Kristina Mody

From: NCQA <noreply@ncqa.org>
Sent: Wednesday, April 26, 2017 1:56 PM
To: David Lown
Subject: NCQA PCS Response to Case #00142587

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Dear David Lown,

You asked the following question:
Advanced Directive
Question from a DPH: The way we understand the Timely Transmission of Transition Record metric, we are to transmit a copy of patient's advance directives (when we have one) along with the transition document. Our organization's Hospital Information Management department has concerns regarding this practice and advises against it. Their reasoning is because the Advance Directive copy that we have would not be valid for any other provider. The next provider would have to verify the patient's wishes and obtain their own copy of the directive when they have contact with the patient. HIM recommends sending only information we collect about the advance care plan such as: the patient has an advance directive (or not); the type of healthcare directive i.e. durable power of attorney, health care treatment directive, living will etc.; name and phone number of surrogate decision-maker; and pre-existing DNR/DNI POLST order (yes or no). We would value additional clarification regarding the expectation for transmitting a copy of a patient's advance directive document. Thank you.

NCQA's response:
Per the measure steward (PCPI): We consulted with our Technical Expert Panel and they determined that it is not the intent of this measure to provide an advanced directive as part of the transition record. Rather, the measure requires documentation of the following: Existence/availability of advance directives or a surrogate decision maker OR Reason for not documenting the existence/availability of an advance care plan or a surrogate decision maker (e.g., advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan, OR the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship) The measure does not require a facility to materialize and submit an advance care plan as part of the transition record.

NCQA's requirements are updated periodically, and organizations must follow the most current requirements. Policy/Program Clarification Support (PCS) responses are not valid after updates are released.

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This case is closed. PCS cases are now part of my.ncqa. To review this inquiry or submit additional questions, log in to my.ncqa.

Regards,

Holly Spalt