



Patricia A. Bomba, MD

Vice President and Medical Director, Geriatrics

January 14, 2013

Office of the National Coordinator for Health Information Technology
HIT Policy Committee

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

On behalf of the Community-wide End-of-life/Palliative Care Initiative (Initiative) and New York's Medical Orders for Life-Sustaining Treatment (MOLST) Statewide Implementation Team, I submit these comments in response to the DHHS Office of the National Coordinator for Health Information Technology HIT Policy Committee's Request for Comment on its draft recommendations for meaningful use Stage 3, published on November 26, 2012, at 77 Federal Register 70444.

The Community-wide End-of-life/Palliative Care Initiative (Initiative) is a healthcare and community collaborative based in Rochester, New York. In 2001, the Initiative began work on development and implementation of several end-of-life/palliative care projects that aimed to improve quality and reduce suffering of those facing the end of life, including a two-step approach to advance care planning: Community Conversations on Compassionate Care, MOLST, eMOLST, among other projects housed on CompassionAndSupport.org.

The MOLST Statewide Implementation Team was created in 2010 in response to a request from the late NYS Commissioner of Health to oversee effective statewide implementation of the MOLST Program and to support NYSDOH implementation of the FHCDA and revision of the MOLST form to conform to the procedures and decision-making standards set forth in the FHCDA. Goals of the MOLST Statewide Implementation Team include:

- To disseminate information concerning the use of the MOLST form
- To create a forum for discussion about implementation issues of MOLST as a key pillar of palliative care and an end-of-life care transitions program
- To establish a centralized repository of information about MOLST and end-of-life decisions

MOLST is New York State's POLST Paradigm Program and is known by a variety of names.¹ POLST is now in use or in development in a majority of states and is a vital program for patients with advanced medical conditions. Like POLST, MOLST is a clinical process designed to facilitate communication between health care professionals and patients with advanced illness (or their authorized legal 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

¹ 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."



Patricia A. Bomba, MD

Vice President and Medical Director, Geriatrics

transitions, is reviewable, and respects the patient's goals for care in regard to the use of CPR, breathing machines, hospitalizations and other life-sustaining treatment interventions.

New York State developed eMOLST², a secure web-based application, as a result of a New York State Department of Health HEAL 5 (Health Care Efficiency and Affordability) grant. The eMOLST application documents the clinical process, including goals for care discussion, as well as the legal requirements. The eMOLST application upgrades the workflow around completing the information required for a legal medical order with automated user feedback for quality review and notification of missing information and training tools for users. A DOH-5003 MOLST form and a MOLST Chart Documentation Form for adult or minor patients or OPWDD checklist for individuals with developmental disabilities who lack medical decision-making capacity are created. eMOLST improves clinical and legal outcomes, as well as provider satisfaction, and is a system-based solution that is available for use throughout New York State.

By moving the MOLST form to a readily accessible electronic format, health care providers, including EMS, will have access to MOLST forms at all sites of care including hospitals, nursing homes and the community. This approach will allow for EMS to view in the event of an emergency and will allow for other systems to view at the time of need, as the document is shared across the care continuum. A YouTube describes the need to accelerate eMOLST statewide: <http://youtu.be/MjL8Qz944IU>.

Current EHR technology and its usage are not optimized to adequately prompt and facilitate a community-wide approach to advance care planning and the patient/family centered needs that palliative care addresses. The HITPC's laudable recommendation that stage 3 be the time to begin to transition from a setting-specific focus to a collaborative, patient- and family- centric approach is an opportunity to optimize utilization of the EHR for the benefit of those with serious illness. Integration of eMOLST with current EHR technology aligns with HITPC's recommendation.

The Stage 2 meaningful use criteria establish the objective "Record advance directives" in the menu set, not the core set, and only for eligible hospitals and critical access hospitals (CAHs). It is not applicable to eligible providers (EPs). The criteria are deemed to be met if more than 50 percent of all unique patients 65 years old or older admitted to the eligible hospital or CAH inpatient department during the reporting period have an indication of an advance directive status recorded as structured data. The criteria and measure provide little in the way of useful data. The Initiative and the MOLST Team recommend that in Stage 3 this criteria and measure be replaced by a much more robust and relevant criteria as outlined below. While the following comments focus on advance care planning, we recognize there are additional needs and opportunities for optimizing utilization of palliative care.

² To learn more about eMOLST, visit CompassionAndSupport.org and/or contact Patricia Bomba, MD, FACP, eMOLST Program Director at Patricia.Bomba@lifethc.com.



Patricia A. Bomba, MD

Vice President and Medical Director, Geriatrics

General Comments:

Our work in New York State on advance care planning aligns with the National Quality Forum (NQF), *A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report*. Washington, DC, 2006. We urge the HIT Policy Committee to consider aligning its work on advance care planning with these NQF preferred practices as well: Domain 8. Ethical and Legal Aspects of Care, Preferred Practices, (pages 42 to 44):

Surrogate/Decision maker Designation

Document the designated surrogate/decision maker in accordance with state law for every patient in primary, acute, and long-term care and in palliative and hospice care.

Patient/Surrogate Preferences

Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as conditions change.

Medical Orders

Convert the patient treatment goals into medical orders, and ensure that the information is transferable and applicable across care settings, including long-term care, emergency medical services, and hospital care, through a program such as the Physician Orders for Life-Sustaining Treatment (POLST) program.

Advance Directives

Make advance directives and surrogacy designations available across care settings, while protecting patient privacy and adherence to Health Insurance Portability and Accountability Act (HIPAA) of 1996 regulations, for example, by using Internet-based registries or electronic personal health records.

Advance Care Planning Promotion

Develop healthcare and community collaborations to promote advance care planning and the completion of advance directives for all individuals, for example, the Respecting Choices and Community Conversations on Compassionate Care programs.

In order to better utilize EHRs to prevent medical crises through transitions in order to provide better quality *patient* care, as well as, to engage patients in their care to ensure that patient's wishes are being honored, the following are recommended:

1) Explicitly recognize the difference between traditional advance directives (health care proxy, durable power of attorney, living will) and actionable medical orders (POLST/MOLST/other POLST Paradigm forms) and continue to focus on the importance of thoughtful advance care planning discussions.



Patricia A. Bomba, MD

Vice President and Medical Director, Geriatrics

The EHR should contain all necessary legal documentation of a patient's preferences. This must contain, at a minimum, the identity and contact information of a patient's authorized healthcare decision-maker, any advance directives, and any POLST/ MOLST forms where applicable and available. Traditional advance directives are appropriate for all adult patients. Patient-centered goals for care and thoughtful POLST discussions are most appropriate only for those with serious illness who may die in the next year, reside in long term care or receive long term care services and/or have explicit wishes regarding receiving or refusing any or all life-sustaining treatment.

POLST is now in use or in development in a majority of states and is a vital care planning tool for patients with advanced medical conditions. The POLST Paradigm Program, known by a variety of names,³ 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.

2) Include advance directives and POLST forms as core requirements for meaningful use, in the list of inpatient, office visits and patient data summaries, as well as elements that should be included in a longitudinal care plan.

We support the inclusion of the content of the advance directive in the EHR, either as structured data or, because the format and content of advance directive forms and state requirements for executing a valid form are diverse, as a scanned copy viewable through the EHR. However, including just the advance directive may not provide information on patient preferences regarding unwanted emergency medical care. Stage 3 measures should also include recording patient preferences for end-of-life care in the form of actionable medical orders.

Supporting EHR access to the eMOLST, and to other electronic POLST forms as they develop, would promote both MU goals of improving safety, quality, and efficiency and of engaging patients and families in their care. Stage 3 final rules can encourage adoption of eMOLST by allowing newly emerging models of care delivery, like Accountable Care Organizations and Patient Centered Medical Homes, to meet MU-3 requirements through system implementation of eMOLST.

³ 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."



Patricia A. Bomba, MD

Vice President and Medical Director, Geriatrics

Worthy of an alert prompt: Though we are sensitive to ‘alert fatigue,’ advance care planning represents a basic aspect of informed consent and shared medical decision-making, and should be considered a priority in triaging prompting alerts.

Flag of crucial information: If a healthcare decision-maker has been activated and/or a POLST has been completed, this should be flagged and highly visible on the homepage of the EHR. If this is not immediately visible, patient safety can be compromised due to confusion regarding consent, and patients may suffer delays in treatment as well as superfluous care transitions.

3) Document Patient/Surrogate Goals for Care

Patient-centered goals for care discussions are a critical component of advance care planning for those with serious illness, who are candidates for POLST. Goals of care discussions begin with questions such as “What makes life worth living?” or “What really matters to you?” and focus on discussion of an individual’s values, beliefs and personal goals for care, such as relief of pain or ability to interact with loved ones. The EHR must be equipped with a space to record what was said in these goals of care conversations and what the agreed upon goals are. This will tremendously aid communication between providers, and its benefit to patients is obvious: a care team that is working together towards a goal—an outcome: high-quality care, as defined by the patient. The critical information to be captured in goals of care includes:

- Did a patient-centered goals for care discussion occur?
- With whom were the patient-centered goals for care discussed?
- What providers were present?
- What was discussed?
- What decisions were made?
- What is the care plan in light of those decisions?

Goals for care can and should be captured as **structured data** so that future measures can be developed related to goals for care that will not require laborious chart abstraction. A measure concept of importance is whether the treatment provided to the patient was in alignment with the stated goals of care, and this measure concept will never be feasible without the necessary EHR infrastructure.

To help imagine what this might look like, see the attached screenshots from the eMOLST application. MOLST forms are only appropriate for those very ill individuals with very poor prognoses, but we cite the below as illustrative of what is possible for goals of care generally. Indeed, forward-thinking health systems are, in concert with their CEHRT vendors, actively developing EHRs that can record goals for care. The meaningful use program should include objectives for health systems that are not so forward-thinking in leveraging EHRs in this way.



Patricia A. Bomba, MD

Vice President and Medical Director, Geriatrics

In keeping with NQF's, "Document the patient/surrogate preferences for goals of care, treatment options, and setting of care at first assessment and at frequent intervals as conditions change," eMOLST contains the patient's goals for care as health status changes and is available across care transitions.

4) Document prognosis.

The EHR should contain information about prognosis and what was communicated to the patient regarding prognosis. Providers often fail to record this crucial aspect of treatment, and indeed frequently fail to communicate prognoses to either the patient or the care team. Insisting that this be recorded will greatly enhance communication between providers and facilitate communication with patients. We suggest consideration of the importance of structured data here to facilitate future measurement of communication.

Documenting prognosis will facilitate targeting of the most apt recipients of thoughtful POLST discussions and other elements of palliative care. Thus, the possibility of a new objective is suggested: Use clinically relevant information stored within the CEHRT to identify patients who should have a thoughtful POLST discussion and to receive palliative care services.

Health status and prognosis are both included in eMOLST and permits collection of structured data for future measurement.

5) Use age 18 as a threshold for recording the existence of traditional advance directives.

Currently, all patients admitted to an eligible hospital or CAH who are age 65 or older at admission is the target group as the denominator of the measure. While age can be correlated to death and disability, it is a poor proxy for the need for advance care planning.

The Patient Self-Determination Act (PSDA) passed in 1990 (Pub. L. No. 101-508) applies to all adults 18 years of age and older. Anyone can face acute injury or illness and experience a period of time when the ability to make medical decisions is lost. During this period of time, health care providers turn to surrogates/decision maker. Further, patients may recover capacity to make decisions and medically recover as well. It is not solely about death and dying and not solely for the Medicare population.

6) Use death, rather than age, to capture appropriate target group to measure the appropriate existence of POLST.

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. A more accurate denominator to capture in this target group is total number of patients who die.



Patricia A. Bomba, MD

Vice President and Medical Director, Geriatrics

In New York State, the MOLST program applies to all ages. Babies are sometimes born “dying”. Legal requirements exist for ethical decision-making for minor patients, adult patients, patients with developmental disabilities who lack the ability to decide and patients in mental hygiene facilities.

Measure on Advance Care Planning:

In terms of measures, we recommend that Stage 3 include a “Record advance care planning” objective that is met by the following measure: more than 50 percent of all patients who die in an eligible hospital or critical access hospital inpatient department during the reporting period have at least one of the following in the patient’s medical record: a copy of the patient’s advance directive, advance care planning notes, or a copy of a POLST form.

Measure on Advance Care Planning for Innovative Health Care Systems

To foster innovation on care transitions, an optional Stage 3 measure should include an “Record advance care planning” objective that is also met by ACO’s and PCMH’s who adopt and implement eMOLST in New York State as a community approach to advance care planning.

Implementation of eMOLST helps expand on or meet new EP/EH objectives:

- **SGRP 113:** Use clinical decision support to improve performance on advance care planning for seriously ill patients
- **SGRP120:** Record electronic notes documenting goals for care discussions in patient records.
- **SGRP304:** eMOLST provides the care plan information, including:
 - Health/Functional status, including ADLs using Clinical Frailty Scale
 - Prognosis
 - The patient’s values, beliefs and goal(s) for care, including time frame (not specific to setting) and initial steps toward meeting these goals
 - Specific advance care plan (Physician Orders for Life-Sustaining Treatment (POLST)) and the care setting in which it was executed.

For further information on eMOLST, view 1-page description of eMOLST and Why do eMOLST goo.gl/GszlO and feel free to contact me at Patricia.Bomba@lifethc.com.

Sincerely yours,

[signed]

Patricia A. Bomba, M.D., F.A.C.P.

V.P. & Medical Director, Geriatrics, Excellus BlueCross BlueShield

Leader, Community-wide End-of-life/Palliative Care Initiative

Chair, MOLST Statewide Implementation Team

Chair, National Healthcare Decisions Day New York State Coalition

New York Representative, National POLST Paradigm Task Force

165 Court Street Rochester, NY 14647 phone: 585.238.4514 fax: 585.453.6365

Patricia.Bomba@lifethc.com
CompassionAndSupport.org