

Arizona Health Care Cost Containment System (AHCCCS)  
Arizona Long Term Care System (ALTCS)  
**Performance Improvement Project (PIP) Methodology**

**Project Title:** Documentation of Advance Directives

**Background:** An advance directive is a document that provides health professionals and/or family members with an individual's choice of preferred medical treatments when the person executing the document no longer has decision-making capacity (Sahm, Will and Hommel, 2005). An advance directive can also be used to record a patient's wishes to direct physicians to withdraw or withhold life-sustaining procedures (Smedira, Evans, Grais, 1990).

There are essentially two types of advance directives: living wills and health care powers of attorney. A living will is a document that informs health care providers of the kind of medical care the individual wants provided or withheld. Living wills can be nonspecific statements, scenario- and treatment-specific statements, or include value profiles. Under state laws, a living will typically takes effect when the patient is determined to be close to death from a terminal illness or is permanently comatose and cannot communicate his or her wishes for medical care. In general, once a physician receives a living will, he or she either must honor its instructions or transfer the patient to another physician who will honor them. States also have imposed requirements on what medical conditions can make a living will operative.

A health care power of attorney is a document that identifies a health care agent as decision maker for the patient. The health care agent has decision-making authority when the individual is terminally ill or permanently comatose. In addition, the agent may be given the authority to make any other kind of health care decisions, regardless of the condition of the patient, thereby giving the agent broader decision-making authority than typically specified in a living will (American Bar Association: Commission on Law and Aging, 2005). Under state law, a health care power of attorney typically becomes operative when a physician decides the patient is unable to make a decision.

Under the Patient Self-Determination Act (PSDA) of 1990, all Medicaid and Medicare providers are required to document, at the time of inpatient admission or enrollment, certain information about enrollee rights under state laws governing advance directives (OBRA-90, Pub.L. 101-508, 104 Stat. 1388). Medicaid Managed Care Regulations also requires that adults enrolled in Medicaid managed care organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs) receive information on advance directives and applicable state laws (Federal Register, 42 CFR 438.6(i), 2002).

A 1995 Report by the Government Accountability Office (GAO) looked at

implementation of the PSDA, and estimated that only 10 to 25 percent of Americans had documented their end-of-life choices or appointed a health care agent to do so. More recent studies suggest that the overall prevalence of advance directives in the U.S. is still very low, with one study finding that only 18 percent of adults had advance directives (DeLuca and Havens, 2000). The prevalence of advance directives was only 30 percent among older adults, seniors in HMOs, and nursing home facilities (Ibid). Another study found the prevalence of advance directives to be about 35 percent among nursing home residents (Bradley, Wetle and Horwitz, 1998).

The Arizona Health Care Cost Containment System (AHCCCS) requires that contracted health plans (Contractors) provide written information about advance directives to members as well as ensure that their contracted providers give such information to patients and document in medical records whether or not adult members have been provided the information. In addition, health plan contracts or agreements with hospitals, nursing facilities, home health agencies, hospices or organizations responsible for providing personal care must comply with federal and state requirements regarding advance directives for adult members, including documenting in a member's medical record whether or not an advance directive has been executed. Contractors also should encourage those health care providers to provide a copy of the member's executed advanced directive or documentation of refusal to the member's PCP for inclusion in the member's medical record. (See Appendix A: AHCCCS Contract/RFP No. YH07-0001).

Arizona maintains an electronic registry for advance directives – including living wills and health care powers of attorney – maintained by the Secretary of State, which may be accessed by providers through a secure, password-protected process. AHCCCS members may have advance directives filed with the Arizona Advance Directive Registry.

**Purpose:** The purpose of this PIP is to increase the use of advance directives by ALTCS members, as documented in their medical records. Baseline data will be used to assist ALTCS Contractors in implementing strategies to increase the use of advance directives among elderly and physically or developmentally disabled members and/or their authorized representatives (ARs). It is expected that Contractor education efforts will result in a greater percentage of ALTCS members and ARs utilizing advance directives to guide treatment decisions at the end of life or under other, specified circumstances.

**Measurement Periods:** Oct. 1, 2006, through Sept.30, 2007 (baseline measurement)  
Oct. 1, 2008, through Sept.30, 2009 (first remeasurement)  
Oct. 1, 2009, through Sept.30, 2010 (second remeasurement)

Additional measurements will be conducted until all Contractors demonstrate significant and sustained improvement from the baseline measurement.

**Study Question:** 1. What is the number and percentage, overall and by Contractor, of ALTCS

members with documentation of advance directives in medical records maintained by service providers?

**Population:** All ALTCS members, ages 18 and older, enrolled with Contractors as Elderly and Physically Disabled (E/PD) or Developmentally Disabled (DD) members.

**Sample Frame:** The sample frame will consist of ALTCS members who are:

- Continuously enrolled with the same ALTCS Contractor, with no more than a one-month gap in enrollment during the measurement period.
- 18 years of age or older at the start of the measurement period.

**Sample Frame Exclusions:** The sample frame will exclude:

- Members younger than 18 years of age at the start of the measurement period.
- Tribal and fee-for-service members will be excluded due to the inability to accurately collect complete data on these populations.
- Members who did not meet the continuous enrollment criteria.

**Sample Selection:** A statistical software package will be used to select a representative random sample by Contractor from the sample frame. The sample size will be determined using a confidence level of 95 percent and a 5-percent confidence interval. A 10-percent oversample will be used to account for missing records.

**Data Sources:** AHCCCS recipient enrollment data will be used to identify members who meet the sample frame criteria. Member medical records will be used to identify whether each sample member meets numerator criteria.

**Data Collection:** Recipient data will be collected from the AHCCCS Prepaid Medical Management Information System (PMMIS). When a representative random sample is identified, AHCCCS will request that Contractors verify whether service providers have documented any form of advance directives in those members' medical records, according to specific instructions from AHCCCS.

Contractors will collect data using the AHCCCS standardized methodology in an electronic format provided by AHCCCS and return the data in the predetermined electronic format.

To meet Balanced Budget Act (BBA) requirements for valid and reliable data, Contractors will maintain documentation for all numerator data that collected (i.e., a copy of the pertinent section of the medical record documenting that a member has executed an advance directive). Refer to "Operational Definitions" for acceptable documentation of an advance directive. The documentation must include the patient's name and date of birth or other unique identifying information.

**Confidentiality Plan:** AHCCCS continues to work in collaboration with Contractors to develop, implement and maintain compliance with Health Insurance Portability and

Accountability Act (HIPAA) requirements. The Data Analysis & Research (DAR) Unit maintains the following security and confidentiality protocols:

- To prevent unauthorized access, the sample member file is maintained on a secure, password-protected computer, by the DAR project lead,
- Only select Division of Health Care Management (DHCM) employees, who enter or analyze data, have access to study data.
- Sample files given to Contractors are tracked to ensure that all records are returned.
- Member names are never identified or used in reporting.
- Upon completion, all study information is removed from the computer and placed on a compact disk, and stored in a secure location.

**Data Validation:** The sample frame will be validated to ensure that members meet criteria for inclusion in the study.

Data files received back from Contractors will be reviewed to ensure that:

- all members included in the sample are listed in the returned data file,
- returned data meets numerator criteria for this measurement,
- all requested information is provided.

Contractors may be asked to supply copies of advance directives maintained in service providers' files, or other documentation in the member's chart that an advance directive exists and where it is located, for their sample members, in order to validate Contractor-supplied data. Contractor's will , at a minimum, supply the provider name, address and phone number where the advance directive is located.

**Indicator:** The number and percent of sample members who have any form of advance directives documented in one or more medical records maintained by the Contractors' service providers.

**Denominator:** The number of members who meet the sample frame criteria.

**Numerator:** The number of sample members who have any form of advance directive, as documented in medical records maintained by at least one of the Contractor's service providers.

**Analysis Plan:**

- The numerator will be divided by the denominator to determine the indicator rate.
- Data for members who have advance directives on file with the Contractor's service providers (numerator) will be analyzed and reported as a statewide aggregate and by Contractor.
- Numerator data also may be analyzed and reported by gender, by urban versus rural counties, by racial/ethnic groups, by age and by placement.
- Statistical software will be used to determine differences between and within groups.
- Where appropriate, multivariate logistic regression analysis will be used to determine characteristics of those with or without advance directives.

**Deviations from HEDIS:** This indicator is based on an AHCCCS contractual requirement and is not based on any nationally recognized methodology, such as the Health Plan Employer Data and Information Set (HEDIS).

**Quality Control:** To ensure consistency and reliability in data abstraction, AHCCCS:

- Will provide each Contractor with the methodology for this measure,
- Will provide each Contractor with a data specification sheet, file layout, and data dictionary for this measure,
- Will provide Contractors with detailed written instructions for data collection,
- Will provide each Contractor with technical support.

Data validation may be conducted using a double-blind methodology.

**Data Limitations:** Arizona maintains a state registry for advanced directives, housed with the Secretary of State, which may be accessed by providers through a secure, password-protected process. AHCCCS members may have ADs filed with this registry or kept in other locations, which are not documented in medical records maintained by those members' service providers. Thus, measurements for this project may not reflect the actual proportion of members who have executed ADs.

Prehospital Medical Care Directives, which are directives refusing cardiopulmonary resuscitation by emergency medical system and hospital emergency department personnel in the event of cardiac or respiratory arrest, will not be included in the numerator of this measurement. These directives are excluded from the Arizona Advance Directive Registry because they are intended to be used in emergency situations, when immediate access to the registry may not be possible.

**Operational Definitions:** Acceptable documentation of an advance directive includes any of the following:

- a copy of the living will or health care power of attorney
- a copy of a document used by a skilled nursing facility or other residential facility that includes, at a minimum:
  - Preferences for care, such as resuscitation, tube feeding, intravenous fluids, medications and hospital transfer.
  - The member's or surrogate decision maker's dated signature.
- a signed and dated notation in the medical chart stating that an advance directive has been executed and where it is located. Acceptable documentation will include a notation that the patient has filed an advance directive with the Arizona Secretary of State.

For purposes of data validation, the Contractor must be able to supply documentation of advance directives from members' medical records (any organizational or individual provider), as requested by AHCCCS.

Urban versus rural counties: Maricopa and Pima counties will be considered

urban counties; all other counties will be considered rural for the purpose of analysis.

Placement: Placement will be analyzed as follows:

- Nursing Facility (Q placement)
- Home and Community Based Setting (H placement; may be further analyzed by home vs. other HCBS settings, such as assisted living facilities)
- Other (missing, D or Z placement)

Race and Ethnicity will be categorized as follows:

- White Non-Hispanic (CW)
- Hispanic (HS)
- Black or African American (BL)
- Native American (NA)
- Other (AS, CH, OT, UN, or Missing)

## References

American Bar Association: Commission on Law and Aging. (2005). Consumer's Tool Kit for Health Care Advance Planning, second edition, Available at: [http://www.abanet.org/aging/publications/docs/consumer\\_tool\\_kit\\_bk.pdf](http://www.abanet.org/aging/publications/docs/consumer_tool_kit_bk.pdf)

Bradley EH, Wetle T, Horwitz SM. The Patient Self-Determination Act and Advance Directive Completion in Nursing Homes. *Arch Fam Med*. 1998;7:417-423. Available at: <http://archfami.ama-assn.org/cgi/content/abstract/7/5/417>. Accessed May 14, 2007.

DeLuca Havens GA. Differences in the execution/nonexecution of advance directives by community dwelling adults. *Research in Nursing and Health*, 23(4), 319-333. 2000.

Federal Register. Rules and Regulations. 42 CFR 438.6(i). Vo. 67 (115), pp. 41098-41099. 2002.

United States Government Accountability Office. Patient Self-Determination Act: Providers Offer Information on Advance Directives but Effectiveness Uncertain (Letter Report, 09/01/95,GAO/HEHS-95-135). Available at: <http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=gao&docid=f:he95135.txt>. Accessed May 14, 2007.

OBRA-90, Pub.L. 101-508, 104 Stat. 1388

Sahm S, Will R, Hommel G. Attitudes towards and barriers to writing advance directives amongst cancer patients, healthy controls, and medical staff. *J. Med. Ethics* 31: 437-440. 2005.

Smedira NG, Evans BH, Grais LS. Withholding and Withdrawal of Life Support from the Critically Ill. *The New England Journal of Medicine*, Vol. 322, pp. 309-15. 1990.

**APPENDIX A:**  
**Arizona Long Term Care System Contract**

**34. ADVANCE DIRECTIVES**

The Program Contractor shall maintain policies and procedures addressing directives for adult members that specify [42 CFR 422.128]:

- a. Each contract or agreement with a hospital, nursing facility, home health agency, hospice or organization responsible for providing personal care must comply with federal and state law regarding advance directives for adult members [42 CFR 438.6(i)(1)]. Requirements include:
  - (1) Maintaining written policies that address the rights of adult members to make decisions about medical care, including the right to accept or refuse medical care and the right to execute an advance directive. If the agency/organization has a conscientious objection to carrying out an advance directive, it must be explained in policies. (A health care provider is not prohibited from making such objection when made pursuant to A.R.S. § 36-3205.C.1.)
  - (2) Provide written information to adult members regarding an individual's rights under State law to make decisions regarding medical care and the health care provider's written policies concerning advance directives (including any conscientious objections) [42 CFR 438.6(i)(3)].
  - (3) Documenting in the member's medical record whether or not the adult member has been provided the information and whether an advance directive has been executed.
  - (4) Not discriminating against a member because of his or her decision to execute or not execute an advance directive, and not making it a condition for the provision of care.
  - (5) Providing education to staff on issues concerning advance directives including notification of direct care providers of services, such as home health care and personal care, of any advanced directives executed by members to whom they are assigned to provide services.
- b. Program Contractors shall require subcontracted PCPs which have agreements with the entities described in paragraph a. above, to comply with the requirements of subparagraph a. (2) through (5) above. Program Contractors shall also encourage health care providers specified in subparagraph a to provide a copy of the member's executed advanced directive, or documentation of refusal, to the member's PCP for inclusion in the member's medical record.
- c. The Program Contractor shall provide written information to adult enrollees that describe the following:
  - (1) A member's rights under State law, including a description of the applicable State law
  - (2) The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience
  - (3) The member's right to file complaints directly with AHCCCSA
  - (4) Changes to State law as soon as possible, but no later than 90 days after the effective date of the change [42 CFR 438.6(i)(4)]

# **Arizona Health Care Cost Containment System (AHCCCS)**

Arizona Long-Term Care System (ALTCS)

Performance Improvement Project (PIP)

Advance Directives

## **Contractor Instructions for Submission of Data**

Contractors will submit information via the SFTP server. The data layout and instructions described must be followed for submission to ensure accuracy of data translation and acceptance of data elements by AHCCCS.

- All variable fields must be left justified.
- All variable fields are to be used exactly as indicated in the proceeding tables.
- If information does NOT exist for any variable field, leave blank spaces in the columns.
- Do not add any “new” variables that are not listed in the proceeding table.
- Do not change variable names.
- Do not change the order of the variable fields.
- All dates should be formatted as mm/dd/yyyy. Thus, January 2, 2010 would be reported as 01/02/2010.
- Use the file provided by AHCCCS. Do not change the formatting.
- The format has been designed for accurate importing of the data into AHCCCS software. Any changes to the format could result in lost information and a request for the Contractor to resubmit the data.
- Do not change information provided by AHCCCS. Any discrepancy in provided information, please provide AHCCCS with separate notation of difference and reason for change.
- Submit the data files using the SFTP server. If file size is an issue, please compress the files into a .zip file. If this does not solve the file size problem, please contact Lucy Valenzuela (e-mail: [lucy.valenzuela@azahcccs.gov](mailto:lucy.valenzuela@azahcccs.gov)).

**Data must arrive at AHCCCS by close of business Mon., July 25, 2011.**

**ANY DEVIATIONS FROM THE INSTRUCTIONS FOR SUBMISSION OF DATA WILL NOT BE ACCEPTED AND RETURNED TO THE CONTRACTOR.**

Contact information:

Technical questions related to the data request: should be directed to Lucy Valenzuela email: [lucy.valenzuela@azahcccs.gov](mailto:lucy.valenzuela@azahcccs.gov) or call at (602) 417-4753.

All other questions related to the project should be directed to Rochelle Tigner at [rochelle.tigner@azahcccs.gov](mailto:rochelle.tigner@azahcccs.gov) or (602) 417-4683.

## LAYOUT OF MEMBER IDENTIFIED FILE

Variable	Variable Name	Format	Length	Start Column	End Column
1	AHCCCS ID	Text	9	1	9
2	Health Plan ID	Text	6	10	15
3	First Name	Text	20	16	35
4	Last Name	Text	30	36	65
5	Date of Birth	Date	10	66	75
6	Date of Death	Date	10	76	85
7	Sex	Text	1	86	86
8	Race	Text	2	87	88
9	County	Text	2	89	90
10	Health Plan Begin Date	Date	10	91	100
11	Health Plan End Date	Date	10	101	110
12	Placement	Text	1	111	111
13	Age	Text	2	112	113
14	Advance Directive	Text	3	114	116
15	Provider	Text	10	117	126
16	Contact to confirm medical record	Text	30	127	156
17	Contact Phone Number	Text	10	157	166
18	Other/Comments	Text	50	167	216

## Description of Included Elements

1	AHCCCS ID	9-digit alpha number assigned to a member upon enrollment into AHCCCS
2	Health Plan ID	6-digit number that tells what Health Plan the member was enrolled with
3	First Name	First name of member as listed in AHCCCS system
4	Last Name	Last name of member as listed in AHCCCS system
5	Date of Birth	Date that member was born as listed in AHCCCS system
6	Date of Death	Date that member expired as listed in AHCCCS system
7	Sex	Male or Female
8	Race	Race of member as listed in AHCCCS system
9	County	Residential County
10	Health Plan Begin Date	Date that member was enrolled in the Health Plan
11	Health Plan End Date	Date that member terminated with the Health Plan
12	Placement	ALTCS placement code
13	Age	How old the member is at the start of the measurement period

14	Advance Directive	Member has or does not have an advance directive
15	Provider	The provider maintaining the advance directive
16	Contact to confirm medical record	Name of individual supplying medical record
17	Contact Phone Number	Phone number of individual supplying medical record.
18	Other/Comments	Comments