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Submitted electronically to: https://www.healthit.gov/isa/ONDEC

Re: ONC's Draft United States Core Data for Interoperability (USCDI) Version 5

Dear Dr. Tripathi:

We appreciate the opportunity to submit comments on the standardized health data classes and constituent data elements eligible for promotion to version 5 of the USCDI. We particularly want to **express our gratitude** for specific improvements noted in version 4 of the USCDI, such as **expanding the health data class "Goals"** into **"Goals and Preferences"** so clear acknowledgement of the role of the person and what is important to them as they move through our healthcare system is expressly supported by the ONC. Further, we **applaud inclusion of the "Treatment Intervention Preferences"** and **"Care Experience Preferences"** data elements within the expanded Goals and Preferences health data class, as it sends a clear message to all technical implementers of health technology that the ONC is leading the way to a person-centered healthcare system and intends to honor the voices of those receiving care.

As we look to version 5 of USCDI and those items that will enable individuals to express the most impactful and personally important aspects of their healthcare experience, by ensuring systems make those expressed values and preferences for their healthcare journey available across care settings, MyDirectives **strongly recommends** that our suggestions related to the following health data classes and constituent data elements, including clarifications to their naming convention, be considered.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
General comment		General Recognition of the Role of Data Classes in USCDI	We understand that a Data Class within USCDI is an organizing concept and is not intended to be prescriptive or restrictive to the administrative, clinical, financial, or technical processes that capture Data Elements. We further recognize that the use of Data Classes helps the humans reviewing the 112 Data Elements within USCDI v4 more accurately understand context for the grouped Data Elements when related to logical categories associated with common healthcare workflows.
Supporting Narrative: An alphabetical list of the USCDI v4 Data Elements, with no organization to the list beyond that, would have the potential to be contextualized incorrectly without the notion of a Data Class to organize them. For example, **Race** and **Ethnicity** are both organized within the **Patient Demographics/Information** Data Class, which clarifies that this kind of data is about the patient and is not about the **Care Team Members**, a different Data Class. This baseline understanding informs the subsequent comments related to the Data Classes and Data Elements for which we have provided guidance.			

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Advance Healthcare Directives		Modify the Name to Clarify the Intended Use and Promote from Level 2 to USCDI v5	We want to suggest that, in order to retain the broad intent and meaning of this diverse category of information, we **modify the name of this Data Class to be Advance Healthcare Directives**. This shift in naming would clarify that any type of document or declaration intended to guide care can be found in this Data Class. We further strongly believe that **promoting the broad Data Class of Advance Healthcare Directives from Level 2 to USCDI v5** will incite systems to make these important documents, which are being stored and not liberated to other providers, more available to all providers across the healthcare ecosystem through data exchange. We believe this is another critically important step to informing the ongoing move to a more personalized, culturally-aware, and individual values-informed healthcare delivery system.

Supporting Narrative to Modify the Name of this Data Class:

Systems used across the U.S. have captured scanned images of paper advance healthcare directive documents, and stored them without a requirement to make them available to other systems, for many years.

Documents such as state or jurisdictional **Advance Directives**, **Living Wills**, or **Medical Powers-of-Attorney** would be associated contextually to the Advance Healthcare Directives Data Class. Various types of well-established and spiritually or culturally-aware **Advance Care Plans** would also be associated with this Data Class.

Portable Medical Orders such as POLST or MOST, or those used often to guide emergency care such as Do-Not-Resuscitate (DNR) Orders or Do-Not-Attempt-Resuscitation (DNAR) Orders, would be associated with this proposed expanded naming convention without the friction of perception that exists within a system or provider not associating a Portable Medical Order Data Element with an Advance Directive Data Class, which is the currently proposed naming convention for this Data Class.

Lastly, documents intended to inform behavioral health treatment based on an individual's own knowledge of their preferences for care to enable the best outcomes of those services are often referred to as **Mental Health Advance Directives** (MHADs) or **Psychiatric Advance Directives** (PADs). These types of documents would also be associated with this Data Class to enable those forms to be made available to treating care teams, crisis responders, and behavioral health medical professionals in order to provide more effective, personalized responses to mental health or psychiatric crises.

Supporting Narrative to Promote this Data Class to USCDI v5:

We further support **inclusion of the Advance Healthcare Directives Data Class in USCDI v5** to enable other related Data Elements to be associated with, as a means of adding context to the Data Elements without enforcing constraints that limit their use or their associated clinical workflows.

Unlike many encounter-specific Data Elements found within USCDI, the concepts found within Advance Healthcare Directives are intended to span multiple healthcare encounters and care settings. This Data Class groups all of the document types and important declarations an individual has memorialized related to what is important to them that their care teams and medical providers should know to inform care delivery on an individual, personalized basis.

These changes are essential to all certified electronic health record technology (CEHRT) systems releasing and having access to the information available to inform care that fully accommodates and honors the voice of the individual receiving care.

Data Class	**Data Element**	**Recommendation**	**Reasoning for Recommendation**
Goals and Preferences	Care Experience Preference AND Treatment Intervention Preference	Reflect these Data Elements in the Advance Healthcare Directives Data Class	We believe **referencing Data Elements in multiple Data Classes where it is relevant for context**, such as the Care Experience Preference and Treatment Intervention Preference Data Elements, enhances clarity and reduces ambiguity on the intended scope of USCDI.

Supporting Narrative to Associate Two Data Elements to Two Data Classes in USCDI v5:

Whether the Data Element concepts are intended to inform the current episode of care and impact the current Plan of Care, so that associating them with the **Goals and Preferences Data Class** indicates a context for use, or whether they are intended to inform a future potential episode of care and treatment interventions, so that associating them with the **Advance Healthcare Directives Data Class** indicating an alternative context for use, the intent is more easily understood when related to more than one Data Class with which the Data Elements may be associated.

The **Care Experience Preference** and **Treatment Intervention Preference** Data Elements are prime examples of this approach to relating a Data Element to more than one Data Class. The Moving Forward Coalition is an example where these concepts can be captured and made available for data exchange as part of admission to a Skilled Nursing Facility (SNF) or Home Health Agency (HHA) which is intended to enable personalized care delivery for those who receive care from SNF or HHA providers. In this use case, these two concepts are **not** related to a potential future event where the individual is unable to communicate with the care team. Those important concepts are intended to inform the Plan of Care at the SNF or HHA and should be available to any other providers who would treat the individual during a transition of care.

These same concepts are **also** one of the three foundational aspects of advance healthcare directive documents, Healthcare Agent being the third foundational aspect, when they are expressed to inform potential future medical care where the individual is indeed unable to communicate with the care team. When these two concepts are expressed in Advance Healthcare Directives information, the resultant documents or information serve that alternative yet intended purpose.

Whether those concepts are intended to inform the current episode of care and impact the current Plan of Care, so that associating them with the **Goals and Preferences Data Class**, or whether they are intended to inform a future potential episode of care and treatment interventions, so that associating them with the **Advance Healthcare Directives Data Class**, the context of the use is more easily understood when related to more than one Data Class with which the Data Elements may be associated.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Advance Healthcare Directives	Advance Directives	Promote from Level 2 to USCDI v5	We recommend **promoting the Advance Directives Data Element from Level 2 to USCDI v5** to ensure that access to existing scanned or structured documents is maintained across care settings and systems. The **Advance Directives Data Element** would require CEHRT systems to liberate those many existing scanned forms that are stored and not made available for data exchange, which currently greatly limits their opportunity and capacity to inform care.

Supporting Narrative to Promote the Advance Directives Data Element to USCDI v5:

Systems used across the U.S. have captured scanned images of paper advance healthcare directive documents, and stored them without a requirement to make them available to other systems, for many years. For those hundreds of thousands (or more) of existing scanned documents currently housed in disparate systems, there may historically have been very few if any "document type" codes and meta-data applied to the scanned, stored document. The end result of this is that only the highest level of document type may be available for use in an interoperable data exchange scenario.

This Data Element will also accommodate proper document type coding of statutory forms that contain both Healthcare Agent and Living Will preferences and goals, as those "combined" forms are in use in many jurisdictions that chose not to create two separate advance healthcare directive documents but instead chose to combine them into a single form which they call an Advance Directive.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Advance Healthcare Directives	Personal Advance Care Plan	Promote from Level 1 to USCDI v5	We recommend **promoting the Personal Advance Care Plan Data Element from Level 1 to USCDI v5** to ensure access to those documents across care settings and systems.

Supporting Narrative to Promote the Personal Advance Care Plan Data Element to USCDI v5:

Systems used across the U.S. have captured scanned images of paper advance healthcare directive documents, and stored them without a requirement to make them available to other systems, for many years. The **Personal Advance Care Plan Data Element** enables those many existing scanned forms, which some individuals intend to take the place of jurisdictional advance directive documents or intend to further clarify the documented choices in those high-level advance directive documents for greater context as to their personal values and priorities, to be liberated for data exchange and accessibility.

Personal advance care plan documents, like advance directives, are intended to inform care when the individual receiving care is unable to communicate with the medical team due to health status.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Advance Healthcare Directives	Healthcare Agent	Modify Name of Data Element and Promote from Level 1 to USCDI v5	We recommend that the **name of this Data Element be modified** from Durable Medical Power of Attorney **to Healthcare Agent**. We also recommend that the **Healthcare Agent Data Element be promoted from Level 1 to USCDI v5.**

Supporting Narrative to Modify the Name of this Data Class:

We suggest that, in order to retain the broad meaning of this wide category of information, we modify the name of this Data Element from Durable Medical Power of Attorney to Healthcare Agent. The term "Durable Medical Power of Attorney" is only found on a subset of existing statutory documents – it is a highly prescriptive term with a narrow legal definition. The term "**Healthcare Agent**" is a broader term that encompasses the content that can be identified and exchanged, of which the "Durable Medical Power of Attorney" is a subset.

Concepts such as "Resident Representative," "Healthcare Proxy," and "Health Care Surrogate" from existing forms and documents would be reflected in the proposed **Healthcare Agent** Data Element, and those instruments do not use the "Durable Medical Power of Attorney" term.

Furthermore, in many states, the valid expression of designating a person to speak on the individual's behalf can be done via verbal, recorded, or hand-written means and retains a legal status that is able to be honored without the legal formality that a "Durable Medical Power of Attorney" requires.

Therefore, we recommend the more inclusive term of "Healthcare Agent" for this Data Element.

Supporting Narrative to Promote the Healthcare Agent Data Element from Level 1 to USCDI v5:

Individuals are able to designate someone to speak for them if they are unable to express their goals, preferences, and priorities for healthcare themselves due to a health crisis or emergency. This is a critical step to enabling a person-centered healthcare delivery system and is often the easiest and most frequently completed step in the advance care planning (ACP) process.

These documents enable the voice of the individual receiving care to be honored through a trusted designee. The health condition of individuals can be highly complex and unique, making statutory documents difficult to honor in some cases, but the voice of the individual represented through a trusted designee can bring the person-centeredness of care back into focus.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Care Team Member(s)	Proxy Decision Maker	Remove from Level 0 and do not promote	The proposed Data Element's concepts are accommodated in the previously detailed Healthcare Agent Data Element, making this Data Element redundant and an enabler of yet more disparate terms and references that will cloud data exchange.
Goals and Preferences	Religious & Spiritual Preferences	Remove from Level 0 and do not promote	The proposed Data Element's concepts are accommodated in the existing value sets which will populate the content found in the Care Experience Preferences Data Element and is therefore redundant. Further, it does not refer to the many different *cultural* or *values-based* goals, preferences, and priorities that an individual may want to express so as to guide their care or treatment, making it too narrow to achieve the intended purpose.
Orders	Orders	Include in USCDI v5 and modify description of Data Class	**We support the introduction of the organizing concept of Orders Data Class in USCDI v5**. This Data Class will enable other concepts to be associated with it, such as admission orders or dietary orders, all of which are essential to fully informing providers when a transition in care occurs.

Narrative to support changes to Orders Data Class Descriptions:

To support the below recommendations, we would like to suggest that the description of this Data Class be modified in the following way, to **omit use of the word "Directive" and use the word "Orders"** and **replace the term "Patient Care Services" with "Treatment Interventions"** since these documents do not typically contain Care Experience Preference information.

Current Description:
Provider-authored directive for the delivery of patient care services.

Proposed Description:
Provider-authored order for the delivery of treatment interventions.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Advance Healthcare Directives	Portable Medical Orders	Promote from Level 2 to USCDI v5 and Associate with an alternative Data Class	We recommend that the **Portable Medical Orders Data Element be promoted from Level 2 to USCDI v5**. We further recommend that this **Data Element be associated with the Advance Healthcare Directives Data Class** so that important context of these documents and the workflows that accompany document creation and use are maintained within the hierarchy that USCDI brings to the implementer community.

Supporting Narrative to Promote the Portable Medical Orders Data Element to USCDI v5:

Portable medical orders are a familiar concept to the majority of healthcare practitioners and emergency responders who also understand they may include not only those state-specific instruments known as POLST or MOST, but also those forms used to guide emergency care such as DNR Orders or DNAR Orders used predominantly by EMS responders.

Systems used across the U.S. have captured scanned images of paper advance healthcare directive documents, and stored them without a requirement to make them available to other systems, for many years. The **Portable Medical Orders Data Element** enables those many existing scanned forms, which some individuals intend to take the place of jurisdictional advance directive documents, to further clarify the documented choices in those high-level advance directive documents or "transform" the documented choices of individuals into medical orders to ensure emergency responders or emergency medical teams at acute and emergent care settings are able to honor those preferences for treatment interventions without delay or additional verification needed.

Supporting Narrative to Associate this Data Element with the Advance Healthcare Directives Data Class:

The term "Portable" indicates that these orders apply across care settings and follow the individual, rather than being applicable to only one encounter of care. Due to the nature of what these documents represent, we recommend that **this Data Element be associated with the Advance Healthcare Directives Data Class**.

While these documents are "order sets" so that associating them with the Orders Data Class gives the human viewer context on what is intended with this Data Element, they are not orders in a more traditional sense that they apply to a single episode of care. This concept is more closely associated with the context of Advance Healthcare Directives and represents a widely used and relied upon set of jurisdictional forms across the healthcare system.

To enable the grouping mechanism that Data Classes are intended to communicate to those who review USCDI and seek to accommodate the requirements of CEHRT systems, we recommend that this Data Element be associated with an alternative Data Class, but we are open to it being associated with the Orders Data Class **as well** if the ONC believes the dual Data Class association is meaningful to CEHRT.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Orders	Orders for End of Life Care	Remove from Level 2 and do not promote	This is an outdated and redundant term with our above recommendation to use "Portable Medical Orders" for this Data Element, so we **recommend that the Orders for End of Life Care not be promoted to USCDI**. The proposed Data Element's concepts are accommodated in the recommended Data Element "Portable Medical Orders." Further, the term "Orders for End of Life Care" has a narrow scope that in actuality is no longer used by most state organizations that guide the rules surrounding them.
Advance Healthcare Directives	Advance Healthcare Directive Observation	Promote to USCDI v5, Move to an Alternate Data Class, and Modify Name of Data Element	We support **promotion of the Advance Healthcare Directive Observation Data Element to USCDI v5** as an important aspect of completing the clinical workflow once these documents or preferences are known. As part of ensuring that context of this aspect of the clinical workflow is associated to a Data Class that will provide guidance that these organizing principles are intended to provide, we recommend that **this Data Element be associated with the Advance Healthcare Directives Data Class AND be re-named Advance Healthcare Directive Observation** to achieve consistency in naming conventions.

Supporting Narrative to Promote the Advance Healthcare Directive Observation Data Element to USCDI v5:

The steps in the workflow process that involve review, validation, and determination of how the Advance Healthcare Directives information will/will not inform treatment, and the documentation of this part of the workflow is what the "Advance Healthcare Directive Observation" would represent.

Providers don't immediately adjust treatment interventions and act on the preferences found in advance healthcare directive documents, with the possible exception of Portable Medical Orders during emergency encounters, without some level of validation that the information is accurate due to the need to mitigate risk for the patient and their organization.

Without this component of the clinical workflow process, which can bring the individual's personal preferences for care delivery to life and fulfill the promise of what advance healthcare directive documents are intended to deliver, we have not moved the needle beyond the capture and store process that exists today.

Improving health equity for the underserved and marginalized, improving the health care delivery system to be more personalized and respectful of individual differences and values, and focusing on what matters to the people we treat, renders the Advance Healthcare Directive Observation Data Element critical, and subtly

messages providers that this step in the workflow needs to be captured and made available for data exchange, thereby moving the industry forward in a very meaningful way.

Supporting Narrative to Associate the Advance Healthcare Directive Observation Data Element with an Alternative Data Class and Rename it for Consistency in language:

The Advance Healthcare Directive Observation refers to summarizing, in the context of a care encounter, that the advance healthcare directive documents were known about (assertions that they exist), and if accessed/read by the clinician, that the clinician observed there was information contained in these documents which they determined to be relevant to the patient's care. The Advance Healthcare Directive Observation is about summarizing which information from the "external" document or information source was reviewed and considered relevant.

To enable the grouping mechanism and context that Data Classes are intended to communicate to those who review USCDI and seek to accommodate the requirements of CEHRT systems, we recommend that this Data Element be associated with the Advance Healthcare Directives Data Class, but we are open to it being associated with the Observations Data Class **as well** if the ONC believes that the dual Data Class association is meaningful to CEHRT.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Advance Healthcare Directives	Advance Healthcare Directive Observation	Modify text description of this Data Element	**Suggest modification of the DRAFT wording that describes the Advance Healthcare Directive Observation Data Element to be more accurate.**

Supporting Narrative to Modify the Description of this Data Element:

Current Description:

Statement of presence and properties of patient or provider authored documents that record a patient's goals, preferences and priorities should a patient be unable to communicate them to a provider.

Usage note: May include whether a person has one or more advance directives, the type of advance directive, the location of the current source document, and whether it has been verified.

Examples include but are not limited to indication that a living will is on file, reference to or location of durable medical power of attorney, and validating provider.

Proposed Description:

Documentation that states the presence of patient or provider authored documents that record a patient's goals, preferences, and priorities for care and treatment should the patient be unable to communicate them to a provider.

Usage note: May include whether a person has one or more advance healthcare directive documents, the type of document or expression reviewed, the source of the information or location of the source, and whether it has been verified as current and accurate.

Examples include but are not limited to indication that a living will was reviewed, where it can be found, whether the information contained in that living will was reviewed with the patient or their healthcare agent, and if not, the conditions that prevented that review, and who made the decision to use the information to inform care delivery or treatment.

Data Class	Data Element	Recommendation	Reasoning for Recommendation
Provenance	Author	Promote from Level 2 to USCDI v5	We recommend that the **Author Data Element be promoted to USCDI v5**.

Supporting Narrative to Promote the Author Data Element to USCDI v5:

Technology has made it easier than ever for people to self-monitor their own health and participate in their own care using tools such as apps, devices, and sensors. This information can be used to understand progress, deterioration, or cyclical variations in health conditions. This information can further offer a depth of insight that has not been available in the past and can illuminate previously unappreciated patterns and trends relevant to the person's health or disease state that only they are aware of that occurred outside of an encounter.

There is a legacy clinician bias or reluctance to accepting person-authored information of all kinds due to their concerns about being liable for any information that is not authored by, or validated by, a clinician. While there is the notion in clinical document architecture (CDA) of "Performer" of an observation, which is often considered the "Author" by systems and their users, there is an opportunity to clearly define through standards who is the "enterer" and who is the "doer" of the observation activity. A Preference is a "self-observation" and is an important aspect of data exchange, accessibility, and inclusion into electronic systems to ensure is accommodated.

All that said, promoting the Author Data Element within the Provenance Data Class to USCDI v5 would enable systems to clearly delineate the information accessible to them based on the source of the information, potentially reflect it differently in the system than information authored by clinicians or care teams, and further enable recognition of the value of the patient and their information while also fostering compliance, buy in, and respect.

Since 2007, MyDirectives has focused solely on empowering individuals to have a voice in their healthcare experience, especially during those times in their lives when they experience a medical or behavioral health emergency or crisis and cannot communicate with those providing care and treatment. MyDirectives provides digital solutions that enable creation and update of structured, interoperable advance healthcare directives and interoperable creation and storage of all types of unstructured, scanned paper ACP documents. Our solutions facilitate ACP document management for individuals, providers, care teams, and health systems with tools such as:

- MyDirectives®, our **free** consumer-facing ACP platform
- MyDirectives for Clinicians™, our provider-facing ACP solution which enables healthcare providers to manage their ACP process and the resultant documents, such as creation of structured, interoperable Portable Medical Orders (e.g., POLST and MOST), and Mental Health Advance Directives
- ADVault Exchange™, our HITRUST-certified national Advance Healthcare Directive document registry and repository framework is built on interoperable data exchange standards in order to enable documents to be securely and safely exchanged and made available from all types of systems that store or need to access these documents to inform care delivery.

MyDirectives also works with some of the largest healthcare payers in the United States to support engagement of their members in the process of creating, storing, and sharing high-quality digital ACP documents. We provide those health plans with reports and analytics to help them comply with requirements established by the Centers for Medicare & Medicaid Services (CMS) for Value-Based Insurance Design (VBID) Model participation.

In addition to the products we have created, which tangibly demonstrate our company's commitment to supporting the evolution of the U.S. healthcare system to a truly person-centered care delivery model, we have devoted thousands of staff hours to the work HL7® undertakes as they create interoperable data standards to support the data exchange and accessibility of advance healthcare directive documents across transitions of care within the unique care settings. Our leadership co-authored the development of the Personal Advance Care Plan (PACP) CDA Implementation Guide (IG) in 2015, which has since been through ballot in 2016, 2020, and again in 2023. Our leadership also contributed advance directive section specifications to the Consolidated CDA (C-CDA) Supplemental Templates for Advance Directives in 2018, which was re-balloted in 2022 and has since been incorporated into C-CDA 3.0. We are also leading the Advance Directive Interoperability (ADI) Fast Healthcare Interoperability Resources (FHIR) IG development that enables interoperable data exchange of advance healthcare directive documents using FHIR. This work has diligently endeavored to achieve alignment between the CDA and FHIR data exchange standards, so as to enable implementers to have optimal backward and forward compatibility, while also incorporating changes in the healthcare delivery systems to keep pace with the industry at large. We remain committed to this important work and are today still actively involved in leading these projects within the standards development organizations.

We are aware of the concerns expressed by other commentators that the inclusion of digital patient treatment and care preferences in the electronic medical record is "too difficult" or "too complicated" due to state variations of ACP documents and terminology used. In our leadership role for the standards creation projects previously mentioned, we have worked with a wide variety of other HL7 standards development participants to conduct exhaustive environmental scans to ensure we included as many versions of these forms as possible to inform our national standards creation work. We have further been guided by large, actively-contributing communities comprised of healthcare workers, medical professionals, ethicists, electronic medical record vendors, personal health record vendors, and various other thought leaders on this topic. Our company's leadership is often relied upon to advise the industry and associations on the importance of interoperable ACP documents as experts in this space, and we evangelize the work frequently through our speaking engagements, publications, and educational sessions across the country. These projects often bring the opportunity to engage with, and educate, not only stakeholders at CMS, the ONC, and representatives of HHS, but also those executives or front-line workers within the healthcare system, as part of the culture change required to actively lead the nation's efforts to ensure these important documents can be accessed in a secure, interoperable, and standardized manner to inform care and treatment whenever, and wherever, they are needed. Based on the vast amount of these interactions and the work we have witnessed that is currently live and in use in many care settings, we can tell you the standards discussed above are ready, they are mature, and our recommendations related to USCDI v5 are necessary to continue to drive change and improve care.

In addition, inclusion of the above detailed Data Classes and Data Elements in USCDI v5 will drive the broader objectives of HHS, CMS/CMMI, and the ONC: **health equity** and **patient access**. Racial minorities, ethnic minorities, and other historically marginalized populations such as LGBTQ2S+ individuals distrust the healthcare system. Ensuring their goals, preferences, and priorities for treatments and interventions are included in the systems used by healthcare teams can go a long way to decreasing this distrust of the healthcare system, especially if healthcare providers and their systems are able to easily retrieve digitized ACP documents to inform and shape personalized care and treatment. Ample published research also exists showing that ACP document completion rates for historically marginalized populations are about half of those populations that are outside this important category of individuals. Even when such documents exist, under the current paradigm, patients and their providers cannot find or access them in siloed EHRs – they have no idea how to look for them. As long as CEHRT systems are not required to surface those documents, if they indeed exist despite low confidence they will be used to inform care, providers will continue to argue "there are no required standards" around ACP information as a basis for **not** providing personalized care during emergencies or health crises and will stick with their existing, one-size-fits-all "Standard of Care." Adopting the above detailed recommendations related to USCDI v5 to remove that baseless argument is long overdue.

In short, we believe the ONC in concert with CMS and CMMI have made a great difference in both the healthcare provider space and the health plan payer industry with their recognition of the importance of ACP. However, we believe there are additional steps HHS, CMS/CMMI, and the ONC can and should take to further enable people to be able to receive personalized, goal-concordant care which can reduce the cost of unwanted or low value care, or over-treatment, that costs the nation hundreds of millions of dollars each year. Increasing the confidence of the consumer that their ACP documents will be accessible to medical teams to inform the care they receive is based on what is important to them as individuals, due to the existence of advance healthcare directive document Data Classes and Data Elements that support data exchange by the nation's electronic health information systems, will go a long way to continuing the steady march of our healthcare system to being truly person-centered. Through USCDI we can move the technology companies that enable interoperable health information exchange to add the Data Classes and Data Elements to their systems that inform care and treatment plans based on the patient's values, goals, and preferences for treatment interventions. For these reasons, MyDirectives **strongly recommends the adoption of the suggestions we have provided for USCDI v5**. Thank you for your consideration.

Respectfully submitted,

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