May 29, 2015

Office of the National Coordinator for Health Information Technology
Hubert H. Humphrey Building, Suite 729D
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically via regulations.gov

Re: RIN 0991-AB93: 2015 Edition Health Information Technology (Health IT) Certification Criteria, 2015 Edition Base Electronic Health Record (EHR) Definition and ONC Health IT Certification Program Modifications

Thank you for the opportunity to comment on the 2015 Electronic Health Record Certification Criteria proposed regulation issued by the Office of the National Coordinator for Health IT (ONC).

Facing death presents profound challenges for people, their relatives, their community and their caregivers. Ensuring that patients have articulated what kind of care they want can help address some of these challenges at the end of life. Advance care planning supports patients and families in discussing and documenting care preferences, with the goal of ensuring that the care patients receive is aligned with their goals, values and preferences. People use advance care planning documents in articulating the type of care they want if they cannot speak for themselves.

Stage 1 and Stage 2 of Meaningful Use took a vital first step in recognizing the critical role of EHRs in advance care planning by ensuring that EHRs could document whether a patient had an advance directive. The proposed Stage 3 rule takes a significant step forward by including a provision that requires EHRs be able to store a patient's advance directive or provide a link to an external location where the document resides.

There are additional opportunities to support advance care planning in Stage 3 Meaningful Use, including facilitating the transmission of advance care plans across sites of care. We encourage ONC to modify the proposed rules for Meaningful Use to ensure that these documents can be easily found by providers, transmitted between EHRs and accessed by patients.

Comments on EHR Certification Criteria

We support provisions in the EHR certification criteria that would ensure that providers have access to patients' advance care plans—either by directly including them in the EHR or through a link to an external site. This will help ensure that the documents are available whenever they are needed, and will make it much easier for providers and patients to access and update the plans. We strongly support this provision.

In addition, ONC proposes that EHRs properly label documents such as advance directives. Because there are many types of advance care plans—such as advance directives, living wills,

durable power of attorney, and Physician Orders for Life-Sustaining Therapy (POLST) forms—the use of different labels for each of these documents may confuse providers. Accordingly, we recommend that the term "advance care plan" be used to refer to all these types of documents.

Although storing and labeling an advance care plan is critically important, these documents need to be transmitted across care settings. A 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."[1]

To ensure that advanced care plans are transmitted between providers, we recommend that any document labeled as an advance care plan should be included as part of the summary of care plan by including it in the Common Clinical Data Set (CCDS). The CCDS contains the core data elements that providers must record for each patient transitioning to a new site of care (§170.102). The date and time when the advance care plan was stored in the EHR should be transmitted as well to help ensure that the most recent version of the advance care plan is used. We urge ONC to make this change to the CCDS in the final rule.

Finally, we recommend that the view download and transmit function (§170.314(e) (1) View, download, and transmit to third party) for patients include access to any documents labeled as advance care plans. In this way the patient can view current advance care plans, ensure that the most recent versions are being used and transmit to other providers.

Thank you for considering our comments on Meaningful Use Stage 3. Should you have any questions or if we can be of assistance, please contact Josh Rising, Director of Healthcare Programs at The Pew Charitable Trusts, at 202-540-66761 or jrising@pewtrusts.org.

Sincerely,

AMDA: The Society for Post-Acute and Long-Term Care Medicine
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Pain Management
American Geriatrics Society
American Heart Association
California State University Institute for Palliative Care
Center for Medicare Advocacy
Center to Advance Palliative Care
Health Care Chaplaincy Network
National Hospice and Palliative Care Organization
Providence Health and Services
Supportive Care Coalition
The Pew Charitable Trusts
Visiting Nurses Association of America

[1] Yung, V.Y., A.M. Walling, L. Min, N.S. Wenger, and D.A. Ganz. 2010. "Documentation of Advance Care Planning for Community-Dwelling Elders." *Journal of Palliative Medicine* 13 (7): 861–67.