVERSATIONS AND DOCUMENTATION

Izumi Shigeko and Fromme Erik K.. Journal of Palliative Medicine. March 2017, 20(3): 220-221.

    - The TEP noted, regarding the billing code, they agree there is an opportunity to capture that a conversation happened, but not necessarily the documentation. The limitation in the hospital setting is that those conversations theoretically happened with the physician (someone with a National Provider Indicator [NPI] that can bill); if a registered nurse (RN) or social worker held those conversations it may not be captured with a code. The teams can vary depending on the hospital bylaws. These conversations should never be “one and done” and should be introduced at the initial diagnosis of a serious illness, and then be ongoing depending on any change in condition. Hospitalization is an inflection point which indicates that another conversation needs to be had. They have stress around AD because often people comment they want everything done and that is not a good way to introduce a conversation. Everybody wants everything done, and they worry sometimes these conversations are potentially not helpful for underserved populations or populations who have been traditionally mistreated by the medical system. We need to be very careful on how these conversations are introduced.
- A TEP member noted it is also important to think about the inpatient applications in this space. In their clinical role as a medical interventionist, they spend an hour or two each day having GOC conversations with patients and family members, and they have never billed for the ACP CPT code in the inpatient setting because it gets folded into the critical care they are providing for patients and their families. They do their best to document those conversations in that ACP tab of the EHR. The hospital has worked to enhance that centralized documentation. The point earlier about thinking of this at the hospital system-level rather than focusing on the individual patient level, by making sure that their EHR has a centralized place for documentation and then incentivizing or promoting clinicians to document that information in the right place is going to have a transformative impact on the care we provide. If we could see all those conversations, then the AD or POLST do not matter as much. They do matter for the more narrowly defined populations that others have referenced, but the content evolves and having a centralized place is a key thing. CMS could somehow incentivize those builds in Epic or whatever system, and then get the clinicians to put the information there.
    - Another TEP member agreed having a centralized place to document conversations would be a great opportunity.
    - Dr. Kline expressed support for a quality measure that quantified GOC discussions that incentives health systems to document these conversations and/or forms in a centralized EHR location.
        - A TEP member suggested being mindful that if overly incentivizing (or exclusively recognizing) these legal documents, it will have unintended consequences, and on the whole, do more harm than good.

Discussion Session #3: Measure Cohort

- Dr. Khidir stated that CORE is proposing limiting the measure to include those 65 years and older who are hospitalized, as this population has the greatest need for ACP discussions and it aligns with the existing Merit-Based Incentive Payment System (MIPS) ACP measure. She noted the CORE team’s interest in getting feedback from the TEP in the short amount of remaining time, as well as if there are other criteria or exclusions that should be considered.

Question 3: What patient populations or criteria, if any, should be considered as exclusions?

- A TEP member noted these discussions can be had at the PCP office during the patient's yearly Medicare visit, to meet the needs of the population including the disability community because those are the people we need to reach, as well as those who are being well-managed with serious illness outside the hospital.
- A TEP member noted including everybody over 65 is simple, but there are a lot of people over 65 who visit the hospital for things like elective joint replacements or other types of elective surgery. They wondered if capturing patients' status (e.g., fair, serious, critical) could be used to indicate a level of seriousness, because maybe everyone over 65 is not the right population. They noted that more 65-year-olds are appropriate for these serious illness GOC conversations than the population at large. If you are in the hospital with a serious condition that is not self-limited or expected to resolve, these discussions should occur.
    - Another TEP member noted they would like to see the measure applied to patients with serious illness as plenty of 65-year-olds are healthy.
    - Another TEP member noted using age is administratively simple but will not drive the desired behavior as much as limiting to serious illness, and suggested selecting broad diagnostic categories and acknowledging it will not be perfect but would make this less of a check-box measure.
    - Dr. Kline asked about an approach to extracting "serious illness" from claims.
        - Several TEP members noted there are many approaches that have been used for research that look at International Classification of Diseases, Tenth Revision (ICD-10) codes during the preceding 12 months and suggested asking information technology (IT) experts, looking at ICD-10 codes used in palliative care consults, or at codes used for those diagnosed with a progressive chronic illness.
        - Another TEP member noted the best models are proprietary, but some have been published. If we include healthy people, we just need to be sure there is no incentive to complete a POLST for them. Completing a POA or AD is okay for healthy people. As you pointed out, over time the measure can be improved, and one way to improve it would be to discriminate between seriously ill patients to ensure they have documented conversations.
            - A different TEP member noted agreement but stated it could complicate implementation.
        - Dr. Kline noted the 65-year-old healthy male who has a heart attack shoveling snow would not have an AD in this scenario.
- A TEP member suggested an obvious exclusion is if the patient does not want to do it. And they cited the federal Self-determination Act, and noted the point is it must be voluntary. It is an opportunity that should be offered to patients, but they should never be compelled to do it and there needs to be a clear mechanism for patients that wish to opt out. They noted as long as you count documents that are relevant to healthy 65-year-olds, they would exclude patients who opt out as it is part of federal law.
- A TEP member did not think 65 was the gold number and noted 18 and older might be better. Once a patient is 18 and in an inpatient situation, they need to give permission for parents to be included in care planning. Parents have decision making authority for patients younger than 18.

They noted it is not just EOL and not just Medicare patients that have the need for these discussions.

- A TEP member agreed that there should not be a golden age because they have friends who were much younger that had something happen where a conversation about their preferences would have been beneficial. It is not a difficult conversation when people are healthy. They supported the idea of bringing this up at the annual Medicare physical. We should stop stigmatizing the EOL and death because it is not such a bad thing and eventually it happens to everyone.
- A TEP member also agreed with the comments about expanding the age to include 18 and older, and even those who are relatively healthy and having elective procedures. If we only focus on 65 and older, we lose a significant part of the population that would benefit from this. They noted they are seeing hospice patients getting younger and younger in the past few years. Unexpected things can happen even during "routine" surgeries and for those under 65.
    - Another TEP member wondered if we are already restricting the measure to people who are hospitalized, if we still need to include the 65 and older age restriction. They suggested excluding those younger than 18 from the measure, but not from the opportunity, as decision making is different in that population.
- A TEP member noted that broadening the age range and capturing language of seriously ill patients would complicate implementation. On the other side, they also know anecdotally from research that 25-year-olds who are not seriously unwell and do not live with chronic illness really cannot dwell in hypotheticals. Trying to have a conversation with somebody about this regarding what they want in 20 years may not really work. They stated that Figure 1 was phenomenal in that it illustrates a level where people can talk about what the backup plan is when you need somebody to make decisions on your behalf. Having the healthcare proxy conversation makes sense, even for younger patients. They did not think focusing on everyone 65 and older was right.
    - Another TEP member noted a systematic review on EOL treatment preference stability found that community-dwelling older adults (e.g., not those with serious illness) had the lowest rates of preferences stability and a single document for that group of people is likely to be irrelevant if/when an actual new health situation arises.
- A TEP member noted the challenge of asking people to elect what an acceptable quality of life is for an experience they have not had yet and is not proximate to them would result in forecasting errors that are extreme, as humans are adaptable. They agreed having a designated decision maker is a no-brainer and relevant for everyone and stated that having conversations about what makes life meaningful to you with your designated decision maker and your doctor makes sense as well. They did not think AD or POLST makes sense for everyone.
- Another TEP member noted the denominator for the TJC measure is patients receiving specialty palliative care in an acute hospital setting for one or more days. They confirmed this is part of the palliative care specialty certification and stated it is a self-limiting population.
- Multiple TEP members expressed gratitude in the shift of the discussion and expressed hopefulness this is moving in a more positive and helpful direction.

Wrap-up

- On behalf of CORE, Ms. Thottam thanked the TEP participants for their time and valuable feedback, as well as their flexibility in adapting the agenda. She noted their continued feedback was welcome and encouraged TEP members to send emails with additional input at any time to CMSPatientGoalSetting@yale.edu.
- Ms. Thottam noted the next steps for CORE's Patient Goal Setting team including:
    - Following up by email with the TEP regarding the third discussion question in the slide deck for input following today's meeting;
    - Sharing a summary of today's meeting for TEP review in mid-February; and
    - Considering TEP feedback during the measure development process.
- Ms. Thottam noted next steps for the TEP members, including:
    - Reviewing and sending any suggested edits to the meeting summary;
    - Completing a brief survey about their experience during this meeting; and
    - Reaching out via email if they have any questions and watching their email for future project updates.
- Dr. Kline thanked participants for sharing their thoughts and noted understanding of and appreciation for the complexity of this conversation.

Appendix C. Email Communication Following the TEP # 1

This appendix includes a summary of feedback from a TEP member not present during the live meeting as well as responses from various TEP members regarding an additional question posed to the TEP via email.

Responses From Member Not Present During Live Meeting

Follow-up email from a TEP member who was unable to attend the virtual meeting and was provided the meeting recording.

Question #1

I agree that there needs to be a way to determine that end-of-life (EOL) documents are in place or a minimum the patient has been informed.

Question #2

Using the primary care physician to query for this information and provide guidance during a yearly physical may be a good course of action. Start this process at age 18 years of age. This obviously will evolve as the individual ages.

Question #3

I know you tabled discussion 3 but I will give my input now.
Ages to exclude should be 17 years and under.
65 and older would just be a starting point. Once the process is debugged it should then be visited yearly by the PCP starting at 18 years of age.

CORE Post-TEP Email Message (sent to all TEP members January 29, 2024)

The Patient Goal Setting Measure Team reached out to TEP members on January 29, 2024, asking for TEP members to share feedback on the following question: *Should psychiatric advance directives be included in the measure numerator? Why or why not?*

TEP Member Response #1

It would be valuable to capture documentation, as discussed in the meeting. One relatively easy way to do that would be through using a note type called “Advance Care Planning” – this could be standardized in all EHRs and would not require extensive informatics build (i.e. does not require natural language processing) and is for good clinical care. Clinicians should enter discussions related to goals of care in a note in the EHR.

Like the way that patients need Admission H&Ps, discharge summaries, operative notes, etc., this could be a meaningful way to capture that a discussion occurred (as opposed to documents being present – since documents completed by an attorney 20 years ago may no longer reflect the patient’s wishes).

Psychiatric advance directives should be a distinct grouping, as the content of their advance care planning discussions are different and it would be valuable to understand how often these take place compared to advance care planning in the population without serious mental illness.

TEP Member Response #2

I have a few thoughts I'd like to share with you all in regard to questions 2 and 3. #2 All patients aged 65 years and older. Exclusions: Those with severe mental illness or cognitive issues to which they cannot make informed decisions on their own should be excluded from the measure only because it is usually someone else that makes those decisions for them.

Age shouldn't matter for this group.

If it doesn't address end of life issues, then it shouldn’t be included in questions about end of life choices.

My personal feelings on when to ask or talk about end of life wishes should be given to anyone having invasive surgeries or procedures or those being sedated at age 18 up.

With the increase in medical errors at least in this state it seems wise to have that information on hand.

I have had a few incidents where a medical error occurred and the patient did not have an AD or any other mechanism to direct the doctors or hospital to their wishes. This leaves the family or loved ones to make those difficult decisions for them.

Someone I know is currently in the ICU on life support due to an incident involving an air bubble that went to his brain from a simple biopsy procedure. His daughter who is his next of kin was not prepared to make the choices and now has no choice but to.

Another friend went in for a simple heart test and had an error happen and went into cardiac arrest and never regained consciousness. They eventually had to do a procedure to help clear his lungs of phenomena and found he had cancer in both lungs. His Partner of 28 years had to decide what to do, luckily he and his partner had discussed his wishes beforehand. I served on a task force that was convened to discuss medical errors in my state. One of the members was a state representative who had lost his 9-year-old grandson to a medical error. Serving on this task force just reinforced my belief that we should all have something that shares our wishes if something happens.

TEP Member Response #3

This TEP is titled: “Patient End-of-Life Goal Setting Measure”. However, the presentation notes that the proposed measure will not focus on ‘identifying a patients’ personal decisions regarding EOL care; dictating how EOL conversations should be conducted; or influencing patients’ decision-making or preferences for EOL treatment”. The name of this TEP and the proposed measure numerator descriptions contradict each other. There needs to be clarification as to whether this measure is in fact promoting EOL care goal setting or not.

Psychiatric advance directives (ADs) do not dictate preferences for EOL care. The ones I have seen indicate preferences for types of psychiatric medications, whether a person would want to be admitted, electroconvulsive therapy, etc.—all specific to managing psychiatric care. So, if the goal of the measure is to improve documentation of a person’s EOL goals, then a psychiatric AD document should not be included.

If the intent of the proposed measure is to gather documents that indicate patient wishes, not specific to EOL, then I think psychiatric ADs could be included in the numerator.

TEP Member Response #4

No, psychiatric advance directives should not be considered. That has nothing to do with end-of-life care, and in many states they are not even available.

Appendix D. Detailed Summary of TEP #2 Meeting

Advance Care Planning Measure Technical Expert Panel (TEP) Meeting #2 Minutes
Monday, June 10, 2024, 2:00–4:00 PM ET

Participants

- **Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation (YNHHSC/CORE):** Kathleen Balestracci, Shefali Grant, Monika Grzeniewski, Roisin Healy, Hazar Khidir, Prince Omotosho, Michelle Sanchez-Silva, Lisa Suter, Mariel Thottam, Nicole Walton, Patricia Faraone Nogelo, Laura Barrett (X4 Health)

- **Technical Expert Panel (TEP) Participants:** Catherine (Katie) Auriemma, Rory Farrand, Rebecca Gagne-Henderson, Beryl Kenney, Shabina Khan, Leigh Ann Kingsbury, Roger Lacoy, Lydia Mills, MaryBeth Nance, Stephanie Parver, Karl Steinberg, Scott Sussman

- **Centers for Medicare & Medicaid Services (CMS):** Melissa Hager, Ron Kline, Ngozi Uzokwe

Detailed Discussion Summary

Welcome & Introductions

- Ms. Mariel Thottam welcomed the TEP members, provided opening meeting remarks, reviewed the meeting agenda, and introduced the other CORE Stakeholder Engagement team members on the call.
- Dr. Hazar Khidir introduced herself as a board-certified emergency physician, a Yale School of Medicine faculty member, and the measure lead for the CORE Advance Care Planning (ACP) measure; she introduced additional ACP team members.
- Dr. Khidir welcomed attendees from CMS.
- Dr. Khidir noted the project team's appreciation for the TEP members' participation, given the personal and professional expertise they have and their willingness to provide input about the proposed measure.
- Ms. Thottam reviewed the TEP member responsibilities and confirmed the TEP's approval of the TEP Charter.

Measure Updates

- Dr. Khidir noted the goal of the hospital-level ACP measure is to promote person-centered end-of-life (EOL) care in which patients, or their caregivers, have an opportunity to specify their preferences for medical treatment at, or in preparation for, the EOL.
    - She noted that the initial measure concept was presented at the TEP meeting on January 24, 2024, and in response to TEP feedback, CORE has updated the measure specifications.
    - She noted that the measure name has changed from Patient Goal Setting Measure to Advance Care Planning (ACP) Measure.
        - Dr. Khidir highlighted the importance of the measure to promote ACP discussions and prevent unnecessary and potentially harmful clinical interventions that compromise patient safety, increase suffering, and diminish quality of care.

    - This measure marks the first iteration of a hospital-level quality measure that will create the opportunity to incentivize improvements in ACP for patients. Future iterations of this measure will aim to enhance capture of ACP and discussions.
        - Dr. Khidir summarized the TEP's previous valuable feedback about the initial measurement approach and their concrete recommendations for changing the initial measure specifications:
    - The measure numerator should be expanded to capture documentation of patient-centered ACP discussions between patients and their care team;
    - The measure cohort should be expanded to a broader adult patient population as EOL goal setting is relevant to patients of any age and stage of health;
    - The measure numerator should acknowledge the value of setting a health care proxy (HCP) for a broad adult patient population; and
    - The measure numerator should not include psychiatric Advance Directives (AD), as they do not reflect preferences for EOL care.
- Dr. Khidir reviewed the changes to the ACP measure concept specifications:
    - The revised measure numerator is patients who have an ACP document, or documentation of an ACP discussion in the medical record by the time of discharge**.** The numerator may be satisfied by one of the following:
        - ACP document, as evidenced by
            - Health care agent (HCP or Medical Power of Attorney for Health Care)
            - AD or Living Will
            - Portable medical orders (Medical Order for Scope of Treatment [MOST], Medical Orders for Life-Sustaining Treatment [MOLST], Physician Orders for Life Sustaining Treatment [POLST], or Do Not Resuscitate [DNR] Order form)
                - Other documentation that an ACP discussion occurred during hospitalization prior to discharge, as evidenced by the ACP note or the ACP Current Procedural Terminology (CPT®) codes 99497 or 99498.
    - The revised measure denominator:
        - Patients aged 18 years and older who are discharged from an inpatient hospitalization within the measurement period.

Discussion Session #1

- Ms. Thottam presented the following discussion question:

Question 1: Do you agree that this measure, as a first step, can positively impact the provision of advance care planning?

- A TEP member expressed appreciation to CORE for incorporating TEP feedback into the measure. They asked about operationalizing the ACP document options and if the existence of ACP documents completed prior to the hospitalization counted, or if only the document concurrent to the hospitalization would satisfy the measure. They suggested it could be challenging if there is an earlier document that may no longer be relevant. From the population standpoint, they liked that age is not a requirement. They wondered if "all comers" is potentially overly broad for EOL preparations and actions when really this applies more to individuals of any age with a serious illness or an advanced chronic disease. Overall, they think the measure is a great first step and is headed in the right direction.

  - Dr. Khidir clarified the measure aims to capture a note or CPT code for capture of an ACP discussion. The discussion should happen in the encounter during hospitalization by the time of discharge to capture recent ACP discussions. She added the document requirement for the numerator would include ACP documents (e.g., MOLST or POLST forms) completed prior to the qualifying encounter or outside the hospital encounter such as a primary care.
- Another TEP member agreed it is very gratifying to see the amount of TEP feedback that has been incorporated into the measure. They echoed the previous TEP member's sentiments about the revised cohort aged 18 and older and asked about situations when a teenager/young adult is admitted to the hospital for a car accident and expected to recover (and not in the seriously ill population). There are plenty of teenagers admitted to the hospital for serious illnesses such as cancer. In this case the cohort may be overly broad, and they noted concern over capturing ACP documentation or conversations that may be irrelevant to the individual's illness.
  - Dr. Khidir shared CORE's approach to the expanded measure cohort, highlighting the inclusion of HCP as a separate numerator option to ensure applicability to the broader population's needs. The intention is never to force discussions of EOL treatment decisions on an 18-year-old who is not ready to have those discussions. In keeping the numerator options very broad, we are aiming to tailor and cater to a broad audience, ensuring there will be a document that is relevant to anyone.
- Another TEP member agreed with previous comments about including individuals with serious illness and suggested the measure allow for the ACP conversation that may have occurred with a patient's primary care provider (PCP), someone the patient knows and trusts, whereby decisions could occur in a calm and crisis-free environment.
  - Ms. Monika Grzeniewski (in chat) clarified the measure is intended for the hospital setting and will only capture ACP discussions that take place during the hospital encounter. If a patient has completed any documentation in a different setting, such as with their PCP, this could be captured if it is confirmed and documented during the hospital encounter.
- A TEP member echoed previous comments, thanking CORE for listening to the TEP's feedback. They shared observations of watching patients in both the hospice and hospital environments being younger and coming to EOL. They noted experience with emergent situations in which there are a host of other patient-family issues, and they supported including a broader age cohort. For example, in Texas, the medical power of attorney is for anyone 18-years and older. The previous cohort definition of patients aged 65 and older excluded a very active population that may still get seriously ill. Lastly, they expressed that CORE has done a great job.
- Dr. Ron Kline expressed support for the expanded age cohort (aged 18-years and older) because of the uncertainty of recovery from accidents that young people may have (e.g., car accidents). He expressed gratitude for the TEP's previous feedback that designating an HCP is sufficient to accommodate a broader population. Although an 18-year-old may not know their preferences for EOL decisions, they can trust and assign their mother or father as their designated decision-maker. He also raised the challenges of measuring serious illness with claims codes. For example, although there is a code for congestive heart failure, they could be early, mild, or

severe. Serious illness seems like a straightforward issue at a clinician-to-clinician level but oftentimes is not.

  - A TEP member thanked Dr. Kline and agreed with his insight on the inclusion of HCP for younger people.
  - A different TEP member expressed appreciation and complete agreement with the inclusion of an HCP to help balance the inclusion of all patients aged 18 and older. They also asked about the approach to fulfilling this through only a legal document that addresses HCP (barriers to completing while inpatient are still high) versus documentation of who the patient would elect as proxy (perhaps in an ACP note), in the absence of legal document.
    - Ms. Grzeniewski (in chat) confirmed CORE is exploring structured electronic health record (EHR) fields where an HCP is noted in addition to legal documents.
- A TEP member (Shabina) shared about their 18-year-old daughter who recently graduated from high school. In preparation for college, she can provide consent for parental permission to access her educational records (Family Educational Rights and Privacy Act [FERPA]). They suggested this is an ideal time for families and children to have EOL and HCP conversations. They also expressed support for expanding the age cohort.
- Another TEP member agreed that this measure, as a first step, can positively impact the provision of ACP and they supported the expanded age cohort. They noted seeing younger people with complex healthcare needs related to disability. From the lens of disability advocacy, they noted the importance of ensuring the revised measure numerator includes language that speaks to the voluntary nature of choice, especially for people with developmental/intellectual disabilities or dementia, or anyone who is perceived as having a lesser quality of life (QOL) due to the disability with which they present. They expressed respect for the physicians and clinicians who are working in the disability space and noted research to support that there are many physicians who are hesitant to have EOL conversations with people who have disabilities. They recommended specifically calling out that the ACP conversation was voluntary and not an assumed decision for someone (versus a conversation held in partnership).
  - Another TEP member noted they liked to ask about functional impairment and what a patient would be willing to accept, versus what care they absolutely do not want.
  - A different TEP member noted the challenge is that others make judgments about QOL and routinely assume disability equals poor QOL, so having this conversation over time really matters. Asking about QOL before serious illness or infirmity occurs never works. Also, it is important to ask people at different stages of life about, “what QOL works for you and what does not work?"
  - Another TEP member agreed with the previous commentors, adding that people change their attitudes as to what is "acceptable" based on changes in their functional status.
- Another TEP member noted support for the revised measure.
- A different TEP member agreed that the measure would have a positive impact and supported the expanded cohort, noting the measure will help normalize ACP conversations for patients and healthcare teams. Furthermore, it is easier for clinicians in the hospital to do the same thing for all patients. They suggested CORE consider adding a numerator option for patients to decline (e.g., ACP conversation was attempted, and the patient declined). They thanked CORE for incorporating the TEP feedback into the measure updates.

  - Dr. Kline (in chat) noted that the challenge with giving people the option to refuse those conversations is that clinicians use them as an easy-out and say the patient refused. This has been seen with COVID vaccination and depression screening.
  - The same TEP member noted agreement with the "easy-out" by clinicians, but that patients still have the right to decline if they want.
- Another TEP member confirmed general agreement with the measure and the future direction, noting it has potential to bring considerable positive impact and change.
- A different TEP member agreed with the expanded cohort and stated this is an overall positive step. From the delivery standpoint, it may be difficult to increase the uptake of this in the inpatient setting as it is one more thing for people to discuss and document, even though it is a positive step for ACP. It may be challenging to implement if there are no other population characteristics specified, such as the presence of severe illness. Overall, they agreed ACP should start younger than the age of 65.
- Another TEP member thanked CORE for listening to TEP feedback and shared from their experience that oftentimes family members are not the best choice acting in the roles of designated HCP. If patients, regardless of age, are in the hospital then they are probably ill enough to consider ACP, as criteria for hospitalization are strict. Everyone over 18 should be choosing an HCP, and it seems doable. They shared references to Providence Health's trusted decision-maker/ACP form as an easier alternative to a formal AD: https://www.chausa.org/publications/catholic-health-world/archive/article/pandemic-coverage/for-people-who-don't-have-an-advance-care-directive-this-quick-form-could-be-the-next-best-thing and https://www.instituteforhumancaring.org/Advance-Care-Planning.aspx
  - They expressed concerns that the current ACP CPT codes may be over-utilized or used inappropriately given the 16-minute minimum time to bill is hard to meet and conversations can occur in less than 16 minutes. They shared alternative codes that may be easier to capture and show that the conversation occurred:
    - **1123F**: Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
    - **(DEM) (GER, Pall Cr) CPT II 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
    - **(DEM) (GER, Pall Cr) CPT II 1157F**: Advance care plan or similar legal document present in the medical record
    - **(COA) CPT II 1158F**: Advance care planning discussion documented in the medical record
    - **(COA) CPT II S0257**: Counseling and discussion regarding advance directives or EOL care planning and decisions, with patient and/or surrogate (list separately in addition to code for appropriate evaluation and management service)
  - Another TEP member agreed with the 16-minute minimum to bill being hard to meet, and that valuable clinician conversations can occur in less than 16 minutes.
- Another TEP member noted support of the expanded cohort and asked about the approach for multiple patient admissions in the same year and whether there is a percentage of patients that we are expecting to meet the measure (e.g., 70% of all patients who are 18 and older met the measure).

    - Dr. Khidir noted no decisions have been made about thresholds or the approach to selecting the encounter to use in the event of multiple hospitalizations in the same performance year. She noted that CORE would update the TEP as the measure development process and discussions with CMS evolve. She stated that the TEP's suggestions for improving the capture of the different numerator options have been very helpful to CORE.
- Another TEP member noted that for doctor appointments, the front desk staff ask at intake about having an HCP or AD. It seems redundant to ask the same question at the front desk and then again in the hospital room; they asked if repeating the question was necessary.
    - Dr. Khidir noted that the multiple questions may be related to how the Patient Self Determination Act is handled in certain hospitals, as they must provide patients with ACP documents to complete. She emphasized the intention of this measure is to create something more robust as reflected by the numerator options. CORE is proposing more robust ways to measure that the actual discussion occurred, such as through structured fields and CPT codes. The hope is to give patients the opportunity for meaningful engagement in these discussions, rather than adopting a check-box approach. Future iterations of the measure will include a more nuanced and rigorous approach to capture these discussions.
        - Dr. Kline commented that the number of times people get asked the same question is something CMS is struggling with, most prominently around social determinants of health (SDoH) questions.
- Another TEP member asked about how the identification of ACP discussion documentation might be operationalized.
    - Dr. Khidir noted CORE is investigating a variety of ways to capture these discussions through structured fields and other potential data elements, but no decisions have been made on the final approach.
    - Dr. Katie Balestracci highlighted the iterative nature of measure development, especially for a measure using EHR data; this involves a thorough understanding of data location, source, structured fields, and the best approach to capture the data. This process might require hospitals to determine the best ways to capture data internally, both to support the measure and more importantly, to support higher quality patient care. The same TEP member agreed that it would be great if ultimately this measure drove more consistent ACP documentation across healthcare systems to make this information easier to find and act on for the next treating clinician.
- Another TEP member asked if CORE had considered data capture though an "ACP" note type.
    - Dr. Khidir confirmed CORE is investigating the ACP note type template and module within healthcare record systems and is in the process of identifying the most robust ways to capture data and ensure interoperability and standardization of information across hospitals, healthcare systems, and records.
- A different TEP member noted they were finding that people do not know where the documents are located and whether the facility has the most recent version. They encourage people to take a photo and send it to themselves and their HCP/alternates, and to request that their documents be scanned before they leave the hospital. It seems that there should be an obvious box that provides a yes/no and the date of the most recent document.

    - Dr. Khidir noted that some health systems have the capability for patients to upload ACP documents into their own medical record and stated that we are at the forefront of innovation in this space; the measure will grow as innovation in health systems evolves and improves. The aim is to incentivize hospitals to ensure the ACP documents are useful to patients and easily accessible to patients and their providers.
        - A TEP member shared a chart review study which found that 65% of goals of care conversations were not in the ACP note template tab: https://link.springer.com/article/10.1007/s11606-024-08773-z
    - A different TEP member suggested this could be an opportunity for CMS to drive technology adoption (e.g., if you document a certain phrase in your note it automatically takes that content and adds it to the ACP section/notes).

Measure Importance and Face Validity

- Dr. Khidir noted that CORE is seeking the TEP's input on measure importance and face validity of the measure. TEP members were asked to respond to the following questions:
    - Measure Importance: The ACP Measure is meaningful and/or produces information that is valuable to patients and caregivers in making their care decisions.
        - Of the 11 TEP members present and responding, 55% (6) strongly agreed and 45% (5) agreed.
            - The ACP Measure could differentiate good from poor quality care among hospitals.
        - Of the 11 TEP members present and responding, 55% (6) agreed and 45% (5) disagreed.
    - Ms. Thottam noted a Qualtrics version of the face validity survey would be sent to TEP members who were unable to attend and the aggregated results would be shared with all TEP members in the forthcoming summary report.

Discussion Session #2

- Ms. Thottam presented the following discussion question:

Question 2: What might you like to see included in a future version of the measure?

- A TEP member recommended including the use of portable orders (e.g., MOLST, POLST) for people who want to limit treatments or forego excessively invasive procedures such as CPR or intubation. These portable orders could be created during the hospitalization and be sent home with the patient upon discharge. Oftentimes meaningful conversations about preferences do occur and orders are written while the patient is in the hospital, but when the patient goes home, it is as if it never occurred. For people who want default treatment (the most aggressive treatment), it is unnecessary to create a document because providers assume that is what everybody wants.
- Another TEP member asked if there is a specification for who could have the documented ACP conversations (e.g., social worker) or if they must be a physician or an advanced practice provider.
    - Dr. Khidir clarified learnings from the environmental scan and literature review (ESLR) showed that there are many different clinical care team members who can be important in supporting and facilitating ACP discussions. As the measure stands now, there is no requirement that a specific type of provider must complete the ACP discussion. Some of

    the numerator options are limited to clinicians and advanced practice providers, such as the CPT code and MOLST/POLST forms that require a medical provider signature. Multiple numerator options, including a generic ACP discussion documented in a note, can be fulfilled by other members of the care team. She confirmed this is an issue for CORE to consider in the future stages of the measure development.

- Another TEP member thanked CORE for writing the measure with the assumption of capacity, which is important in the disability space, and agreed with earlier comments to include the voluntary element and the patient option to decline the ACP conversation. They agreed with earlier sentiments to call out more specificity related to treatment preferences and they strongly cautioned about limiting who can have ACP conversations because limiting who is permitted to initiate and engage in these conversations may limit the occurrence of conversations and potentially alienate people.
- Another TEP member noted support of being inclusive about who can initiate and engage ACP conversations.
- A TEP member shared their experiences working at hospice and with three different hospitals within the same system noting there are differences related to who engaged in the ACP conversations with patients. Oftentimes nurses and doctors are too busy. As a chaplain, they are often called upon to talk with patients about ACP, and social workers are also engaged in these conversations. They agreed that limiting who can have the ACP discussion with patients would limit the decision-making capacity of the individual who needs to make specific choices, especially regarding changes to a MOLST or POLST. Hospitalists in their area do not have ACP conversations, so the patient would have to follow-up with another provider to complete the form.
    - They also noted decisions can differ wildly depending on whether it is an inpatient decision versus one when things are less emergent.
- A different TEP member noted it is not fair to criticize doctors, and they do not know many people who feel skilled in or "want" to have these conversations.
- Another TEP member noted that PCPs often do not feel comfortable having these discussions, so they did not think we can rely on them either. If a seriously ill patient in the hospital says they do not ever want anyone pounding their chest or ramming a tube down their throat, which is heard frequently in skilled nursing facilities (SNF), it is completely appropriate to write enduring orders for that and it would not be ethical to wait for the person to talk to their PCP.
- Another TEP member noted after discussing AD when charting, the language they always include (as appropriate) is something like, "Patient was alert and oriented, and clearly communicated his/her/their desire to name (insert name, relationship), who can be reached at (contact information)."
- A different TEP member noted several considerations.
    - They understand the desire to expand on who is permitted to have the ACP discussions, but they also recognized that some states have more stringent laws about who is authorized to have the ACP discussions, and they expressed concern about scope of practice when discussing the risks and benefits of therapeutic interventions.
    - They raised the issue of assessing the measure quality (e.g., the face validity poll) noting the quality depends upon the communication skills (e.g., presentation style, euphemisms, truth telling) of the clinician who is having the discussion. They suggested

    adding to the CMS conditions of participation a certain amount of required training on ACP discussions.
  - Lastly, they asked about which orders or discussions would take precedence when the patient had the discussion with their PCP.
    - A different TEP member confirmed the more recent POLST generally takes precedence because people can change their minds and it is not rare for hospitalists and/or inpatient primary care practitioners to complete a POLST; it should be common practice.
- Another TEP member supported the discussion about which conversation/order takes precedence given the conversation with the PCP occurred when the patient is in good health (as compared to their health status in the acute care hospital), whereby their opinions may be very different. Ideally they would like to see the following included in a future version of the measure:
  - Establish concordance that the patient's wishes were delivered (challenging to track) and capture/measure if the interdisciplinary team were included in the ACP conversations. This consideration may address the scope of practice issue. The interdisciplinary team approach represents the whole person (e.g., spiritual, psychosocial, and physical components) and accommodates clinicians' varying comfort levels with these discussions. This could be captured by asking if the ACP conversation was held with the interdisciplinary team or solo (with a section for the rationale, why/why not).
  - Related to distinguishing quality among hospitals, they suggested including a check-box (yes/no) to confirm that the provider looked for and read the ACP documentation. They explained that it is awful when patients and families have gone through these conversations and then their wishes are overridden because someone did not understand the POLST form (referenced the TRIAD study findings: 50% of emergency physicians do not follow the POLST because of difficulty interpreting it).
- A different TEP member recommended that the next iterations of the measure prioritize the inclusion of measure of delivery of goal or value concordant or discordant with care and a way to promote more nuanced and high-quality ACP conversations (as opposed to check-boxes).
  - Another TEP member clarified that the reason some providers or first responders do not know how to interpret a MOLST or POLST is unrelated to a problem with the orders, and rather is as an education problem. Furthermore, these types of orders help patients get goal concordant care outside of the hospital which is something CMS would like to achieve.
- Dr. Khidir thanked the TEP for their input, noting that CORE would consider these suggestions and questions as measure development continues. She underscored the challenges with measure development, including:
  - Competing demands such as the constraints of data availability and interoperability in the healthcare system. The hope is to incentivize hospitals to make improvements, so that iteratively, as health systems and health records improve, measure specifications can become more nuanced with the capture of meaningful information.
  - Varying legislative and legal requirements across states (e.g., AD witnessing requirements). There are competing demands for interoperability across states. This

    also applies to portable medical orders as the names vary across states. Some orders are integrated into the EHRs while others are not.
    - The most critical and difficult issue is measuring across a broad patient population, as these conversations are appropriately varied to meet each patient's needs. For example, an important conversation for a person who has advanced cancer could be when to stop cancer treatment. Although it is challenging to capture nuanced conversations that look different for different patient subpopulations, we can move forward with CMS in trying to better capture quality differences across hospitals in future iterations.
- Dr. Khidir asked for clarification on the mixed responses to the face validity question regarding the ACP Measure's ability to differentiate good and poor-quality care between hospitals.
    - A TEP member noted that not everyone has these conversations well and measuring the quality of the conversation would be difficult. For example, a poor ACP conversation could occur (and the box is checked) but it is unclear how quality is assessed and reflected in hospital quality outcomes. They suggested consideration of using the PRO-PM "Heard & Understood" to incorporate patient input into the quality measurement process (e.g., a follow-up survey). They noted that having a bad conversation is not necessarily better than having no conversation
    - A different TEP member commented about the challenges of measuring quality and asked who decides the definition and best approach. They noted deciding which outcomes to focus on is difficult and subjective.
    - Another TEP member noted disagreement that quality among hospitals could be differentiated by using one question and requested clarification about assessing quality with only one dimension.
        - Dr. Khidir clarified the hospitals are the entities that will be measured, and CORE is interested in the TEP's thoughts about the ACP Measure's ability to differentiate good from poor quality care among hospitals and the TEP's feedback to improve or adapt the measure.
        - Dr. Balestracci clarified that the statement is addressing whether a hospital that performs addresses ACP and engages in ACP discussions for a greater percentage of its patients is providing a higher quality of care compared to a hospital that addresses ACP for fewer patients. Noting that all TEP members agreed that this is an important measure, it is helpful to understand the more mixed response to the measure's ability to differentiate quality of care among hospitals.
    - A different TEP member responded that in some ways we do not know the answer to the quality question until we start to measure it this way and can assess how hospitals respond to the measure. The hope is to encourage meaningful conversations with high-quality communication resulting in the documentation of the conversation. It is impossible to predict the future and we do not know whether this will incentivize the desired behaviors. They asked about CORE's next steps for planned assessment of the measure and determining if the measure influences behavior.
    - Another TEP member commented that like most quality measures, it should be accompanied by quality improvement education. For example, if the hospital said, "at

our institution, we value ACP," and gave clinicians the tools, resources, and time to implement it, it may better reflect a high-quality hospital.

- Another TEP member commented that an important issue is distinguishing between quality and quantity of ACP conversations in hospitals. Secondly, when using the measure with rural hospitals that serve high populations of Medicaid patients with serious illness, it may appear they have better quality because they are doing more of this work. They were unsure whether this is an indicator of quality.
- Another TEP member noted that it would be interesting to learn more about how the process will work in hospitals. Although physicians confirm they are having these conversations, they do not seem to be documented in a recordable or accessible way. Perhaps they will need to make some adjustments in their documentation workflows.
- Another TEP members suggested creating a systems-level solution, similar to a prescription drug monitoring system (PDMP), for example, a centralized system that all hospitals feed into. Upon admission, providers would be required to check the system for the ACP-specific information and document accordingly in the EHR.
- Another TEP member suggested that CMS consider the role of acting as nationwide repository. In Connecticut, they consistently look at the MOLST, but this is limited by funding to create a repository. They thought a national repository would be very beneficial in changing the ACP landscape.
  - Dr. Khidir noted that although there are state registries for MOLST and POLST forms, they differ by state and among states there are differences in capabilities to communicate with EHRs. Maryland’s MOLST registry has the ability to communicate through EHRs, whereby providers can update the MOLST upon patient hospitalization. However, some states have strict regulations and requirements on who can access the information due to the sensitive nature of AD patient information. She agreed that in an ideal world, the information would be readily accessible and interoperable across states and healthcare settings (e.g., PDMP model). However, there are competing demands and constraints of differing state laws and abilities of registries to communicate with EHRs and healthcare systems.
  - Another TEP member agreed it would be lovely to have a federal registry with cross-state consistency in POLST orders, and it would also help if EHR vendors were less focused on making money and more interested in sharing information among people who need it. Most states with POLST registries (Oregon as an example) offer people the option to opt out if they do not want their information included. As health information exchanges and system interoperability evolve, it would help to have the EHR vendors prioritize the accessibility of information to clinicians who need it. They suggested CMS consider supporting this issue.
- A different TEP member suggested an idea similar to an identification (ID) badge for medical conditions (e.g., diabetes), whereby people could have a card in their wallet denoting the presence of an AD in their health record.

    - Another TEP member replied this does not work for people who do not drive or are undocumented, and sometimes wallets get left behind in a vehicle after a motor vehicle accident.
    - Dr Khidir confirmed that as an emergency provider, she sees many patients that do have a MOLST or POLST but it was not brought with/sent with them to the hospital.
    - Another TEP member supported an ID card and suggested that AD information could be included on a driver's license.
  - A different TEP member shared an article that references a "POLST tattoo," noting in some states bracelets or medallions are actionable. But not in all states. https://www.caringfortheages.com/article/S1526-4114(18)30572-9/pdf
    - Another TEP member noted long advocating for a tattoo.
    - A different TEP member noted the Texas Out-of-Hospital DNR (OOH-DNR) Order is paired with a bracelet or a necklace. The necklace or bracelet has to be purchased through the Department of Health and Human Services.
- Dr. Balestracci expressed appreciation to the TEP members for their time, valuable contributions, and impactful input that inspires a careful, thoughtful, and expansive approach to the ACP measure development work.

Wrap-up

- On behalf of CORE, Ms. Thottam thanked the TEP participants for their time and valuable feedback. She noted their continued feedback was welcome and encouraged TEP members to send emails with additional input at any time to CMSAdvanceCarePlanning@yale.edu
- Ms. Thottam noted next steps for CORE's ACP team including:
  - Sharing a summary of today's meeting for TEP review in late July; and
  - Considering TEP feedback during the measure development process
- Ms. Thottam noted next steps for the TEP members, including:
  - Reviewing and sending any suggested edits to the meeting summary;
  - Completing a brief survey about their experience during this meeting; and
  - Reaching out via email if they have any questions and watching their email for future project updates.
- Ms. Thottam thanked participants for sharing their thoughts and noted understanding of and appreciation for the complexity of this conversation.

Appendix E. Detailed Summary of TEP #3 Meeting

Advance Care Planning Measure Technical Expert Panel (TEP) Meeting #3 Minutes
Monday, June 30, 2025, 2:00–3:30 PM ET

Participants

- **Yale New Haven Health Services Corporation — Center for Outcomes Research and Evaluation (YNHHSC/CORE):** Kathleen Balestracci, Leianna Dolce, Floraine Evardo, Shefali Grant, Monika Grzeniewski, Thushara John, Shu-Xia Li, Jon Niederhauser, Nicole Voll

- **Technical Expert Panel (TEP) Participants:** Catherine (Katie) Auriemma, Rory Farrand, Beryl Kenney, Shabina Khan, Leigh Ann Kingsbury, Roger Lacoy, Karl Steinberg, Scott Sussman

- **Centers for Medicare & Medicaid Services (CMS):** Ron Kline

Administrative Items

- Mr. Jon Niederhauser welcomed participants to the third meeting of the Advance Care Planning (ACP) measure's Technical Expert Panel (TEP), and reviewed the agenda and goals for the meeting, which included 1) updating TEP members on the final measure specifications and testing progress, 2) presenting and discussing testing methods and results, and 3) reviewing procedures for determining face validity. He reviewed CMS funding source supporting this work, provided meeting guidance, and gave an overview of the CORE project team.
- Mr. Niederhauser reviewed TEP roles and responsibilities and charter and confirmed the TEP's approval of the TEP Charter.

Background

Measure Overview

- Ms. Leianna Dolce reviewed the project overview and goal.
  - She noted that CMS partnered with CORE to develop an electronic, hospital-level measure for capturing advance care planning documents, discussions and decisions. The goal of this measure is to promote person-centered care in which patients, or their caregivers, have an opportunity to specify the patient's preferences for medical treatment at, or in preparation for, the end-of-life (EOL).
  - She added that this measure is the first iteration of a hospital-level quality measure that will create the opportunity to incentivize improvements in advance care planning for patients and leverages ACP documents or ACP discussions captured electronically, which benefits both patients, and provider understanding of patient wishes.
- Ms. Dolce reviewed how instrumental the TEP has been in the development of the measure.
  - Ms. Dolce noted TEP feedback that influenced expansion of the cohort from patients aged 65 years and older to all patients ages 18 years and older, and expansion of numerator criteria to include identification of Health Care Agent and evidence of an ACP discussion. She thanked the TEP for their contributions in shaping the measure.
- Ms. Dolce reviewed the specifications of the measure.
  - The measure denominator is the number of patients 18 years and older with an inpatient discharge in the measurement period. The numerator is the number of these patients with evidence of an ACP document or discussion.
  - As the measure score is a proportion, a higher percentage score is better. The numerator can be satisfied by any of the four categories:

        - Health Care Agent, including Health Care Proxy or Medical Power of Attorney for Health Care;
        - Advance directive or a living will;
        - Portable medical orders, including Medical Order for Scope of Treatment (MOST), and Medical Order for Life Sustaining Treatment (MOLST), Physician Order for Life Sustaining Treatment (POLST) and Do Not Resuscitate (DNR) Order form or billing code or;
        - Evidence of an ACP discussion.
- A TEP member asked how ACP discussion is being captured.
    - Ms. Monika Grzeniewski stated that ACP discussions will be identified through a series of codes that will be pulled from electronic health records (EHRs), mostly through structured fields. She added that there is one billing code for DNR, which is linked to ACP templates or sections of the EHR.
    - A TEP member asked if the ACP discussion would have to be in the specific ACP note section, rather than free text within another note.
- Ms. Grzeniewski confirmed this and added that some versions of notes allow additional structuring that then allow for mapping on the back end, which is necessary for capturing the data in measure reporting. A TEP member asked if there are specifications on the timeframe for calculating the numerator. They asked for clarification regarding portable medical orders and if this included any patients with a DNR code status, considering that this order would not be written unless there is an ACP conversation.
    - Ms. Dolce responded that ACP discussions captured are those conducted within the measure period. For capture of DNR, the presence of the DNR code will determine whether it has been satisfied.
    - Ms. Grzeniewski confirmed that documents that are found in the measurement period may have dates that reflect an earlier time whereas discussions would need to occur in the measurement period. She added that for the DNR code, the current specifications are meant to be consistent with the DNR Order form, which is one of the documents acceptable in the measure.
- A TEP member asked if the documented code status in the EHR is sufficient in fulfilling the numerator or whether it is tied to the DNR code or order.
    - Ms. Grzeniewski noted that there are many default code statuses that can exist in an EHR and all are not included in the measure specifications. When DNR is coded, because that will never be the default value, it is understood to be the result of explicit conversations and notes that accompany that code.
    - The same TEP member expressed worry regarding this approach as sometimes code status be carried over from prior encounters, can be a placeholder, or at some point in time a conversation can change it. They inquired with other TEP members their opinion on the numerator time frame given their concern regarding the lack of an expiration date for some documents and evidence that these documents can be forgotten and not reflect current preferences for care.
    - A different TEP member stated that the DNR code was a Z code. This was confirmed by Ms. Grzeniewski. They added that this code is only applied if it is part of their Evaluation and Management (E/M) Coding and their Current Procedural Terminology (CPT) coding.
- There was question in the chat regarding whether there must be a resulting decision from an ACP discussion for the discussion to satisfy the measure numerator.
    - Ms. Dolce confirmed that the presence of the discussion is what is required in the coding. The particular outcome of that discussion is not tracked in the measure.

  - Ms. Nicole Voll noted that the focus is on the conversation, which is a billable code, such as "Education about advance care planning (procedure), SNOMEDCT code".
  - One TEP member stated that no decision is a decision in itself – full code and full treatment is a decision made.

Measure Testing Results

- Ms. Dolce reviewed the goals of measure testing assessing usability and use, importance including gaps in care, data element feasibility, and measure validity and reliability.
- Ms. Dolce noted that the team has completed testing utilizing three testing partners.
  - Testing partners A and C contributed data to three of the four sections of testing results, which include data element feasibility, measure performance and measure score reliability; testing partner B contributed to all those categories and additionally to data element validity, which only required testing in one data set.
  - She shared that each partner contributed to form a robust and diverse testing data set with a total of 43 hospital sites across three regions of the country, representing 338,473 patients and data from the 2023 calendar year and Epic EHRs.

Feasibility Testing

- Ms. Dolce reviewed data element feasibility. She noted that feasibility was investigated utilizing the CMS feasibility scorecard. Each testing partner evaluated their data for each data element (numerator and denominator elements) to determine if it was successful in four categories:
  - Data availability, which assesses whether the data element exists in a structured format in the EHR;
  - Accuracy, which assesses whether the information on this data element is from an authoritative source, such as a lab result or directly from the patient record being reported;
  - Data standards which assesses whether each data element uses standardized terminology, such as SNOMED, CPT, or ICD-10 codes. This category also assesses whether hospitals routinely utilize the terminologies for each of these data elements;
  - Workflow which assesses whether the data element is routinely collected during inpatient clinical care and requires no or limited additional data entry from a provider.
- A TEP member noted in the chat that there are many state-specific names for portable medical orders (POLST-type forms). They noted that there are only three out of 13 listed in the measure specifications shared and encouraged that when the final measure is released to include all of them.
- Ms. Dolce reviewed the results for all the required data elements. Overall, the scores revealed that ACP data elements are available, accurate, captured in standard terminologies, and captured during routine workflows.
  - She noted that the only data element that testing partners did not find to be available or fully accurate was the discussion of “Goals, preferences, and priorities for medical treatment.” Ms. Dolce noted that this finding is not surprising as this is a single code composing this category (listed individually due to its distinct code type), whereas the other data element categories have many codes available as options.
  - Ms. Dolce noted a greater number of negative responses across the workflow category. She stated that each testing partner indicated that many data elements are already routinely collected during inpatient care, which indicates that they do have a starting point for capturing some of the data elements and are able to perform well in the measure, but that there's also room for growth.

- Ms. Dolce summarized the key takeaways for each of the categories reviewed.
    - For data element availability, most numerator and all denominator data elements were available for testing partners;
    - For data element accuracy, most numerator data elements and all denominator elements had high agreement for accuracy among testing partners;
    - For data standards, all elements were available using standard terminology as required for selection in the measure.
    - For workflow, routine data capture is site specific and varies across elements; denominator elements were captured at 100% while routine capture of numerator events varied.

Data Element Validity Testing

- Ms. Dolce shared that testing was completed with partner B. She noted that there were six acute care hospitals to conduct the data element validity, and each patient chart reviewed was manually checked for evidence of all data elements. A percent agreement was calculated, which is the percentage of patient charts that had evidence of the document the EHR identified.
- A TEP member asked in the chat how a healthcare agent is identified.
    - Ms. Voll responded that a durable power of attorney and similar documents count as a healthcare agent. She offered to provide a full list. The TEP member noted that they would like to see the list.
    - A TEP member asked if it was required that someone have a durable power of attorney (POA) for healthcare agent. They noted that Dignity Health is utilizing a trusted decision maker (TDM) where they ask patients who they would like to make decisions for them. There is no legal documentation, but in California and some other states it is not required to have a document. Any adult, who has knowledge of what that person's beliefs and wishes are, is allowed to be a legally recognized decision maker. They noted that this was something to keep in mind as only a fraction of people have an actual durable POA for healthcare or medical DPOA.
        - Ms. Grzeniewski noted that this is a great point and that there are over a dozen codes that fall into this category and the team wanted to include the many legal options. The intention is that the measure would map those fields that indicate the healthcare proxy or agent that a person designates.
- Ms. Dolce shared the results of the data element validity. The key takeaway was that most data element testing revealed a high level of agreement, from 92% to 100%.
    - The only data element that did not score highly is the “advance directive” element. Advance directives had lower matching which was often due to the term being clinically interchangeable with other types of ACP documents, such as healthcare agent. Ms. Dolce stated that this is not considered a threat to measure validity. For the 15 instances in which documents were incorrectly coded in testing data as “advance directive” the documents were confirmed as belonging to one of the other acceptable numerator categories. This means that no patient was missed in the numerator.
    - Ms. Grzeniewski added that when the decision was made to expand the cohort to all patients 18 years or older, it was important to include a wide range of ACP documentation for this measure as, in practice, a lot of these terms are interchangeable or related, and most can be considered an advance directive.
- A TEP member asked if patients are seeing multiple doctors or physicians, would every provider have to have a physical copy of these documents?

  - Ms. Dolce noted that the measure is looking for the presence of the codes in the EHR, which is not linked to any specific provider, but to the patients themselves during hospital encounters. The measure is not necessarily tracking to see if hard copies have been provided to specific providers, but the main goal is that a patient chart has these decisions associated with them.
  - Dr. Katie Balestracci added that the team is aware that for patients, these documents frequently may be completed outside of the hospital setting, but it is important that hospitals always have access to them so that when patients are in an inpatient setting, providers treating them have access. This measure promotes hospitals to make sure that ACP documentation with their primary physician gets put into the EHR.
- A TEP member inquired about the charts reviewed. They noted being surprised by the percentage of individuals that had a healthcare agent identified and was curious to see the full list. They inquired about which fields are being drawn from in the EHR.
  - Ms. Voll shared that several of the hospitals surveyed had a dedicated team and were focused on this. They had a high number of patients with healthcare agents because they were looking at all patients to make sure that they had wishes written down, not only those who were sick or flagged the EHR for needing a DNR discussion. She noted that she can pull the list of specific fields in the EHR if it is helpful in seeing if it aligns with the TEP member's site.
- A TEP member also expressed pleasant surprise over the high percentage of healthcare agents. They inquired about data element "Goals, preferences, and priorities for medical treatment" that had a consistent "no" response in testing. They noted that they work with people with disabilities and those who have very complex healthcare needs, and often people who are older. They noted concern over not having significant representation for clear goals, preferences and priorities, despite having lots of identified healthcare agents, and that these agents may not be the person that they would want to make their healthcare decisions.
  - Ms. Voll noted in the chat that healthcare agent for these sites, for data element validity, was often labeled as healthcare proxy, often from social worker fields in the EHR. This also included a state-specific health care proxy form.
  - Ms. Voll added that the "goals, preferences, and priorities" data element was a singular data element, but it is part of the numerator along with healthcare agent, separated out in testing for logistical reasons. She noted that the team was disappointed to see that no testing partner had a specific structured field for that, but hopes that in the future for a structured field in order to prevent it being buried in the clinical note.
  - Dr. Balestracci added that if CMS puts a measure into reporting that has solid testing results, even if some hospitals have not appropriately used the codes, this incentivizes hospitals to correct or update mapping of those sections. She states that what is reassuring about these data results is that it tells us these data elements can be mapped, that many hospitals are using them, and that they are validly representing what is in the chart. For hospitals for which this is not happening, it is feasible to do so and they will be incentivized to do so.
  - A different TEP member added that as far as goals, preferences and priorities, it is hard to imagine any meaningful conversation that results in a DNR order not to encompass some level of goals, preferences and priorities. Those discussions may be with the patients themselves or with a surrogate but if they are ill enough to be in the hospital and has a conversation that results in DNR or comfort care, it is sufficient. They shared they do not see a point in seeing a goals, preferences and priorities conversation in detail.

        - Ms. Dolce added that that this is a good point, especially when any decision is made to create any of the other documents. The team wanted identify when patients have those discussions or caregivers have those discussions, not necessarily requiring a document is completed right there or within the visit.

Measure Score and Measure Score Reliability

- Ms. Dolce presented measure performance score results, calculated as the number of patients with evidence of an ACP document or discussion divided by the number of patients who are hospitalized during the measurement period. This number is a percentage, and results indicate a range of scores across hospitals. One score was calculated per each site of each testing partner
    - She noted that a wide range in measure scores or low measure scores highlight areas for improvement.
    - Hospital measure scores ranged from 13.3% to 84.3% across the 43 testing sites. The median score was 34.7%, and the mean was 40% (SD 16.7%). There is room for improvement for many facilities, but also sites that did extremely well. This shows that it is possible to perform well on the measure and likely certain practices or initiatives can be put into place to improve scores for some facilities that didn’t score as well.
    - Ms. Dolce noted that higher hospital scores in testing aligned with testing sites that have dedicated palliative care teams in place.
- Ms. Dolce presented the measure score reliability, noting use of signal-to-noise reliability testing statistics.
    - She noted that the Partnership for Quality Measurement (PQM), which conducts consensus-based entity (CBE) endorsement for quality measures that are used by CMS, advise having a minimum of .6 signal-to-noise reliability statistic for endorsement of a quality measure.
    - Utilizing data from all three testing partners, reliability testing indicated a median of 0.9991, a mean of 0.9987, with a range of 0.9939 to 0.9998. Ms. Dolce noted that this shows very high reliability, well above the PQM recommended 0.6.
- Ms. Dolce shared a summary of the main takeaways.
    - Testing showed that the data elements are feasible, available in structured fields, deemed accurate and follow national terminology standards.
    - The measure itself shows high reliability, and almost all data elements have a high level of agreement with patient charts.
    - The measure’s scores show an opportunity for improvement in the capture of ACP documentation and discussions, while identifying the attainability of high scores and well-performing facilities.
- A TEP member noted clustering in the bar graph of range of performance, where testing partner B was the higher performing health system, partner A being the lower performing health system. They asked that when thinking about a measure such as this, was it considered that additional contacts with the health system are likely to result in increased documentation and therefore greater ability to capture. They also asked if Care Everywhere [a feature of Epic’s EHR system] or, generally, the sharing of information across health systems, was being considered as all of the testing partners were using Epic.
    - Ms. Dolce responded that patients may get their care at the same hospital frequently, so it might be easier to have that documentation in place, but noted the importance of every patient who visits every hospital to have that documentation in their chart in some way. Even if they are visiting a new facility, that facility should make sure that they know the patients’ wishes.

    - Ms. Voll added that testing partner A is a health system not doing dedicated palliative care initiatives as opposed to testing partner B, who the team had reached out to as we were aware of the palliative care work that they were doing, which matched our needs. Testing partner C was a bigger health system and utilized more hospitals. They also had a bit more resources and pulled information from an electronic health information exchange (HIE). The team made sure that whatever data was pulled was from the front end of the EHR meaning clinicians would be able to see those documents. To the TEP member's point about all of the EHR systems being Epic, they were very different Epic EHRs with different fields. Epic does have a module for ACP specifically which was helpful. The team will continue to do small outreach to non-Epic sites for continued feasibility testing to make sure that other healthcare systems also have those fields to make sure this is feasible. If this measure goes through public comment in the future, we will get feedback from other folks who use different EHR systems.

Discussion

- Mr. Niederhauser asked each TEP member to share their perspective on the results or answer any combination of the following questions:
    - Do you have any questions on any of the results presented?
    - Do any findings surprise you?
    - Are you concerned about any results or aspect of the measure?
    - Do you believe this measure will provide useful data to hospitals?
- A TEP member shared that this is an interesting measure and will provide valuable information to hospitals. They expressed hope that this measure will provide motivation to find better ways to document goals, preferences and wishes in a way that is more easily accessible and ideally to have the content in a way that clinicians at the bedside are able to access more readily. They added that it is interesting that the higher performers seem to be the health system putting resources towards palliative care and might have those resources available to do so; they noted that they hope the measure does not become a proxy for existing resources and can serve as a way to help facilitate resource distribution to sites that don't already have it and not penalize hospitals that are already struggling in this space.
- A TEP member shared concerns regarding ACP as being ongoing discussions and not just one-time decisions.
    - Ms. Dolce added that the development team discussed potential issues with older documents being considered, but that there is an important line to walk with patient and provider burden and bringing up conversations again that a patient feels were already completed and addressed. She added that ACP choices do change and is an ongoing process, and ACP discussions as a portion of the numerator capture this.
    - The same TEP member added that it may not necessarily be an ongoing conversation between patient and provider, but also within the family unit to make sure everyone is on board.
- A TEP member shared their experience and their family members' experiences with healthcare visits and not sufficiently being asked about advance care planning. They noted that this is an important measure.
- A TEP member agreed that having a measure that ultimately is encouraging and incentivizing people to pay more attention to this and to have those conversations is important.
- A TEP member shared their experience with being asked if they had a healthcare proxy but noted it can be confusing to a patient who does not know that there are different types of

proxies. They noted that this is an important measure and that it is important for hospitals to know a patient's wishes.

- A TEP member stated that they think it will be a meaningful measure based on the wide range of scores. They shared that they are not surprised by any of this and that this measure will help move the needle in the direction of having meaningful discussions with people and allowing people to get treatments they want and prevent ones they don't want. They noted that their only concern is that this has potential to be gamed, but by at least putting this out there, hopefully meaningful conversations will occur.
- A TEP member noted this is important work and had nothing to add.
- Mr. Niederhauser thanked the TEP for their contributions and noted that this feedback is extremely valuable for this measure and strengthens the next steps for it.

Face Validity and Next Steps

- Ms. Dolce reviewed the face validity process. A face validity survey will be sent out to the TEP members via email to collect votes and rationale on the following three questions on a scale from strongly agree to strongly disagree:
    - 1. The Advance Care Planning Measure is easy to understand and useful for decision making.
    - 2. The Advance Care Planning Measure could differentiate good from poor quality care among facilities.
    - 3. The Advance Care Planning Measure is meaningful and/or produces information that is valuable to patients in making their care decisions.
- Responses are due by July 8th, close of business (COB). All TEP members are required to vote and provide rationale. Results will be shared as summary percentages.
- Mr. Niederhauser discussed next steps. TEP members will receive a survey link for the face validity vote, which we hope will be completed by July 8th. TEP members will also receive a debrief survey from the stakeholder engagement group via email where the team will inquire about experiences in this meeting and have a platform to share what went well and what can be improved and is a helpful way to continue to enhance all TEP meetings and meetings with the public. Additionally, the TEP summary report will be distributed to TEP members within the next few weeks, which TEP members will be required to review and approve.
- Mr. Niederhauser thanked the TEP for their contributions to this measure. Ms. Dolce also thanked the TEP and noted that they are instrumental to the development of the measure and in making sure it is meaningful to patients, providers, and everyone.
- The meeting concluded.