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December 15, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3310 & 3311-FC
P.O. Box 8013
Baltimore, MD 21244-1850

Submitted electronically via regulations.gov

Re: CMS-3310 & 3311-FC: Medicare and Medicaid Programs; Electronic Health Record Incentive Program-Stage 3 and Modifications to Meaningful Use in 2015 Through 2017

Thank you for the opportunity to comment on the Electronic Health Record Incentive Program-Stage 3 final regulation issued by the Centers for Medicare & Medicaid Services (CMS). The Pew Charitable Trusts is an independent, non-profit research and public policy organization that seeks to advance policies that help people receive high-quality care as they near the end of their lives.

Terminal illness presents profound challenges—for the person who has an illness, for their relatives, and for their caregivers and members of their community. Ensuring that patients have articulated the kind of care they want (and do not want) can help address these challenges, particularly at the end of life when many people cannot speak for themselves. Creating an environment where patients and providers can easily store, share, and access advance care plans across settings and among providers and family members is essential for providing patient-centered care that aligns with patient goals, values, and preferences. We support the recent updates to the Meaningful Use program and electronic health record (EHR) certification criteria that make it easier to capture advance care plans in EHRs.

However, the ability to store an advance care plan is not enough. Clinicians must be able to find an advance care plans in the EHR, and these documents must follow patients as they move from one care setting to another. Only then will health information technology make a major contribution toward helping providers honor the goals and preferences of patients.

Comments on CMS Meaningful Use Stage 3

Stage 1 and Stage 2 of the Meaningful Use program ensured that EHRs could document whether a patient had an advance directive. This was an important first step in recognizing the critical role of EHRs in improving the quality of care at the end of life. The final Stage 3 rule takes another significant step forward by requiring that EHRs can store a patient's advance care plan or provide a link to an external location where the document resides. There are, however, additional opportunities for CMS to ensure that providers are alerted to the presence and location of an advance care plan in the EHR.

Notification of Advance Care Plans in EHRs

The first step to improving accessibility of advance care plans in EHRs is to ensure clinicians are alerted to their presence. In the final Stage 3 rule, CMS removed the existing Stage 2 menu set measure that assessed whether providers had documented if a patient had an advance care plan due to its high rate of use. However, the Stage 3 final rule now allows patients to upload their advance care plans. Given this, it is important that clinicians are alerted when a patient has an advance care plan stored in the EHR. Without a marker, providers may unwittingly share out-of-date advance care plans with other clinicians as part of a patient's record. If providers are alerted, they can verify with the patient that the advance care plan in the record is the most recent version of the document.

Accordingly, we urge CMS as part of future rulemaking to explore regulatory or administrative options that address the goal of ensuring that clinicians are aware of a patient's advance care plans in the EHR.

Standardizing Locations of Advance Care Plans

The second step to improving accessibility is ensuring that clinicians can find the advance care plan in the EHR; awareness of an advance care plan is not helpful if the clinician has difficulty finding it in the EHR. A study of EpicCare's ambulatory care electronic health record system found that a lack of standardization in where advance care plans were recorded made it difficult for providers to find plans in emergency situations.¹ One quality improvement effort found advance care plans were documented in seven different locations within the EHR and the information stored varied considerably.² Clinicians needed more than 12 steps and an average of 4.3 minutes to locate advance care plans. As multiple layers of patient-generated data are added to EHRs, it may become even harder to find a patient's advance care plan.

There are additional concerns over accessing EHRs in the context of care transitions. CMS' proposed revisions to Hospital and Home Health discharge regulations increase the discharge planning requirements for facilities by increasing the number of documents, including advance care plans that must be sent with patients to the new site of care. The draft regulations showcase the importance of ensuring that a clinician can easily locate advance care planning documents.

We believe that this issue could be addressed as part of future rulemaking that would ensure that providers could easily locate the advance care plan in the EHR.

Future EHR Certification Criteria

The Office of National Coordinator of Health Information Technology (ONC) will have a significant role to play in ensuring the accessibility of advance care plans across care settings by ensuring the proper labeling of advance care plans and improving interoperability of EHR systems.

¹ Caroline J. Wilson et al., "Multiple Locations of Advance Care Planning Documentation in an Electronic Health Record: Are They Easy to Find?," *Journal of Palliative Medicine* 16, no. 9 (September 2013): 1089–94, doi:10.1089/jpm.2012.0472.

² Christina Loguidice, "Improving Accessibility to Advance Directives in Electronic Health Records," *Annals of Long-Term Care*, July 1, 2014, <http://www.annalsoflongtermcare.com/news/ags-2014-advance-directives-electronic-health-records>.

Common Labels for Advance Care Plans

The ability of clinicians to locate advance care plans in EHRs quickly and easily is essential to ensuring that patient goals, values, and preferences are followed. This is often difficult because of the many types of documents a patient may use to express his or her wishes, ranging from an advance directive to a living will to a Physician's Orders for Life-Sustaining Therapy. The potential for confusion may increase as work progresses on Fast Healthcare Interoperability Resources (FHIR) based systems in which providers are able to independently query data. Such systems rely on clinicians being able to describe the type of document they are looking for. A common label for advance care plans of any kind could be a major step in reducing provider confusion and in improving consumer satisfaction.

The final Stage 3 rule did not have a provision for EHRs to properly label all such documents as advance care plans, noting that the Office of the National Coordinator (ONC) preferred to keep the definitions of patient-generated data (one of the two places advance care plans are found in EHRs) "as broad as possible." We urge ONC to revisit this issue at some point in the future as progress is made in the development of more interoperable EHR systems.

Access Across Sites of Care

In order to ensure that patient preferences are followed, advance care plans must be able to follow patients across care settings. Unfortunately, one study in the *Journal of Palliative Medicine* found that as very sick patients were transferred between several care settings, the likelihood that advance care plan information was available in new settings was "no greater than chance."³

We see two options for ONC to ensure these plans transfer electronically across settings: including them in Common Clinical Data Set (CCDS) requirements or supporting a new Consolidated Clinical Document Architecture (C-CDA) document that would facilitate the transfer of such plans. Although advance care plans were not identified as a specific and separate element of the CCDS in the proposed rule for Stage 3, we believe CMS' actions in support of advance care planning merit further review of advance care plans as an independent element of the CCDS in the near future.

With regard to the C-CDA, the standards setting organization Health Level 7 is in the process of standardizing a Personal Advance Care Plan Document. The project is intended "to facilitate the exchange of a patient's medical treatment goals, preferences, and priorities to be used in care planning."⁴ This work is expected to be ready for balloting in January and finalized in May. As these initiatives develop, we urge ONC to review how advance care plans can be incorporated into the CCDS and support new document structures in the C-CDA to make advance care plans accessible across settings.

³ Victoria Y. Yung et al., "Documentation of Advance Care Planning for Community-Dwelling Elders," *Journal of Palliative Medicine* 13, no. 7 (July 2010): 861–67, doi:10.1089/jpm.2009.0341.

⁴ "Personal Advance Care Plan Document," *HL7 International*, November 24, 2015, http://wiki.hl7.org/index.php?title=Personal_Advance_Care_Plan_Document#Project_Information.

Thank you for considering our comments on Meaningful Use Stage 3 final rule. Should you have any questions or if we can be of assistance, please contact Lee Goldberg, Director of the Improving End-of-Life Care Project at The Pew Charitable Trusts, at 202-552-2127 or lgoldberg@pewtrusts.org.

Sincerely,

A handwritten signature in black ink on a light gray rectangular background. The signature reads "Lee Goldberg" in a cursive, flowing script.

The Pew Charitable Trusts