

**State Advisory Council on Quality Care at the End of Life
Minutes from January 19, 2007 Meeting**

Meeting time and place: January 19, 2007, 10:00 a.m., in the Department of Aging's Conference Room, 301 West Preston Street, 10th floor.

Council members present: Dr. Cynda Rushton, Chair; Ms. Catherine Boyne; Ms. Ruth Eger; Ms. Karen Kauffman; Dr. Timothy Keay; Mr. Mike Lachance (Secretary of Aging's designee); Dr. Steve Levenson; Mr. Ted Meyerson; Rev. Dan Mindling; Mr. Jack Schwartz (Attorney General's designee); Ms. Catherine Stavely; Mr. William Vaughan (Secretary of Health and Mental Hygiene's designee).

Others present: Dr. Barbara Blaylock; Ms. René Laje; Dr. William Mansbach; Dr. Maziar Massrou; Ms. Leslie Piet; Dr. Susanna Scafadi; Ms. Fran Stoner; Dr. Gary Wilks.

Dr. Cynda Rushton convened the meeting at 10:00 and welcomed the Council members and guests.

The first portion of the meeting was devoted to current items of interest raised by Council members and guests. Rev. Mindling reported that the Catholic bishops were nearing completion of a new pastoral guidance document on end-of-life decision making and advance directives. Ms. Eger announced that, on February 4, Joseph Richey House will be celebrating a dedication ceremony for its children's hospice facility and its 20th anniversary; Council members are invited. Dr. Blaylock informed the Council that plans for an "Advance Directive Day" in Montgomery County were proceeding. The events will occur on April 19, 2007, at numerous sites across the county. Trained volunteers will conduct a significant outreach and public education effort. Mr. Schwartz then distributed copies of a draft form for use in documenting a consensus among equally ranked surrogates that one of them would act as decision maker.

Dr. Rushton and Mr. Schwartz then summarized the portion of the November 13, 2006, Stakeholders' Summit that related to pediatric palliative care. They reported a consensus of Summit participants that the next appropriate step would be a legislatively commissioned study of the issue. Mr. Schwartz distributed copies of a draft bill calling for such a study by the Council and the Maryland Health Care Commission; Mr. Schwartz reported that key staff at the Health Care Commission viewed the proposal favorably. The Council then discussed the scope of the study, with Mr. Meyerson of the view that a broader study of barriers to palliative care, one not limited to pediatric patients, was preferable. Other Council members expressed the view that, while barriers undoubtedly existed for patients across the life span, some factors differentiated the pediatric population, and issues of feasibility weighed in favor of a more limited study. **Council action:** *On approved motion, the Council endorsed the draft bill and directed staff to seek a sponsor for it and testify in support.*

Continuing with a review of the Stakeholders' Summit, Ms. Kauffman and Dr. Keay led a discussion about issues related to end-of-life care for dementia patients. One issue concerned the impact of medical malpractice insurance premiums on physician practice in long-term care. **Council action:** *By consensus, the Council requested a staff report on this issue at the next meeting.*

Another issue flowing from the Summit was capacity criteria and assessment. Dr. Mansbach commented about the importance of the issue and highly variable practice patterns. Dr. Levenson noted that good resources on this topic were available; the problem is an inability or unwillingness on the part of some facilities to adopt, or physicians to follow, sound processes. Considerable discussion then ensued about possible ways in which the Council, through its own efforts or its recommendations about changes in public policy or law, might encourage better practice. The topic will be revisited at a future meeting, after a work group considers existing resources and develops options for a Council initiative. Council members and guests were invited to submit relevant material to Mr. Schwartz.

The Council then turned to the Patient's Plan of Care form (PPOC). René Lahe, of the Research Institute on Aging of the Hebrew Home in Rockville, reported on data resulting from a survey of physicians and social workers about their experience with, and opinions about, the PPOC. The data and the researchers' analysis of it will be submitted for publication and so are not available for dissemination now. The response rate was quite high, however, and more than three-quarters of respondents from both professions perceived the PPOC as somewhat burdensome or a major burden. Council members questioned whether this perception was of the form itself or of the discussion leading up to the form's completion; the latter would be necessary even if there were no PPOC. Sizeable percentages recognized the PPOC as a vehicle for capturing useful information, but many (especially among social workers) would find the document more useful if it had the status of a physician's order. Survey respondents identified as barriers to successful use of the PPOC family and staff misunderstanding or lack of motivation and physicians' lack of time. Council members commented that the survey was a single snapshot that, ideally, would lead to further research, especially on patient outcomes. Some Council members observed that misunderstanding about the PPOC reflects inattention to available resources and an unwillingness to address institutional process problems.

Discussion about the PPOC then shifted to consideration of proposed legislation, put forward by Mr. Meyerson, to change the name of the form so that it would be called "Instructions on Life-Sustaining Treatment Options." The current name sometimes leads to confusion, because the term "plan of care" is often used to refer to a wide range of interdisciplinary services. It is confusing to use the same terminology when the scope of the plan is much narrower, related solely to certain decisions about life-sustaining medical treatments. **Council action:** *On approved motion, the Council endorsed the*

draft bill and directed staff to seek a sponsor for it and testify in support.

The final agenda item was another draft bill, presented by Mr. Schwartz following extensive discussion with key staff at the Maryland Institute for Emergency Medical Services Systems. Under current law, a health care provider other than EMS personnel may, but is not required to, carry out an EMS/DNR order. The bill would leave this discretion in place up until the time that a patient actually suffers a cardiac or respiratory arrest. But once arrest occurs, all health care providers would be required to carry out the DNR order and give comfort care to the patient instead of attempting resuscitation. Mr. Schwartz gave the following example: Suppose a patient with an EMS/DNR order is brought to a hospital emergency room. If the patient has not yet suffered an arrest, it is a good idea for the emergency room physician to have discretion in deciding how best to respond. Maybe the patient has an easily reversible condition like hypoglycemia (low blood sugar). But if the patient arrives already in cardiac or respiratory arrest or arrests once in the hospital, the DNR decision embodied in the EMS/DNR order should be honored. Comfort care should begin right away, without more paperwork. **Council action:** *On approved motion, the Council endorsed the draft bill and directed staff to seek a sponsor for it and testify in support.*

The Council set its next meeting for Friday, April 13, 2007, at 10:00 at the Department of Aging.

No further items of business having been presented, Dr. Rushton adjourned the meeting at 12:10.