January 11, 2013

MacKenzie Robertson  
FACA Program Lead  
Office of the National Coordinator  
Patriots Plaza III  
355 E Street, SW  
Washington, DC 20201

Re: Comments Regarding the Stage 3 Definition of Meaningful Use of Electronic Health Records (EHRs)

Dear Ms. Robertson:

On behalf of the American Bar Association, which has nearly 400,000 members, I write in response to the request for comments by the Health Information Technology Policy Committee on its draft recommendations for meaningful use Stage 3, which was published on November 26, 2012, at 77 Federal Register 70444.

Our comments relate specifically to SGRP 204B, SGRP 304, and SGRP 112, all of which address advance directives. The American Bar Association has a long-standing history of policy supporting the use and recognition of advance care planning tools, including support for health care advance directive uniform laws (1986 and 1994); health care powers of attorney (1989); better health care planning opportunities for people with HIV, AIDS, or other serious eventually fatal illnesses (1995); Physician Orders for Life-Sustaining Treatment (2008); and strengthening of federal law to give patients an opportunity to discuss advance care planning with health care providers after admission and as part of annual Medicare wellness exams (2012).

The ABA commends the Policy Committee for including the following elements that have the potential of supporting advance care planning efforts:

- SGRP 204B, a new menu item for including patient-generated health information in the record, such as advance directives; and

- SGRP 304, an objective for future stages to ensure care plan information is communicated in transitions across care settings, including information about the patient’s goals of care and advance care planning documents, such as POLST and advance directives.

However, with respect to SGRP 112, the proposed objective and measures provide little in the
way of useful data, and may even do harm in light of research that shows that a significant proportion of providers make erroneous assumptions about the wishes of patients when told of the existence of a directive without details of its contents.\footnote{Ferdinando L. Mirarchi, et al., “TRIAD III: nationwide assessment of living wills and do not resuscitate orders,” \textit{J Emerg Med}, 2012 May;42(5):511-20; Ferdinando L. Mirarchi, et al., “TRIAD I:The Realistic Interpretation of Advanced Directives,” \textit{J Patient Safety} 2008 December; 4(4): 1-6.} We recommend that this objective and measure be replaced by much more robust and relevant criteria in Stage 3, as further explained below.

Under SGRP 112, the Stage 3 Recommendation maintains the objective from the Stage 2 Final Rule: “Record whether a patient 65 years old or older has an advance directive.” The proposed measure for this objective is: “More than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital’s or [critical access hospital’s] inpatient department … have an indication of an advance directive status recorded as structured data.” As described below, this objective and measure miss the mark in supporting patient advance directives and other advance care planning tools in three ways.

The most salient shortcoming of SGRP 112 is the ineffectiveness of recording that an advance directive exists without any documentation of its contents or of the identity of a legally authorized representative for health decisions. The justification for not including the directive in the record in the Stage 2 final rule merely noted:

“As we stated in our Stage 1 final rule (75 FR 44345), we have continuing concerns that there are potential conflicts between storing advance directives and existing state laws.”
77 FR 53968-01

No further explanation of this comment was given. We have tracked and reviewed state advance directive legislation for over two decades and know of no legal barrier for hospitals or other health facilities to store advance directives in the medical record. Without documentation of the patient’s wishes or identity of their duly appointed surrogates, the goal of patient-centered care medical care, which is one of the statutory goals of the Office of the National Coordinator for Health Information Technology, is substantially undermined.\footnote{“The National Coordinator shall perform the duties under subsection (c) in a manner consistent with the development of a nationwide health information technology infrastructure that allows for the electronic use and exchange of information and that— *** (2) improves health care quality, reduces medical errors, reduces health disparities, and advances the delivery of patient-centered medical care;” 42 U.S.C.A. § 300jj-11.} All patients should be requested to provide a copy of their advance directive, and it should be included in the record if provided by the patient.

The second serious shortcoming is the failure to capture the key components of advance care planning. Advance directives are just one component of documentation for advance care planning. A second component is advance care medical notes written or dictated by the physician that reflect a discussion with the patient regarding goals of care, treatment preferences, or related
decisions. In at least 15 states, if these medical notes are properly witnessed, they actually constitute a formal advance directive. A third component, now in use or in development in a majority of states, is Physician Orders for Life Sustaining Treatment (POLST), a vital care planning tool for patients with advanced medical conditions. The POLST Program, known by a variety of names, is a clinical process designed to facilitate communication between health care professionals and patients with advanced illness (or their authorized representatives) that facilitates shared, informed medical decision-making. The result is a set of portable medical orders that is applicable in all settings and across care transitions, is reviewable, and respects the patient’s goals for care in regard to the use of CPR, breathing machines, and other interventions. Research on the POLST program confirms that it improves documentation of a range of treatment preferences and is associated with low rates of unwanted hospitalizations.

The third serious shortcoming of the proposed measure for SGRP112 is the inadequacy of the target group as the denominator of the measure, which currently consists of all patients admitted to an eligible hospital or critical access hospital (CAH) who are age 65 or older at admission. While age is globally correlated to death and disability, it is a poor proxy of the need for advance care planning. Advance care planning documentation is most essential for adults facing advanced and eventually fatal illnesses. Many people in this group are younger than age 65, and many people age 65 or older are not in this group. The most accurate denominator to capture those in this target group is the number of patients who die during the reporting period. Most deaths today occur after a period of chronic, progressive illness, which should be a conspicuous trigger for advance care planning.

To address the concerns outlined above, we recommend that the required documentation in the record include a copy of the patient’s advance directive, or advance care planning notes, or a copy of a POLST form. We also recommend that the meaningful use measure specify that a minimum percentage of adult patients who have died in the eligible hospital or CAH have an advance directive, or an advance care plan, or POLST in the medical record of the treating institution at the time of death. For Stage 3, we recommend that this percentage be set at least at the same level or higher than the 50 percent level set in the Stage 2 criteria.


5 POLST originated in Oregon, but examples of the program using differing names include West Virginia’s Physicians Orders for Scope of Treatment or “POST” and New York’s Medical Orders for Life-Sustaining Treatment or “MOLST.


7 Centers for Disease Control and Prevention, “Chronic Diseases are the Leading Causes of Death and Disability in the U.S.” See: http://www.cdc.gov/chronicdisease/overview/index.htm.
One last consideration important to emphasize here is the timing of advance care planning. Measuring the documentation of advance care planning at time of death can be an unintended incentive for last minute initiation of advance care planning. To avoid or at least assess that result, it is important to look at the timing of advance care planning documentation. By way of example, one health system that has looked at such data as part of its effort to incorporate advance care planning into the fabric of its delivery system is the Gunderson Lutheran Health System in La Crosse, Wisconsin.

A retrospective evaluation of Gunderson’s advance care planning processes published in 2011 found that 90 percent of a sample of 400 deceased patients had advanced directives, and 99.4 percent were available in the electronic medical record. On average, the directives were 3.8 years old. This compares to 1.3 years old in a 1998 study of the same practices, suggesting that advance care planning is occurring earlier in the patient population than had previous been the case. The study also found that 67 percent of decedents had a POLST form in the record. Because POLST provides a set of medical orders addressing the here-and-now status of patients with advanced care, these are expected to be initiated and reviewed as a patient’s condition changes closer to the time of death. The study found that POLST forms were created a median of 4.3 months before death.

The ideal timing of various components of advance care planning depends on many variables, and existing research only suggests that too little occurs too late. For purposes of meaningful use criteria, we recommend that the recording of advance care planning documentation should include the length of time before death the planning documentation was created. This will provide a necessary marker for quality improvement.

In summary, we recommend that the Stage 3 meaningful use criteria include the objective “Record advance care planning status,” which is met by the following measure: more than 50 percent of all patients who die in an eligible hospital or CAH inpatient department during the reporting period have at least one of the following in the record: a copy of the patient’s advance directive, advance care planning notes, or a copy of a POLST form. In addition, we recommend that the record documents the length of time before death that the planning documentation was created.

Thank you for considering the views of the ABA on these important issues. If you have any questions regarding the ABA’s position on the proposed rule, please contact me or Charlie Sabatino, Director of the ABA’s Commission on Law and Aging, at (202) 662-8686.

Sincerely,

Thomas M. Susman