

State Advisory Council on Quality Care at the End of Life
Minutes from the January 24, 2020 Meeting

Meeting time and place: January 24, 2020, 10:00 a.m., Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422

Council members present: Alan Eason; Paul Ballard (Attorney General's designee); Tiffany Callender; Carol Eckerl; Christine Watts; Sister Lawrence Mary Pocock; Chris Kearney; Elena Sallitto; Hank Willner; Tricia Nay (Department of Health's designee); Geoff Coleman; Marian Grant; M. Jane Markley.

On speakerphone: Yvette Oquendo-Berruz; Stevanne Ellis; Michele Williams.

Others present: Brandon Neiswender; Jack Schwartz; Sara Hufstader; Peggy Funk; Phyllis Gray; Niel Rosen; Julie Deppe.

Chairman Alan Eason opened the meeting and welcomed Dr. Geoffrey Coleman to the Council. The Council approved the minutes for its meeting held on September 13, 2019.

Brandon Neiswender, Chief Operating Officer of the Chesapeake Regional Information System for Our Patients (CRISP), the State-designated health information exchange, made a presentation to the Council regarding putting advance directives on CRISP. He said that CRISP aggregates, collects, and disseminates clinical data from multiple sources. All Maryland hospitals and approximately 50% of ambulatory and specialty groups participate in CRISP. He said that CRISP manages the Prescription Drug Monitoring Program (PDMP) and that over 50,000 users in Maryland access the PDMP for pain management and to avoid overprescribing opioids. Hospitals and the Maryland Department of Health use CRISP for collaborative IT interoperability, for the PDMP, for clinical data in the form of transcription, and for images and notifications that go out to the provider community.

Hank Willner asked whether CRISP is a repository for advance directives. Brandon Neiswender responded that CRISP holds links to advance directives. Patients upload directives outside of CRISP's workflow to MyDirectives.com, a vendor certified by the Maryland Health Care Commission (MHCC) to be linked to CRISP.

Tiffany Callendar asked whether there are other vendors besides MyDirectives that will be certified by MHCC to link to CRISP. Jane Markley said 2 vendors are on hold in addition to MyDirectives.com. Brandon Neiswender said that as soon as Vynca becomes certified as an approved vendor, that CRISP would then provide to Vynca the same link that CRISP now provides to MyDirectives. He noted that CRISP has integrated with West Virginia's advance directive registry.

Alan Eason said that Maryland permits electronic advance directives be electronically signed without witnesses. He said that in other states MyDirectives will send emails to persons to have them function as witnesses. He said one advantage of using MyDirectives is that the most recent advance directive will be accessible on their website if you use only their website. Paul

Ballard noted that Maryland does not require witnesses for electronic advance directives that meet the National Institute of Standards (NIST) authentication standards. He stated his view that the validity of an electronic advance directive that meets such NIST standards would not be defeated by emailing the advance directive to persons to act as “witnesses” even though these persons would not be in the physical presence of the person signing the electronic advance directive.

Paul Ballard explained that Maryland’s law allowing unwitnessed electronic advance directives that meet NIST authentication standards does create an issue of education for consumers and health care providers who may not realize that such unwitnessed electronic advance directives are valid. Furthermore, he said people may not know how to verify that an electronic advance directive vendor has met NIST authentication standards. He said one way to know that the vendor has met such standards is for them to have been certified by MHCC to link to CRISP. But he noted that such certification is not a requirement if a vendor otherwise meets NIST authentication standards. Marian Grant asked whether legislation might be needed to address this issue. Paul Ballard responded it is difficult to find a good legislative solution to the problem.

Elena Sallitto wondered about the security of unwitnessed electronic advance directives given that authentication questions could be answered by a family member with access to that information. Brandon Neiswender noted that the authentication requirements are similar to those used by banks. Marian Grant said the bigger problem is that people are not completing advance directives. Brandon Neiswender said that CRISP had a similar issue. He said people have the ability to opt a patient out of participating in CRISP with just a little information about the patient. CRISP decided this was an acceptable risk given the benefits of CRISP.

Tiffany Callender said when the Horizon Foundation considered this issue during the 2016 legislative session, they believed there was nothing to stop a malicious adult child from falsely completing a written advance directive with fake witnesses. She said because health systems don’t call witnesses for paper advance directives, Maryland’s authentication requirements for electronic advance directives are actually stricter than the witness requirements for paper advance directives.

Sara Hufstader said that to use MyDirectives.com a person is required to provide a phone number, social security number, or a credit card number, which information they are not excited to share. She noted that even phone numbers are hard to verify, depending on whether it is listed by first name, last name, or middle initial. Given these difficulties, some people will simply choose to utilize the opt out button on MyDirectives.com.

Brandon Neiswender said CRISP is notified by MyDirectives when an advance directive is prepared. MyDirectives gives CRISP a link to the advance directive so that CRISP can put the link in its repository to enable CRISP to communicate to providers that an advance directive is available. The consumer and CRISP both get a confirmation that an advance directive was created. CRISP put the advance directive information into the health care provider’s workflow experience which is “in-context,” i.e., the workflow experience remains inside a provider’s Electronic Health Record (EHR), which is CRISP’s preference.

Brandon Neiswender noted that not every EHR system has the capacity to get access to CRISP's information in-context. Thus, CRISP has a unified landing page, which is CRISP's public-facing website where the user signs in and gets access to the information. He said that an advance directive shows up as a care alert. The user then opens the advance directive in a new window outside CRISP, i.e., MyDirectives.com.

Phyllis Gray asked whether a user can cut and paste an advance directive into CRISP. Brandon Neiswender responded that the user has to download the advance directive and that it cannot be cut and pasted. He said that as soon as there is a static document, you don't know whether it is the most recent advance directive. He said the best practice is to download it and put in into the EHR because you can't be sure that there's no other advance directive. Marian Grant noted that is what most people do because they want the advance directive in their EHR. She noted that this is a problem even with paper advance directives, i.e., the advance directive in the provider's system may not be the most recent one that reflects the patient's wishes.

Tiffany Callender said that health care systems using Epic are using the advance care planning tab. She said they are going into CRISP, printing out their advance directive, and uploading it onto Epic. She said that a local hospital is not using the care alert for advance directives and asked what the barrier is for a health care system that wants to use CRISP's care alert when they use Epic. Brandon Neiswender responded that the issue is the implementing cost for the health care provider's IT team. He said that CRISP would love to help facilitate the discussion of a national network's integration of advance directives into an EHR like the one Epic is a part of, that is, a clinical continuity of care document.

Brandon Neiswender said that if you open up the patient snapshot in CRISP, you see the care team where providers tell CRISP who their patients are. So, this patient snapshot identifies who the payor is, who the care coordinator is, all the hospitals where the patient has been, who the discharge planner is, the advance directives, and the medical orders. He said you can click on "advance directive" and it takes you to another website. He noted that the original load of advance directives on CRISP was 1,400 and that it has about 2,000 now. He said that over the last 3 months that 60 advance directives have been accessed. He wondered whether there were end of life events that prompted providers to access these advance directives.

Marian Grant said that a provider cannot put an advance directive on CRISP and that the patient has to do it instead. Brandon Neiswender responded that a patient must put the advance directive on MyDirectives. He said that if the provider references the advance directive in a note, it might be buried in clinical documentation. But CRISP is not pulling that data out and making it known. No data curation is being performed by CRISP.

Jack Schwartz said that if a conversation regarding an oral advance directive was embedded in a clinical note and if that note was uploaded to CRISP, it would then be available to everybody. He said the problem with an oral advance directive is that no one knows about it. He said this is a topic for conversation regarding how to integrate oral advance directives into this technology. Brandon Neiswender said it is difficult for CRISP to be a repository to ensure the

accuracy of a document. If providers would update the MOLST form, he said that CRISP would be open to noting that a MOLST form exists.

Marian Grant said that Epic and Cerna are mostly hospital-based EHR systems where advance directives are more accessible. She said that the primary care system is not on Epic or Cerna. Tricia Nay said that CRISP is helpful for updates. She said that the challenges for allergies, medication, etc., is that a hospital's systems don't connect to each other and that the user must figure out what information is current. Marian Grant said that an IT does not facilitate this dynamic system to be interoperative and be updated across systems whenever you need access. Chris Kearney said that in clinical practice the ability to find information on CRISP is revolutionary because a lot of CRISP information is valuable.

Brandon Neiswender asked how can we curate this data to give an easy, simple snapshot to a provider of the data sets, for example, when you have a medication listed from 4 different sources, how do you marry it together to give a single early snapshot to providers. Alan Eason acknowledged this is not easy and said they need to start somewhere for the future and that's what CRISP is doing. Brandon Neiswender acknowledged that CRISP can be an annoyance to providers, which adds another piece of information and multiple clicks to their work. He said that logging into CRISP is a tertiary (additional) workflow. Thus, he said that CRISP is trying to keep it as easy as possible to use.

Jane Markley said it is the Council's role to understand what roadblocks are preventing other electronic advance directive vendors beside MyDirectives.com from being linked to CRISP. Marian Grant asked Paul Ballard who determines that. He responded that MHCC certifies the electronic advance directive vendors who may link to CRISP.

Brandon Neiswender noted that the business model of electronic advance directive vendors requires them to be able to say they have a specific number of customers so that they can sell their platform to others. If they opened it up for free and no hospital had to buy it, and if the hospital is going to get all their integration through CRISP, then he wondered what business value would be retained by the vendor. Phyllis Gray noted she saw lots of electronic advance directive vendors when she googled advance directives. Brandon Neiswender said he would be willing to work with other groups to upload documents to CRISP.

Marian Grant talked about the Serious Illness Coalition. She said progress is slow without resources and infrastructure. She said they had a successful conference hosted by CareFirst for 2 hours in December that was attended by about 30 people from around the State. The attendees included leaders of health systems, palliative care systems, hospice organization, and community groups. The conference's attendees then formed the following subgroups: Landscape Mapping, Silo Busting, Model Building, and Culture Shifting. The Landscape Mapping subgroup discussed the need to find out what is going on in Maryland and to gather information to ultimately go on the Coalition's website. The Silo Busting subgroup discussed how to get people from different health systems and organizations to talk more with each other. The Model Building subgroup talked about whether there are models for serious illness care that could be promoted in the State. Finally, the Culture Shifting subgroup discussed the lack of awareness among the public

regarding the availability of options for serious illness care, that is, a lot of people assume there are only bad end-of-life options when there actually are good options available before that time.

Marian Grant said that the Coalition to Transform Advanced Care (C-TAC) is going to try to develop some resources to help state coalitions. She noted if the Coalition had someone who was able to give 100 % of their time, that would be great but that right now people involved in the Coalition can only give part of their time. She said that a common theme emerged around advance care planning. Their plan is to meet again soon and pick concrete things to do and either do them with or without funding, or to seek funding to do them. She invited people to participate in the Coalition. They will keep the Council updated, even between meetings.

Marian Grant said the Oregon coalition was heavily funded by CareFirst. They had hoped CareFirst would also underwrite the Maryland Coalition but that at this time CareFirst is focused on diabetes. She said that the Coalition would need \$250,000 needed to get this running. CareFirst offered space, some personnel time, but can't make a large financial commitment at this time. States that have successful coalitions have 1 or 2 statewide meetings per year where they are free to attend and they provide food, for example. The Coalition can't get anyone to underwrite it yet and she asked people to let her know if someone would be willing to underwrite the Coalition. She said this is a difficult time for people to find extra money.

Sara Hufstader asked if the Coalition had a proposed budget. Marian Grant responded that the Coalition established the 4 working groups and wants to organically let those workgroups form plans. If those plans need a budget, the Coalition would then prepare a budget.

Paul Ballard discussed the issue of opioid restrictions and its effect on pain management for patients. He reminded the Council that the American Cancer Society rated Maryland poorly on its pain report and that he and Christopher Kearney promised to look at the issue and report back to the Council. He noted the report found that Maryland lacked policies for integrated treatment for pain that enunciate pain treatment issues effectively so that practitioners would know the rules of the road. He looked at Maryland's laws and said they exempt end of life care and other diseases relevant to the Council's mission from the additional restrictions these laws place on opioid prescriptions. Thus, he did not think that new laws were needed. He said that he informally spoke with physicians in the pain management field and got the impression that there is some fear among prescribers about the consequences of prescribing opioids even though these exemptions exist. He thought that perhaps that education of prescribers was needed to alleviate prescribers' fears.

Paul Ballard said the Council could try to persuade the Board of Physicians to issue policies to alleviate such fears. The Council would probably need to present statements from people having difficulty obtaining prescriptions. One physician told him that even patients at the end of life are afraid of becoming addicted to opioids, so there is a need for patient education too. Paul Ballard said he had been struggling with what role the Council might play regarding this issue given that the Council's attention is rather divided and that it meets only 3 to 4 times per year. He wondered what action the Council might take, whether it would be a letter to the Board or to the General Assembly.

Paul Ballard said it appears that education rather than legislation is needed to address the issue. He said that some statements are needed to soothe practitioners' and patients' fears regarding prescribing opioids at the end of life and for the diseases also exempted in Maryland law from the additional restrictions. To be effective, such statements would need to come from an agency with the authority to sanction prescribers, such as the Board of Physicians. He noted that the Board of Physicians had issued a guidance statement regarding opioid prescribing on their website, but he noted that the guidance statement said that compliance with that guidance did not guarantee that a practitioner would not be disciplined. He said that this seems to be a very complicated problem. Nonetheless, he thought that the Council might be able to make some discrete and concrete contributions toward addressing it.

Marian Grant said other states have restrictions on the number of days that opioids can be prescribed. She said that the Council could play a monitoring role to guard against such unhelpful future legislation. She said that these restrictions on opioid prescribing are entirely arbitrary and there is no evidence that if you break your ankle that the opioid prescription should be limited for a certain number of days. She said she guessed 3 months would be too long but noted that some states have restricted it to just 3 days. And she noted to get the prescription refilled, the patient had to physically go see the provider. She said such restrictions are all right if you are an ambulatory patient but create problems for frail elders with chronic pain, people who are actively dying, and people not yet in hospice because of the emotional issue of accepting hospice. She said the Council should advise against such legislation if it should ever be offered because it becomes difficult to practice with these kinds of restrictions.

Peggy Funk said that the Hospice and Palliative Care Network is always monitoring this type of legislation to make sure that such bills carve out exceptions for hospice patients along with palliative care. But what the Network has heard is that palliative patients are having trouble getting the prescriptions they need filled because the Board of Physicians tends to discipline prescribers. So, she said that there is a lot of fear and physicians are very cautious. She recommended that the Council ask someone from the Board of Physicians to come to a meeting to talk with the Council about this issue. Tricia Nay asked whether it might be helpful for the Board of Physicians to present data on how many physicians were sanctioned for improper opioid prescribing and what the sanctions were. She said that the Office of Health Care Quality (OHCQ) has seen the more extreme cases of prescribing that failed to meet the accepted standard of care.

Paul Ballard read what the State law provides: "On treatment for pain, a health care provider, based on the clinical judgment of the health care provider, shall prescribe: (1) The lowest effective dose of an opioid; and (2) A quantity that is no greater than the quantity needed for the expected duration of pain severe enough to require an opioid that is a controlled dangerous substance unless the opioid is prescribed to treat: (i) A substance related disorder; (ii) Pain associated with a cancer diagnosis; (iii) Pain experienced while the patient is receiving end-of-life, hospice, or palliative care services; or (iv) Chronic pain." So, he said that the legislature already anticipated that these would be the exceptions and thus no new legislation is needed. Rather, he believed that a solution involving education was needed instead. Marian Grant responded that the Council should stop any further proposed legal solutions that might make things worse.

Hank Willner said that some pharmacies seem to limit opioid access. Thus, whatever restraints physicians are under get further complicated by some pharmacists who seem to arbitrarily restrict filling or refilling some of the prescriptions. Marian Grant said because CRISP data shows which pharmacies patients are getting their opioids from, the pharmacies don't want their names on the list of pharmacies that are dispensing these prescriptions. Chris Kearney said that in Baltimore City they don't even stock opioids in pharmacies. Peggy Funk responded that this is because pharmacies are afraid for the safety of their staff by having opioids in stock.

Chris Kearney said it is such a tsunami for prescribers in the other direction, that is, prescribers are getting a wave of messaging to restrict opioid prescribing. He said the CDC partnered with MedStar in coming up with the CDC guidelines. In the course of doing so they went to 20 outpatient sites that said they don't even prescribe opioids anymore unless they already have had the patient, and that no other patients get new prescriptions for opioids. He said that these outpatient providers didn't care about the guidelines and instead were done with the issue. He said that is how bad this problem has gotten. He agreed that there is no legal solution but said that the drumbeat is so strong against opioid prescribing that the problem has swept well into the palliative world.

Tricia Nay said that OHCQ did a review of cases involving citations they issued for opioid prescribing violations. She said there were just 3 cases they cited, all involving transdermal fentanyl patches. On the other hand, the nursing home industry had many examples of residents not getting adequate treatment for their pain. So, she said statistically that OHCQ is much more likely to cite a facility for not treating pain than for giving too much pain medication.

Alan Eason said overreacting seems to be the pattern where you go crazy the other way, for example, that in some states with a chronic condition you have to go back to your doctor every 3 days for refills of opioid prescriptions. The policies seem to bounce back and forth between extremes. He said he liked the idea of the Council focusing on pain control in end of life care.

Marian Grant said that after hearing that OHCQ is only rarely citing people for egregious misuse and is much more concerned about pain management, she thought that establishing more contact with the Board of Physicians and the Board of Nursing might not be a bad idea to see about the possibility of their getting information out to their membership. Geoff Coleman said that the Board of Pharmacy should also be involved.

Marian Grant said that she writes comments on the federal level reminding Medicare that these are FDA-approved medications and not street drugs. She said these drugs have an appropriate use for some people and yet she meets patients all the time at the hospital at the end of life who are not getting adequate pain medications.

Alan Eason liked the idea of the Council keeping informed of legislation introduced in the General Assembly where the bill may be going the wrong way. Marian Grant said the Council could educate the legislature about the unintended consequences of such bills. Alan Eason agreed, saying that educating the legislature goes to the central function of the Council.

Geoff Coleman asked whether the MOLST form could be provided in other languages. He said that when a MOLST form is placed in the patient's home, there is no translation into the patient's primary language. He noted that English is not the primary language for 40% of Montgomery County's population and that patients don't understand the MOLST form. He said that other states have side-by-side translations and didn't know whether this was a legislative issue or a policy issue. But he said this is certainly a problem because primarily Spanish speaking patients have no clue regarding what the MOLST form says.

Alan Eason said that completion of a MOLST form requires a conversation with the patient or their authorized decision maker. Marian Grant responded that hospitals are required to have an interpreter to help the health care provider have that conversation. So, hopefully the conversation about the MOLST form does involve someone interpreting for the patient. But she noted that when a patient goes home, the patient's children might not understand the MOLST form.

Phyllis Gray said her facility invested in 5 Wishes in Spanish. Marian Grant said that prepareforyourcare.org is a website where advance directives in Spanish are available.

Paul Ballard said that the Maryland MOLST form is used by EMS personnel, most of whom primarily speak English and need to understand it to comply with the orders to protect patients. Also, he noted that the form has been adopted in Maryland regulations in English. Maryland is not alone in having the actual order form available only in English. He said that some states have tried to deal with this issue by having a translation of the form in different languages but will put a disclaimer on the form saying the translated form is for educational purposes to be used for discussion only. He noted that in all these states the official MOLST, POLST, or similar form with the authorized signature(s) must be in English so that emergency medical personnel can read and follow the orders. For example, California stamps such a disclaimer on these forms in other languages that the translated form is used only for purposes of education and discussion. He said his concern is that you might have a form in another language besides English that looks somewhat like a MOLST form but which would not be the official order form set forth in regulation.

Tricia Nay said the challenge is that EMS providers are not going to follow a MOLST form in a language other than English. She said that if the MOLST form is in a different language, the result will be that the patient will be full code. This is because if the MOLST form is not in English, EMS providers are not going to assume that the form means the same thing as the form would mean in English.

Jane Markley asked whether there could be a Spanish translation of the MOLST form that could accompany the MOLST form that is in English. Tricia Nay said that the MOLST form is written at a very high reading level, so what health care providers have done is to provide information regarding end of life care, end of life wishes, advance directives, and pain management written in a way that consumers can understand at a different reading level. She said that some of the health care systems have done a great job of putting that together but that there are over 100 languages spoken in Maryland. Marian Grant noted that the major ones are

Spanish, French, Chinese, and then it drops off percentagewise after that. She wondered whether there might already be translations prepared elsewhere. Tricia Nay responded that the translations are different depending on the translation service used. She said that there is not one translation of Spanish because a particular translation can depend on where the person came from. She said that one Spanish version is not going to work for all persons given the very subtle concepts that are involved.

Niel Rosen suggested that it might be good to develop a summary of what is in the MOLST form as opposed to directly translating the form. His students as physicians love the Maryland MOLST form but when he asked them to imagine being a child of a patient using one, he said that they prefer the New Jersey form which has the goals of care at the very top of the form. He suggested that a summary of the Maryland MOLST form might help the patient communicate to their family regarding what the MOLST form said. Tricia Nay noted that goals of care could be written in an advance directive.

Elena Sallitto said that a summary of the MOLST form in English might not be a bad idea given how much staff turnover exists in assisted living units. She said that staff members don't understand the MOLST form and that clients have no clue they have a MOLST form. She said some clients have a DNR order on their MOLST form when they are supposed to be full code, or that conversely, they are full code when they are supposed to have a DNR order.

Jack Schwartz explained that the Maryland statutory advance directive form is in English and that the Attorney General's website as far as he knew has not attempted to do an official translation of that form into Spanish. He agreed with Tricia Nay that there are some difficulties when the State puts its imprimatur on a translation. Paul Ballard explained that the Attorney General's Office in the past had put a link on its website to the Montgomery County Coalition on End of Life Care's website, which website made available advance directives in several languages besides English. He noted that those advance directives were not verbatim translations of the Maryland form. Instead, these were advance directives in other languages that met Maryland's legal requirements. He said that the Coalition no longer has those advance directives in other languages on its website.

Discussing a news article Marian Grant had shared with the Council, Alan Eason said that New Jersey implemented a law that requires nursing homes and hospitals to provide annual training of staff in end of life care. He said that staff in nursing homes need to have this knowledge to interact with residents and have conversations with them. Carol Eckerl said that she would welcome such a requirement.

Tricia Nay said that when the Office of Health Care Quality looked at the possibility of mandated training for various things, they found that when California mandated continuing education in some areas, that there was no resulting change in providers' behaviors. Marian Grant said that some states require a certain percentage of practitioners to obtain continuing education credits in end of life care. She said it is an interesting idea but that she doesn't know how much of a difference it would really make to educate people, that is, does the requirement really change their practice. Tricia Nay noted that a high percentage of Maryland physicians do research and do not practice medicine, but those physicians would be required to get the same

CEUs as other physicians who practice. Marian Grant said that New York enacted a law that says you have to offer palliative care to all patients who qualify, but she is not sure that law has been successful in getting a lot of people access to palliative care.

In response to an article Alan Eason had shared with the Council regarding the refusal of a physician to follow the wishes of a patient's authorized decision maker, Hank Willner said that there is a general dilemma of getting physicians to stop treatments that are no longer useful. He said that the Choosing Wisely Campaign, at choosingwisely.org, calls on different specialties to delineate 5 different interventions that they should think twice about before doing.

Alan Eason was struck by the article's account of how the physician rejected the authorized decision maker's request for a palliative care consult on a Sunday. Hank Willner said that one of the problems is that hospitals sometimes only offer palliative care on weekdays. Marian Grant says some hospitals have palliative care practitioners on call on weekends. Hank Willner said he wants to have a goals of care conversation with every patient. He said there are just a few questions that need to be asked.

Marian Grant said Medicare's goal is to get to 100% value-based payments by 2025. She said that currently health care providers are paid for doing stuff, not for not doing stuff. Under value-based payments, if the outcome is going to be a certain way despite the medical intervention, then the medical intervention is not going to get reimbursed. So, she said that Medicare may push things in a better direction by requiring value-based payments.

Hank Willner said the problem is that the training of health care professionals in having these conversations is deficient and they are reluctant to have these conversations. Alan Eason said there is a culture that says you do everything. He said that in the last 100 years many new medical treatments have been developed during our life spans. He said that practitioners should not be pressuring patients to undergo a certain treatment, which is ultimately the patient's choice, and that practitioners should be educated in having conversations with patients. Marian Grant said that kind of education is more likely now in nursing and medical education but that in the real world, practitioners are still practicing the old way. So, she said it is going to take some time to work through this period until the mind-set is different.

Marian Grant reported that Maryland was ranked number 6 in the nation in the Palliative Care Report published by the Center to Advance Palliative Care. She said this positive ranking was because Maryland has palliative care programs in 95% of its hospitals. She wondered what that fact means in actual practice though, for example, a particular program might consist of one harried nurse who sees 3 patient a day as compared to another program that has a robust team of 20 people. She said that Maryland is at least doing better than other states because most hospitals in Maryland have palliative care programs.

Alan Eason said that National Healthcare Decisions Day will be on April 16. Jane Markley said that Montgomery County is putting on a program and as soon as she got fliers that she would share them with the Council. She said they will have a guest speaker, two workgroups, including one for providers and one for the public, and that the focus will be on

palliative care and advance care planning. Tiffany Callender said that she would let the Council know what the Horizon Foundation is planning to do.

Alan Eason said that the Aid in Dying bill will be introduced in the legislative session again this year.

Finally, Alan Eason said he was able to contact the Baltimore County Department of Aging and set up 15 advance directive training sessions for seniors at 15 Baltimore County senior centers during 2020. He said he got better results when he talked to someone at the top of the government structure rather than contacting each individual senior center.