

State Advisory Council on Quality Care at the End of Life  
Minutes from the May 13, 2019 Meeting

Meeting time and place: May 13, 2019, 10:00 a.m., Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, MD 21046-3422

Council members present: Alan Eason, Chair; Paul Ballard (Attorney General's designee); M. Jane Markley; Tiffany Callender; Karen Smith; Tricia Nay (Department of Health's designee); Carol Eckerl; Christine Watts; Sister Lawrence Mary Pocock; Donald D'Aquila; Christopher Kearney; Rabbi Steve Glazer; Elena Sallitto Boisvert; Marian Grant. On speakerphone: Jocelyn El-Sayed; Stevanne Ellis (Department of Aging's designee); Christian Miele (Department of Disabilities' designee).

Others present: Phyllis Gray; Sara Hufstader; Megan Mitchell; Paul Gleichauf; Brandon Neiswender; Susan Lyons.

Chairman Alan Eason convened the meeting at 10 am.

Alan Eason introduced the first topic regarding the integration of advance directives into Maryland's designated health information exchange, the Chesapeake Regional Information System for our Patients (CRISP), by recounting a discussion from the February, 2019 Council meeting regarding Anita Tarzian's personal experience with a hospital whose staff members were unaware they could access her electronic advance directive through CRISP. Following the meeting, Council members decided it might be good to invite representatives from CRISP to explain how they integrate electronic advance directives into the health information exchange.

Brandon Neiswender, Chief Executive Officer of CRISP, and Paul Gleichauf, Account Executive with CRISP, discussed how CRISP shares electronic medical record information between healthcare organizations, particularly regarding the sharing of patient's advance directives. Mr. Neiswender stated it is difficult to make sure the clinical care record is with the patient to insure continuity of care. He said that CRISP performs 5 main functions: (1) delivers health information at the point of care; (2) engages in care coordination activities, including the provision of four million clinical service encounters every month; (3) engages in reporting and analytics, for example, regarding readmissions; (4) manages public health registries to insure information is communicated effectively across systems, for example, immunization and Zika registries; and (5) engages in program administration for new hospital programs as they sign up, with CRISP acting as a non-interested party that keeps the score on these programs

Jane Markley asked whether CRISP covers Delaware as well as Maryland, West Virginia, and the District of Columbia. Brandon Neiswender replied that Maryland, West Virginia, and the District of Columbia use the CRISP infrastructure. CRISP also

exchanges information with organizations like CRISP in other states such as Delaware and Virginia, among others.

Alan Eason asked about the reach of CRISP in Maryland. Brandon Neiswender replied that there are 50,000 users, including every hospital. He said all hospitals have a single sign-on to CRISP that just allows them to click on a CRISP button or click on a patient's identifying information and it goes right to a tool set. He said that about 4.3 million of Maryland's 6.3 million people are registered with one or two providers in CRISP, including hospitals, long term care providers, payors, and primary care physicians. These persons have stated they have an active relationship with a patient and have asked CRISP to send them notifications of patient events when they happen.

Jane Markley asked whether the military was involved with CRISP. Brandon Neiswender replied that there is no active trading of information at this time because of current issues with the military's data but that there may be such sharing in the future.

A Council member asked whether CRISP does any outreach with estate planning or elder law attorneys. She said that these attorneys' clients prepare advance directives but may not yet have been seen in a clinical setting where an advance directive is needed. Brandon Neiswender replied that CRISP does not do any active engagement right now. He stated that CRISP had been in a pilot stage to store advance directives or other documents at the end of life at the point of care. He explained that in the original integration of services CRISP created a button that someone could push if they wanted to check if there was some documentation on file that was capturing that information. He said that will not be successful if you don't train people that the button is there or if it is not intuitive.

Brandon Neiswender said that keeping in mind that everything that people do in CRISP in the provider world takes 2, 3, or 4 extra clicks, the question is whether CRISP could integrate with electronic advance directives vendors and hospitals' electronic medical records systems. He said there were a couple of things that the CRISP wanted to insure: (1) that CRISP is not the source of truth for these documents; and (2) that CRISP communicates that these documents exist somewhere else and that they are managed by someone else in a way that they need to be managed. He said that CRISP is only a conduit that tells the user if you want to get to these documents, then push this button to see them and they will be there. He noted that not many Maryland residents have put their advance directive there yet, although there are lots of initiatives to encourage them to do so.

Tiffany Callender asked whether the patient's records kept by, for example, EPIC or Johns Hopkins, tell the user where the advance directive is, or does the user instead have to log out and go into CRISP to find the advance directive. Brandon Neiswender replied that is mostly correct and said that such a system makes for a bad workflow. He

said that his answer depends on how the particular hospital deploys the services of CRISP. He said the current system under CRISP does not tell the provider there is an advance directive. Rather, if the provider thinks there might be one, then they go onto CRISP and click a button and go out to another system and see if it is there. He said in general that would happen 1 or 2 times and then the provider would never go there again if there was nothing there.

Marian Grant said she was working at a hospital and that in anticipation of the Council meeting logged onto CRISP. She said the hospital is on the EPIC system and that she can go into the patient's EPIC record. There is then a tab she can click on that takes her into CRISP. She said that once she got into CRISP, there was a whole bunch of stuff to sort through that took some figuring out, that she had to click on additional information, that there was then a separate set of options, and there was then a place called "advance directives." She said there were no advance directives for all 12 patients she had clicked on and thus they had no idea whether any of the 12 patients they were taking care of that day in their palliative care system had advance directives. She said she could have gone into the hospital's EPIC system and rooted around for advance directives but that's actually harder because it is filed under "media" and then one has to look at a bunch of PDFs and hope that someone titled them "advance directive." So, she said that would be two places to look, which of course is not what a busy clinician wants to do, and it's not the fault of CRISP. But she noted that advance directive information is generally not listed on the top of electronic medical records as are allergy information and code status. She said she had to do a lot of digging to find advance directives, if she could ever find them, at least in her hospital's electronic medical records system.

Paul Gleichauf said that one additional add-on is that advance directives are unique in that they are consumer-generated while virtually everything else is provider-generated that has been put into the electronic medical record. Marian Grant asked if CRISP stores MOLST forms under "advance directives." Paul Gleichauf said it does not store MOLST forms at this time. Christopher Kearney noted that MOLST forms are provider-generated. Brandon Neiswender said that CRISP's clinical advisory committee is handling some questions on MOLST. He said the committee has had some discussions on how CRISP can play in that space. He said there is a lot of functionality in each one of these work flows that require very good record keeping. He said CRISP is not the source of truth. He said that there are other systems that are designed to handle the type of record keeping that is necessary to check a MOLST form in and out, like different kinds of work flow, which CRISP's clinical committee is working on.

Brandon Neiswender noted that the pilot program attempting to integrate electronic advance directives into CRISP was not very successful. He said they took a second stab at it after the Maryland Health Care Commission tasked CRISP with finding a solution that would make the work flow more valuable to the health care community, that is, that would help them not only understand when these directives are available

through CRISP but would also be somewhat agnostic as to the different places where they could be stored because not everybody is going to choose one vendor or another. He said that there are different software companies that want to manage these documents in different ways with different business models. So, CRISP has decided and is close to deploying an end-of-life registry similar to a Zika registry or some other public health code set in accordance with this plan. CRISP will allow any organization that can provide a link that says they have an advance directive or other type of document on file to just send CRISP the link. The link will then be stored as an advance directive in CRISP's system but CRISP won't have the actual document. What CRISP does with this link is to expose it directly inside the hospital's in-context widget that might say, for example, "advance directives: 2" or "advance directives: 1". He said this will be information about information and when the link is clicked it will take the user to the list of potential electronic advance directive vendors on file. He explained that the link will then take the person to that vendor's user's experience and will give a history of the documents depending on what's happening. CRISP will hold these links from multiple organizations. CRISP will display as one of the front widgets "advance directives" and the user won't have to dig deep into all the areas. It will just say "advance directives on file, Yes or No" and state the number of them on file, etc... He said that CRISP should have this deployed sometime in the summer of 2019.

Tiffany Callender asked whether it is dependent on the health system to be using some kind of in-context widget. For example, if she is using a small health care provider's electronic medical records system, she asked whether she would be able to simply push a button to directly access CRISP through the health care provider's electronic medical records system or whether she would have to leave that internal system to access the advance directive. Brandon Neiswender replied that when an organization does not have some of the same technical capabilities of some of the big systems for direct integration, what CRISP can do is provide that organization with a unified landing page. CRISP will then bring that information forward to be in the home screen and he said it will then be usable and manageable. But he noted that the user will still have to click out or go into another platform if they don't have the deep integration that some of the big hospitals have at this point. He said that organizations across the country are trying to get better interoperability in general and that CRISP is also trying to get better at this.

Brandon Neiswender said that there are other opportunities now available with new functionality. For example, he said the Council may wish to consider disseminating information through notification services in a way that says this patient just had a new document created and these are the care team persons who will receive those notifications. He said there are a lot of nuances with these notifications, for instance, some people would not want to subscribe to these notifications because they already get a lot of notifications about lots of other things. He said he just wanted to bring that up as an option because CRISP understands a little more about where these documents are stored.

He said that because CRISP gets information about this data, that there are interesting opportunities that potentially could serve the Council because new workflows can be created. But at the same time, he said that these are patient-generated documents and just because that technology exists does not mean there are going to be lots of advance directives at the end points. For that reason, he said the community's role in this is to create the infrastructures for storing advance directives that CRISP can see. He noted there is an advance directive program at the Maryland Health Care Commission for certified electronic advance directive vendors.

Paul Gleichauf said that the more that the work that the Horizon Foundation is doing succeeds, starting now in Montgomery County to actually get Maryland residents to both create advance directives and then save them onto an electronic registry, and the more that providers actually find an advance directive when they search for something, that this is going to be a self-fulfilling prophecy. Until that happens, he said, a provider will want to do less clicks when they are in an electronic record. Marian Grant said she looked 12 times and the advance directives were not there. She stated her belief that after such an experience the average practitioner in the hospital would not look in the future because they would just assume the advance directives were not there.

Cristopher Kearney said that someone from CRISP's clinical advisory committee contacted MedStar to ask whether MedStar would be interested in eMOLST. Christopher Kearney said that it seemed to him to be a slightly different topic than advance directives and wondered why MedStar wouldn't be able to see an eMOLST form. He said that he has been spending a lot of time going from outpatient setting to outpatient setting talking about advance directives and palliative care and all of these settings report to him that they don't have access to a lot of the records related to advance directives and palliative care. He said the other thing they ask him is whether decisions that have been reached in hospitals, often in the palliative care program, could somehow be available on CRISP. He wondered what people are notified of by CRISP at this time. Brandon Neiswender replied that they have lots of different notifications. He said that at any time they get a message of any sort that they get new documentation. He said that CRISP knows within seconds when someone steps foot into an emergency room, when they are transferred to inpatient status, or when they are discharged, and that all of these are the biggest number of notifications.

Christopher Kearney asked whether the notifications would include the fact that a MOLST form has been completed at the hospital and that the patient now has a DNR order. Brandon Neiswender replied that would not be a problem at all for CRISP to be able to do that. He said data is data but that the issue is what does the community want to broadcast beyond their own 4 walls, or sometimes within their own 4 walls depending on how big their system is. He said that CRISP can collaborate but that raises the original question about penetration. He said CRISP has notification services and that 70% of Marylanders are subscribed to CRISP through one or more organizations. He said that

one of the really important things from CRISP's perspective is that 4 million notifications per month is way too many. He said it is important to minimize these notifications. He said that people are already overwhelmed with data in ways that are not even effective any longer for clinical decisions. He said that one could tailor the individuals who are receiving certain types of notifications and allow them to be very proscriptive in terms of what they see. Or a better job could be done to filter out noise to organizations that don't need to know every time one of their patients show up at the emergency department with a broken arm.

Marian Grant asked whether CRISP could do this by patient population. For example, if there are frail elders who are in the emergency department with a broken arm, she would want to know that information, but would not need that information about every healthy 40-year old person who shows up with a broken arm. Brandon Neiswender replied that CRISP could do that and this occurs by subscribing to clinical service encounter notifications for a cohort of patients, for example, the care coordinator for Medicare Advantage has 25 patients and could ask CRISP to only send notifications for these 25 people. He said that most organizations that CRISP works with are heading in that direction now, subscribing for very specific, small cohorts where they are working to receive some sort of patient outcome with that patient cohort. He said that is the way most people are using CRISP's services.

Sara Hufstader asked what the cost to consumers will be in the future regarding accessing advance directives through CRISP. Brandon Neiswender said that CRISP is not involved in that discussion. He said it would be better to ask the Maryland Health Care Commission or the electronic advance directive vendors. He said that CRISP does not intend to offer this as a service. Marian Grant stated that the beauty of the CRISP system is that when CRISP aggregates online advance directive registries, health care providers can get to that data through CRISP. Brandon Neiswender replied that they would go to the electronic advance directive vendor's user interface from links on CRISP. Paul Gleichauf acknowledged that this makes it challenging for providers to determine when the advance directive was executed if there is more than one advance directive online for a patient.

Christopher Kearney asked what is useful for the Council to be doing in this area that would help CRISP. He said his sense was that the integration of advance directives into CRISP was not being done well.

Tiffany Callender said that CRISP's functionality is awesome, noting that not a lot of states have the ability to pull an advance directive electronically and allow an electronic directive to be done electronically, and praised Maryland for having that ability. She said the challenge is that people don't trust an electronic advance directives, that they are used to paper directives, and thus gaining their trust that electronic advance directives are legal is a huge issue.

Elena Sallitto Boivert asked whether the patient has individual access to CRISP. Brandon Neiswender replied that a patient cannot access CRISP. Instead, he said that the patient could go online to their electronic advance directive service to see their advance directive.

Tricia Nay said there is a danger in not having access to both the MOLST form and the advance directive together in one place because the advance directive may have been written 25 years ago and doesn't pertain to the patient's current situation while the MOLST form's orders would be applicable to the patient's current situation. Brandon Neiswender replied that CRISP would put MOLST forms and advance directives in different places. He said that CRISP would most likely just provide a link to an eMOLST form and make it available in the same way that an advance directive is made available on CRISP. Tricia Nay said that in situations where there are multiple MOLST forms and advance directives in the paper record, that the health care provider would look for the dates of the MOLST forms to see which one is valid. Thus, she said that issue is not unique to the electronic world.

Elena Sallitto Boisvert said in her experience with her clients that the MOLST forms are not completed correctly in Community Care Retirement Communities or assisted living programs. She said it is terrifying to have an inaccurate electronic MOLST form to which the patient does not have access and has no clue as to whether it was done right. Brandon Neiswender replied that is why he is very specific that CRISP is not the source of truth and that the source of truth is instead the endpoint registries as long as CRISP passes the user through to those registries. Paul Gleichauf noted that third party registries have the current capacity to store MOLST forms. He said the challenge is that MOLST forms change more quickly than advance directives, for example, MOLST forms' Do Not Resuscitate (DNR) orders are often suspended during surgery and then reinstated once the patient is out of surgery.

Christopher Kearney said there is a high error rate in MOLST forms when a hospital completes it at the last minute before a patient is transferred and that often the hospital ends up erroneously putting full code without having a discussion with the patient or the authorized decision maker. Alan Eason said such a practice would violate Maryland regulations. Tricia Nay said that audits conducted by the Office of Health Care Quality show that the vast majority of MOLST forms are completed correctly.

Marian Grant said it is a fluid situation and that no amount of documentation is going to substitute for what that patient wants in the moment in a particular health care setting with that health care provider. She said the paperwork is helpful if you can't speak with the patient, that at least you have something to look at, but the family is going to be making decisions as well. So, even if this process could be seamless electronically, it is still a dynamic situation. Carol Eckerl agreed, saying that validation and

conversation is an ongoing process. She said the provider is confronted with a document and has to determine whether it is right or wrong. So, she said that the provider has a conversation with the decision maker to make sure.

Christopher Kearney said that the expectation is that you do negotiate again if there is a change in venue. He said that his naïve question is why doesn't the State of Maryland create the repository for the MOLST form that they could access through CRISP? Tricia Nay replied that she had been working on this issue with CRISP and that if this was easy, someone in the country would have already set up the model system that: communicates with every possible system: would be secure; would allow consumers access to certain data, would allow the providers access; would organize everything by date, would be cost-effective and easy to use, and would require no extra clicks for users. She said she has been looking for that system for 15 years and when you look that long and no one has that system, that says it all. She said some of the operability of CRISP is unique to Maryland, which makes Maryland a trend-setter in some of the functionality aspects. She said this is a complex issue about conversations with patients, documenting those conversations on paper and electronically, while keeping those conversations relevant and ensuring they take place with the right person.

Marian Grant said that the opioid crisis is why people are using CRISP because they are required to use the Prescription Monitoring Program. She said this makes people go into CRISP. Consequently, they then see what else is in CRISP, which is an unintended positive consequence of the Prescription Monitoring Program.

Alan Eason said that accessibility of advance directives is what's behind all this. He said in his capacity as an ethics committee member, he had participated in the review of a case where the health care facility had not identified an advance directive that named the patient's son as an agent. In fact, it was the daughter who was instead talking with the committee. He asked whether a health care provider's staff are looking for the advance directive even if it is accessible. He suggested that perhaps training of staff to check for advance directives is needed. Marian Grant said that if only 30% of patients complete advance directives, then health care providers are not going to check every patient's chart for an advance directive on the off chance that they might have an advance directive. Tricia Nay said that what is typically in the record are the current conversations with patients with capacity about what they want now. Christopher Kearney said that paper hardly exists. Tricia Nay said that many assisted living providers are not connected to the Internet or are located in areas without Internet access.

Alan Eason asked whether a person can upload a scanned advance directive to CRISP. Paul Gleichauf replied that CRISP could do that.

Sara Hufstader asked what if a person only designates an agent in MyDirectives.com or in VYNCA but does not prepare an advance directive. Brandon

Neiswender replied that the electronic medical record system could be set up to ask the health care provider whether they want this to just say “health care proxy,” and then say that the documents are on file, and then direct the user to go to that system where the documents are on file. Marian Grant said that the health care provider is usually not talking with the authorized decision maker but usually with whoever happens to be with the patient. Brandon Neiswender replied that CRISP can work with whatever documents get uploaded. He offered to do a follow-up Power Point presentation at another Council meeting.

Tiffany Callender said electronic advance directive vendors like MyDirectives.com take a lot more information than just advance directives, for example, videos, music selections, etc... Brandon Neiswender replied that for advance directives the user can go to MyDirectives.com. He said that CRISP is just directing the user to the fact that there is an electronic advance directives vendor that might have a relevant document and tells the user how to link to that vendor.

Christine Watts asked whether you have to have a password. Brandon Neiswender replied that all that is handled behind the scenes where there is security and audits that can tell who clicked through.

Jane Markley asked whether someone has a plan to begin training to get people to complete their advance directives and upload them onto CRISP. Marian Grant noted that CRISP is for clinicians and Tiffany Callender said it is also important to educate providers that advance directives are on CRISP. Jane Markley agreed and said that two different trainings programs are needed to be done because there is no point in training physicians that advance directives are on CRISP if they are not there. Marian Grant said the Maryland Department of Health had funded several efforts over the last couple of years to educate people about the importance of completing advance directives and that she imagines that they are continuing with those efforts.

Marian Grant discussed the Massachusetts Coalition for Serious Illness Care. She said there are a number of national palliative care organizations that are working on a federal level but there also are a number of successful organizations on the State level. California requires all managed Medicaid programs to offer palliative care benefits. New York has a law that states that patients need to be informed about the availability of palliative care. She said these states coordinate with each other through the National Academy for State Health Policy. She said Medicaid is a huge budget item and so states are very interested in sharing with each other what works and what doesn't. She said that former Delegate Dan Morhaim was president of this organization for the last 2 years. He stepped down from that position because he is no longer a delegate.

Marian Grant said the Johnny Harford Foundation has funded the geriatrics field for the past 40 years. The foundation gave the National Academy of States money for

staff to study palliative care and thus palliative care is a topic at their national conference. She said the Academy had a webinar on State policy on palliative care a few months earlier. She also said the Academy had made up to 10 grants available to organizations. To get such a grant the applicant must already be working with their state policy makers. She said states are considering similar laws to those in California and New York. The foundation said they were going to give money and support to 10 states that are interested in working on legislative initiatives to change palliative care policy. Applications were to be due on May 23. She said that the Serious Illness Coalition was not yet ready to apply on behalf of Maryland because they do not have a policy plan at this time and are not working with legislators. She said that probably 10 other states are ahead of Maryland in pursuing such initiatives but that she wanted to make the Council aware of the fact that there is this national organization, that there is this source of funding, and that there is this effort. She said 10 states will get support and the Council can look at these other states' initiatives and see whether they are good ideas. She said the object is to be efficient in sharing what is and isn't a policy success rather than having all 50 states start from scratch in creating their own legislative initiatives.

Paul Ballard said that Marian Grant, as previously requested at the last Council meeting, had provided the Council with the mission statement for the Serious Illness Coalition to determine whether the Council could endorse the Coalition's mission. Paul Ballard noted that the mission of the Coalition was very generally stated and as such the mission statement could likely be endorsed by the Council. He said that as particular items for the Council's review arise, the Council could then review whether it supports each item and activity. He read the Coalition's mission statement which stated: "Mission: To improve the lives of those with serious illness in Maryland and advocate for care that is accessible and in accordance with their goals, values and preferences at all stages of illness and in all settings. Vision: To build an ecosystem to support those living with serious illness and their loved ones." Marian Grant said that the Coalition is not yet prepared to give an update because the Coalition is trying to nail down its structure.

Paul Ballard updated the Council on the End of Life Option Act bills that failed. He reported that the House of Delegates passed a bill but that the Senate's amended version failed when a Senator refused to vote on the bill. One of the bill's sponsors, Senator William Smith, told the media that it is not likely that the bill would be introduced again in the 2020 legislative session. Dan D'Aquila noted that the cost of the medication that is typically used for aid in dying costs \$3,700 and wondered if the bills contemplated supporting the funding of the medications. Paul Ballard said he was not sure if under existing law whether an insurance company could be required to cover the cost of the medication.

Christopher Kearney noted that based on the media coverage it seemed like most of the testimony in support of the bills were because of instances where people died miserably.

Their rationale seemed to be that there was no other way to die than miserably and that was why aid in dying was needed. He noted that the Council had taken the position on the bills that no one should be seeking aid in dying for lack of good palliative care. He wondered whether there was any discussion in the testimony before the legislature as to what happens in D.C. where aid in dying is not permitted. He said the D.C. Board of Physicians won't tell people what physicians are willing to participate. He does not know yet of any instance in D.C. in which aid in dying was used.

Paul Ballard read Peggy Funk's email to the Council stating that the Hospice and Palliative Care Network does not take a position on assisted suicide but educates people on the benefits of hospice and palliative care. She offered to coordinate with someone from Oregon to offer the Council a webinar on how aid in dying works in Oregon and to discuss Oregon's patient statistics. Marian Grant said the Council should keep an eye on the legislation and that if it is introduced again, maybe that would be a good opportunity for further education.

Paul Ballard informed the Council that his job duties have changed and that he is now working part-time devoted primarily to Health Care Decisions Act and MOLST issues. He said he hopes to work on a handbook on those issues and stated he will have more time available to devote to Council projects.

Marian Grant said that the Massachusetts Serious Illness Coalition just got a large amount of money for advance care planning research. She said the research revealed that the public falls into 5 different categories that help to explain why they choose to complete or not to complete an advance directive. She said that the study concluded that 34% of people complete an advance directive and that based on their study she is not sure how persuadable the rest of the people are. The study looked at messaging to overcome such reluctance to complete an advance directive and test messaging to see if it works. She said that the Council should keep an eye out for this because Massachusetts is going to make this information available to people. She said the study's research that revealed the types of people who complete an advance directive is based on a national sample, which research could be useful to Maryland because the same information may not be available regarding Maryland residents.

Elena Sallitto Boisvert said sometimes her clients are reluctant to sign advance directives because they say their family knows what they want. She explains to these clients that they need to look at the advance directive from the perspective of the audience, that is, the health care providers, who need to know who has the agency on behalf of the patient and what their decisions are.

Marian Grant said you can convince people through one-on-one conversations to complete advance directives. She said some people don't trust their families will honor

the advance directive. She wondered how a system can be created for those people that don't involve their loved ones because they don't trust them.

Elena Sallitto Boisvert said a population that is growing are the orphaned elderly. She and Paul Ballard agreed that is an important issue that the Council should look at. Phyllis Gray said there was a National Public Radio story about parents who chose not to prepare advance directives to force their children to discuss with each other what to do. Alan Eason noted how interesting that story is given how part of the MOLST training he conducts includes a Power Point slide talking about the importance of advance directives in preventing post-death fighting among family members regarding their decisions made on behalf of the patient.

Tiffany Callender spoke of the importance of advocating for legislation that embeds advance directives in institutional things, for example, driver's licenses or other types of documents a person might see when they turn 18 years old. She said that embedding advance directives into routine operations would be beneficial to get people to think about, discuss, and complete advance directives. She cited the example of having the organ donor designation on the driver's license.

There being no further business, the meeting was adjourned.