Health IT Policy Committee
A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

State Perspective - Hearing Questions

Oklahoma Response: September 22, 2013
Prepared by:
Brian Yeaman MD, Principal Investigator on the ONC Long Term Care Challenge Grant
Annette Prince, JD, MSW, MA Bioethics & Health Policy

- What has been the experience thus far with the implementation of advance directives? What is working? What is needed?

  In Oklahoma the advance directive suffers from portability. The Durable Power of Attorney is a complex process that requires an attorney. It is a rate limiting step and the POA is frequently the agent that needs to deliver an advanced directive at the time of need for a patient to the health care providers and too often the POA has not been assigned. A preferable option is to promote the Appointment of a Health Care Proxy. It is a free form off of the internet and requires only two witnesses and no notary. It allows the patient to be empowered and avoid the costs sometimes associated with creating the DPA. The health care proxy can be available in the short term (if reachable by providers to deliver an advanced directive in short order in a time of need). The EHR selection of whether or not an advance directive exists is not enough. The recognition of a health care proxy and their contact information is key. Beyond that, an advanced directive registry controlled by patients with an authentication layer to upload their health care proxy forms and their advance directives that could be shared with a provider in a time of need would be a significant upgrade. Tying these into the Health Information Exchange and EHR during the current state of health care technology still leaves too many gaps between providers in multiple states, within states and even within some regions. Eventually, as more interoperability becomes standard, perhaps there is a different path, but a lightweight offering of patient and proxy empowered mechanisms and pathways make a lot of sense and would be particularly meaningful and have a great impact

- Status of advance directives/POLST/MOST at the state level – legislative, regulatory, and/or administrative requirements?

  POLST has been recognized by OK State Medicaid, but adoption by providers has been low. The University of Oklahoma Medical Hospitals, via the ethics committee, have approved a POLST form for use by physicians in the system. Further research is needed on its current utilization. We do not believe that any other health system has adopted the form and likely few provider offices have adopted it. There are political pressures that create an issue at the state legislative level and it seems unlikely that Oklahoma will approve a state form in the

foreseeable future. End of life and life terminating illness are difficult to understand at times and difficult for all of us to come to terms with, since no one has a crystal ball on the end of life. Oklahoma has favored exhausting all measures of preserving life in lieu of end of life planning.

- Is there a "floor" for compliance, and have there been sufficient analyses to demonstrate where states currently do not meet or currently exceed the "floor" established?

  There are no mandates for use of POLST in Oklahoma as described above.

- As part of advance care planning, what information should be included in or with a patient's advance directive? A POLST/POST/MOSLT form, care planning notes, other?

  At a minimum, patients who are admitted to a hospital should be offered a form to indicate a health care proxy. The University of Oklahoma Medical Hospitals, again at the urging of their ethics committee, has adopted a form and it is included in the paperwork distributed to patients upon admission. The Living Will portion of the Oklahoma Advance Directive is more difficult in terms of convincing patients to complete the decisions for themselves. If they choose a proxy, it creates a pathway for that agent to make decisions based on unique circumstances not covered in the Living Will. A POLST isn't really appropriate unless the patient has a serious, life-limiting illness.

- In consideration of the previous question, how could the meaningful use measure for advance directives be improved (*Record whether a patient 65 years old or older has an advance directive*)? Additionally, please comment on the potential effects of removing or changing the age threshold.

  The meaningful use measure could enable an advance directive contribution via the provider EHR or patient PHR to state or national repositories for advance directives to begin the conduit to store these electronically to be recognized by providers and create "break the glass" opportunities to access them in an emergency. Recognizing there are significant legal and political challenges to a government sponsored registry, the meaningful use requirements adding the structured field for presence of an advanced directive and the contact information of their health care proxy and allowing for entry into the EHR of both of these forms would be a starting point. Added to the CCD upload for interoperability the structured fields of presence of the advance directive and the contact information of the health care proxy could be immediately meaningful and significant for end of life care, as described above.

- What concerns, if any, does an electronic environment (use of EHRs and HIE) introduce for advance directives (e.g., *a transition of care)?*

  Interoperability of EHR and HIE still has a distance to go. Portability must be wider ranging than the limitations we have for the foreseeable future with EHR and HIE. If there are registries for advance directives, they need to be controlled and managed by the patient and their proxy. A concern for broad access to PHI in advance directives is confidentiality. The health care proxy automatically has access to a patient's medical records. It would be helpful to have an electronic registry of the patient and proxy's contact information. This would allow quick contact with the decision makers in an emergency.

- Would the inclusion of the status of a patient's advance directive in a care summary at transitions of care ease the burden of having to share this information with multiple organizations?

  The patient or proxy should be responsible for being sure that any updated advance directive is communicated to providers, electronic registries, etc. In Oklahoma, a patient can revoke an advance directive at any time, in any manner, verbal, written, whatever. And the patient does NOT have to have sufficient mental capacity to complete a new AD in order to revoke an old one.
    - What information should be shared? The status (e.g., you have one or you don't)? The actual directive? Instructions on how to obtain it? Any other information (a POLST/POST/MOSLT form care planning notes, etc.)?
      -See above. The contact information for the health care proxy should be available to anyone in care of the patient. Everything can and should come from that agent and the legal pathways are clean and clear and the patient can receive the end of life interventions they desire. Registries for AD, as they come into existence, must be patient and proxy controlled, not managed by providers and hospitals.
    - If sharing the advance directive in the care summary is something you find helpful, do you have advice on how to make sure it's the latest version?
      -A mechanism is needed for a patient or proxy to assign a MU provider as their advance directive conduit and to validate the status and be the originating source of the data/status/document and for current/future versioning.

- Can you please comment on the structure of an advance directive, such as the importance of readability, individual preferences including culturally-sensitive considerations, etc.?

  The current statutory form for the Oklahoma Advance Directive for Healthcare was the result of a compromise between our former attorney general and the Oklahomans for Life

organization. There is opposition to legislation to simplify for Oklahomans to make their wishes known because of a political premise that ADs are for "refusing" treatment. Fortunately the most recent form for Oklahoma is simpler than the last and the appointment of proxy is just one paragraph requiring only two witnesses.

- Should providers be required to be more responsible for patient's advance care planning (e.g., asking patients about whether they have an advance directive or educating them about advance care planning)?

  Ideally providers would do this, yes. One potential route may be a requirement that when the patient enrolls in Medicare or with a part B or part D plan, there could be a requirement in the enrollment forms and presentation of that information in the welcome to Medicare exam and presentation of these documents to their provider. The AMA code of ethics makes it clear that physicians should encourage patients to complete advance planning and discuss it with them at length. There are currently codes that would allow compensation for these conversations with patients.