

**State Advisory Council on Quality Care at the End of Life
Minutes from October 15, 2010 Meeting**

Meeting time and place: October 15, 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; Catherine Stavely; Michael Safra; Timothy Keay; Paul Ballard (Attorney General's designee); Cari Watrous (Secretary of Disabilities' designee); Karren Pope-Onwukwe; Michael McHale; Gail Mansell.

Others Present: Tricia Nay; Alice Hedt; Richard Alcorta; Harold Bob; Anita Tarzian; Elizabeth Lechner; Adam Brenner; Leah Kaye; Chris Crabbs.

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

Chris Crabbs presented documents that her subcommittee had prepared to implement the House Bill 30 workgroup's recommendation regarding a bill of rights for patients concerning the care they receive at the end of life. The workgroup had decided to change the name from a patient's bill of rights to "Quality End of Life Care: The Conversation Starts with Your Medical Team."

Ms. Crabbs' subcommittee developed various documents to be used in an educational campaign. Her subcommittee made a poster stating in simple language some of the major points that had been included in the previous draft of the patient's bill of rights. The more detailed information in the previous draft would be retained in a Frequently Asked Questions (FAQs) information sheet and a PowerPoint presentation. This presentation could be put on the websites of various organizations and made available to health care organizations to use as an educational tool for patients. She also presented a draft cover letter to physicians that would explain the poster and FAQs information sheet. The poster and the FAQs information sheet may eventually become a brochure that would be available in physician's offices and other health care facilities.

One document would be a poster that patients could see in their physician's office that would give a patient general information to help the patient discuss end of life care issues with their physician. After reviewing the draft poster, the Council suggested deleting the legal disclaimer because the document was no longer labeled as a bill of rights. The Council also suggested language that would clarify that a patient could decide whether to prepare an advance directive without telling the patient to prepare an advance directive.

Dr. Timothy Keay suggested notifying physicians in the cover letter that there was a chart available on the Council's website listing the various laws that supported the information contained in the poster and FAQs information sheet. Ted Meyerson asked Mr. Ballard to re-send this chart to Council members for their review to consider including it on the Council's website.

Cari Watrous was not certain at the time of the meeting whether the Department of Disabilities could support the educational documents as drafted by the subcommittee and said she would have to take it back to the Department for their review. The Council voted to move forward with finalizing and promoting the educational documents, with Ms. Watrous opposed pending obtaining review and approval by the Department of Disabilities.

Mr. Meyerson noted that the next step after the education of consumers would be the education of health care practitioners. In response to a query from Mr. Meyerson, Dr. Keay described the educational programs in end of life care that are offered at the University of Maryland Medical School for medical students, residents, and fellows.

Dr. Richard Alcorta, the Medical Director for the Maryland Institute for Emergency Medical Services Systems (MIEMSS), explained the new Emergency Medical Services/Do Not Resuscitate (EMS/DNR) order form that was revised in August of 2010. MIEMSS decided to add “do not intubate” to Option A (comprehensive care prior to cardiac or respiratory arrest) because patients whose condition made Option A more appropriate were nonetheless declining Option A to avoid intubation. Old EMS/DNR order forms will continue to be honored by EMS personnel. In response to the request of some physicians who wanted an option for intubation for patients who choose Option A, Dr. Alcorta stated MIEMSS plans to again revise the EMS/DNR order to provide a choice regarding intubation when a patient chooses Option A.

Mr. Ballard discussed the proposed Medical Orders for Life-Sustaining Treatments form (“MOLST”), which form is modeled after the Physician Orders for Life-Sustaining Treatment (POLST) that is used or being developed in many states. The MOLST form is a medical order that contains a patient’s preferences for treatment based on the patient’s current conditions and wishes. The MOLST form is not intended to be an advance directive. The primary advantage of the MOLST form is that it contains portable orders that travel with the patient across the continuum of care among various health care providers. Recent studies show that a patient’s wishes regarding end-of-life care are carried out more reliably when a POLST form has been completed. The MOLST form is based on the EMS/DNR order form and the Instructions on Current Life-Sustaining Treatment Options form, which latter form now has a history of use in nursing homes.

The MOLST form was developed by Dr. Steve Levenson of the Council, Dr. Tricia Nay and William Vaughan of the Office of Health Care Quality, Dr. Alcorta of MIEMSS, and Sarah Sette and Mr. Ballard of the Attorney General’s Office. This committee has met with a wide variety of health care provider organizations, has received generally positive feedback, and has incorporated their feedback into a revised MOLST form and a draft bill for consideration of the General Assembly in the 2011 session, which drafts were shared with the Council and guests. Mr. Ballard stated that the Board of Physicians has approved the draft MOLST form. The plan would be to educate all the health care providers once the bill is passed by providing train-the-trainer sessions, followed by

training conducted by health care provider organizations. Also, Dr. Levenson authored a guide on how to use the MOLST form.

The bill would provide that the MOLST form be honored in all health care settings, regardless of whether the health care provider had admitting privileges at a particular health care facility. The MOLST form must be kept in the patient's medical record and transferred with the patient. Only those parts of the MOLST form that relate to a patient's current treatment condition or preferences would need to be completed.

Mr. Ballard noted that the health care practitioner's signature blocks were put on both pages in case the form was not copied onto two-sided paper. Dr. Nay stated that this was because many small health care providers may not have the ability to copy the form onto two-sided paper. The first page is devoted to the instructions, authority for the form, and code status of the patient. Thus, for issues regarding CPR the first page could be a valid stand-alone document containing orders regarding the patient's code status. Mr. Meyerson suggested putting "Page 1 of 2" and "Page 2 of 2" on the form to cue the reader that there may be another page that should be considered by the health care provider reviewing the form. Dr. Nay accepted this suggestion.

Mr. Ballard then described the second page of the MOLST form, which contained orders regarding life-sustaining treatments and other related care issues in their order or priority based on the imminent need for the order. For example, the first specified order concerns artificial ventilation while the last specified order concerns kidney dialysis. The categories of orders contained on the form include artificial ventilation, blood transfusion, hospital transfer, medical workup, antibiotics, artificially administered fluids and nutrition, kidney dialysis, and other orders. The form will not expire but must be voided when a new form is signed. Mr. Ballard noted that the intent of the MOLST form is to generate consolidated orders that relate to current treatment issues and preferences. Periodic review of the form is thus vitally important when the patient's condition substantially changes, the patient is transferred or discharged, the patient loses capacity to make health care decisions, or the patient changes their mind regarding treatments. These events would trigger further review of the MOLST form.

Gail Mansell asked whether the MOLST form would replace a hospital's code sheet. Dr. Nay responded that a facility may choose to have other forms in addition to MOLST. She noted that the MOLST form would replace the LST Options form. Dr. Alcorta stated that the EMS/DNR order will be changed as he previously discussed regardless of the outcome of the MOLST legislation. Dr. Keay noted that education will be necessary to make the MOLST form effective.

Mr. Meyerson stated that no system is perfect and that when providers are in doubt they tend to perform treatments. Mr. Ballard agreed and noted that studies about the use of the POLST form show that while it is not foolproof, it is far more effective in terms of carrying out patients' wishes than not having a POLST form.

Dr. Keay asked whether color forms would be required. Dr. Nay responded that color would be confusing because it may mean different things in different facilities. In addition, she noted that small facilities may not have the ability to make copies in color. Nothing would prohibit a facility from choosing to copy the MOLST form in a particular color.

Dr. Keay also asked whether there would be an electronic version of MOLST. Dr. Nay responded that health care facilities could choose to use an electronic version that was true to the standardized version of the MOLST form. Dr. Nay stated that she has contacted the Chesapeake Regional Information System for our Patients (CRISP) regarding the possibility of funding that would be available to facilitate the use of an electronic MOLST form.

The Council approved the MOLST form and the committee's efforts to support authorizing legislation.

Mr. Ballard updated the Council regarding the issue that was raised at the Council's June meeting regarding the Drug Enforcement Agency's (DEA) 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. In response to concerns raised by the nursing home industry regarding delays in obtaining pain medications that they attributed to this interpretation, the DEA issued guidance stating it would allow nursing home nurses to act as the agents of physicians for the purposes of communicating prescription orders for Schedule III, IV, and V controlled substances to a pharmacy if the nurses entered into written agency relationships with the physicians.

Mr. Ballard distributed a letter from the Centers for Medicare and Medicaid Services. In the letter, CMS notified State Health Officials and State Medicaid Directors that under the Affordable Care Act, children receiving Medicaid and CHIP program hospice benefits will no longer have to give up concurrent curative treatments to receive hospice benefits.

Mr. Meyerson asked Council members and guests for recommendations for the vacant Council positions. Dr. Nay and Karren Pope-Onwukwe said they would make some recommendations.

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