State Advisory Council on Quality Care at the End of Life
Minutes from June 11, 2010 Meeting

Meeting time and place: June 11, 2010, 10:00 a.m., in the Department of Aging's Conference Room, 301 West Preston Street, Room 1007.

Council members present: Ted Meyerson, Chair; Melinda Sauders; Gail Amalia Katz; Catherine Stavely; Michael Safra; Timothy Keay; Paul Ballard (Attorney General's designee); Jim Reinsel (Secretary of Disabilities' designee); Karren Pope-Onwukwe; Steve Levenson; Michael McHale: Mike LaChance (Secretary of Aging's designee); Nancy Grimm (Secretary of Health and Mental Hygiene's designee);

Others Present: Keith Schiff; Richard Alcorta; L.E. Zimmerman; Teresa Robinson; Rebecca Elon; Danna Kauffman; Shawn Brennan, Tricia Nay; Bill Holman

Ted Meyerson convened the meeting at 10:00 AM and welcomed Council members and guests.

Danna Kauffman of LifeSpan and a panel of speakers made a presentation to the Council regarding the provision of pain medications to nursing home patients in a timely fashion. L.E. Zimmerman talked about pain control, stating that the Drug Enforcement Agency (DEA) needs to change its interpretation that a nursing home nurse may not be considered an agent of the physician who may sign prescriptions for narcotic pain medications on the physician's behalf just as hospital nurses are allowed to do. Teresa Robinson stated that the DEA's interpretation of the law interferes with patient care. Ms. Robinson stated that although nurses may typically convey prescriptions to pharmacies over the phone as the physician's agent, they are not allowed to do so for narcotic pain medications. She said that this restriction results in great delays in patients receiving narcotic medications. Instead, under DEA's interpretation of the law, a physician must send a written prescription directly to the pharmacy. The prescription form must be filled out exactly as required by DEA or the pharmacy will delay issuing the prescription. Mr. Zimmerman reported losing a physician due to this burdensome paperwork.

Dr. Rebecca Elon stated her wish that Maryland would take on a leadership role in solving this problem. Dr. Elon reported that in nursing home practice pharmacies are no longer filling prescriptions based on medication orders in the patient's chart that are then faxed to the pharmacy. She stated that this is a problem given that physicians are prescribing more opioids than ever before to address pain issues. She further stated that there are more opioid-related deaths than ever before and thus DEA is being more restrictive in its enforcement policies. Dr. Elon suggested that nursing homes should be allowed to become DEA registrants so that they can be treated in the same way as hospitals. Dr. Elon stated that this would be possible only if Maryland granted Controlled Dangerous Substance permits to nursing homes. If this occurred, she stated that DEA could give the nursing homes DEA registrations that would allow nursing homes to use a DEA number for prescribing as in hospitals.

Dr. Levenson noted that nursing homes do not have the same systems in place as hospitals that would enable them to have DEA registrations. Dr. Timothy Keay asked whether assisted living programs have a similar problem. The panel members said that there was not the same urgency for assisted living programs because they are based on a social model of care rather than a medical model of care. Dr. Levenson noted that DEA thought that e-prescribing may be a possible solution to the problem. Mr. Ballard noted that the Maryland Department of Health and Mental Hygiene's Division of Drug Control issues Controlled Dangerous Substance permits.

Ms. Kauffman stated that DEA needs to know that their interpretation has resulted in the delay of the administration of pain medications to patients and she hoped for a groundswell of support to help nursing homes point out this problem to Congress. Mr. Meyerson asked Mr. Ballard to place this issue on the agenda for the October meeting and asked Ms. Kauffman to come back to the Council with a concrete proposal to address the issue.

Mr. Meyerson updated the Council regarding the workgroup formed to work on implementing the House Bill 30 workgroup's recommendations, including a bill of rights for patients regarding the care they receive at the end of life. Representatives that attended the meeting were asked to go to their respective organizations and affirm their support for the bill of rights. Once the affirmation of support is given for the bill of rights, volunteers will prepare an accompanying educational booklet and figure out how to pay for its printing and distribution. Dr. Tricia Nay offered that OHCQ could electronically distribute the bill of rights and booklets to providers. Mr. Meyerson noted that the workgroup suggested adding a preamble stating that it is not a document that creates legal rights that would form the basis for a lawsuit. The Council agreed to support in principle the concept of having a bill of rights.

Dr. Richard Alcorta, the Medical Director for the Maryland Institute for Emergency Medical Services Systems (MIEMSS), Dr. Nay, Dr. Keay, and Dr. Levenson spoke to the Council about their efforts to develop a form similar to the Physician Orders for Life-Sustaining Treatment (POLST) form that has been adopted in various forms in a number of states. Dr. Nay noted that 8 states have POLST programs and that 29 states may have one in place within the next few years. They are proposing a Medical Orders for Life-Sustaining Treament (MOLST) form because in Maryland nurse practitioners may also sign EMS DNR orders. The MOLST form would contain orders that would be transferable across health care settings to improve the chances that the wishes of patient regarding life-sustaining treatments are honored by health care providers.

Dr. Levenson explained that their workgroup used the Life-Sustaining Treatment Options form (LST Options form) and the MIEMSS EMS/DNR order form as a starting point in preparing a draft MOLST form. He presented a draft MOLST form that the workgroup had prepared in consultation with Assistant Attorneys General Sarah Sette and Paul Ballard. The workgroup attempted to take into consideration what could be implemented practically and tried to make it as succinct and complete as possible. A subcommittee

will be formed over the summer to work on the draft form. A final draft will be prepared by the Fall and a sponsor will be asked to introduce a bill in the 2011 legislative session.

Dr. Nay explained the draft MOLST form. First, the form requires the practitioner to explain the authority for issuing the MOLST form, for example, based on the consent of the patient. The next section would then record the code status for the patient, i.e., whether cardiopulmonary resuscitation (CPR) should be performed when emergency medical services personnel are summoned. Dr. Alcorta explained that originally a "do not resuscitate" order (EMS/DNR order) just provided for palliative care. MIEMSS then revised the EMS/DNR order to provide for an aggressive option that allowed for other treatments prior to arrest (Option A) and another option for more passive treatments prior to arrest (Option B). In practice, MIEMSS is discovering that patients with reversible conditions have been selecting the passive Option B rather than the more aggressive Option A because they did not want intubation. Thus, MIEMSS will be deleting intubation as one of the permitted treatments in Option A.

In the draft MOLST form section on code status, Dr. Alcorta noted that Option A would include the use of a CPAP or a BiPAP machine. Dr. Alcorta noted that MIEMSS only has authority over emergency medical services personnel. Dr. Levenson stated that nursing homes may not have CPAP and BiPAP machines and that therefore the form may need to be clarified to distinguish between what treatments are required to be provided by EMS personnel versus what is required of other health care providers. Dr. Alcorta stated that the draft form provides the choice to receive CPR because the MOLST form would be used for other treatment choices besides choosing to decline CPR. Dr. Nay stated that with the exception of code status, practitioners would be able to leave any or all of the other treatment options blank. Other than the code status section, EMS personnel would not be referring to the MOLST form. Dr. Keay suggested that "or severe symptoms" be added to the section concerning hospital transfer but otherwise approved of the draft form. Dr. Keay agreed that the form should be kept simple and details should be contained in the form's instructions. Dr. Nay stated that the form should be clinically practical. Mr. Meyerson stated that the form should be kept simple for the patient to understand. Dr. Keay noted that some states do a very simple form. Dr. Levenson said that the LST Options form was used as a model because it has broader options than are found in some other state's forms and because the LST Options form has proven to be useful in nursing homes.

Mr. Meyerson asked that a draft MOLST form be ready to be reviewed and voted upon at the next Council meeting. Mr. Meyerson asked Mr. Ballard to be the recipient of comments on the MOLST form and to attend meetings over the summer with the workgroup. Dr. Nay said she would keep the word DRAFT on the document as the workgroup gives the document to other groups for their review and comments. Mr. Ballard suggested getting a draft to the Council by email prior to the next Council meeting.

Mr. Meyerson discussed the need to update the Council's website and asked members to provide suggested updates to him.

Finally, in a follow-up to a question that arose at the February meeting of the Council, Mr. Ballard reported that a health care practitioner must honor an EMS/DNR order after the patient has gone into arrest. Prior to arrest, the health care practitioner has the discretion to provide appropriate treatments for the patient's condition. EMS/DNR personnel must strictly abide by the EMS/DNR order both prior to arrest and after arrest.

No further items of business having been presented, Mr. Meyerson adjourned the meeting at noon.