State Advisory Council on Quality Care at the End of Life

Minutes from the January 28, 2022 Meeting

Meeting time and place: January 28, 2022, 10:00 a.m., via video conference call.

Council members present: Alan Eason; Paul Ballard (Attorney General's designee); Jane Markley; Rabbi Steve Glazer; Tricia Nay (Maryland Department of Health's designee); Susan Lyons; Gail Mansell; Peggy Funk; Stevanne Ellis (Department of Aging's designee); Tiffany Callender Erbelding; Christopher Kearney; Sara Hufstader; Shahid Aziz; Karen Smith; Geoff Coleman, Sarah Hofstader; Donald D'Aquila.

Others present: Ferdinando Mirarchi; Jack Schwartz; Ted Meyerson; Dan Morhaim; Jeff Zucker; Stacy Howes; Jenny Kraska; Harold Bob; Pat Alt; Sarah Oliveira; Michelle Ross; Mary Waldman.

Chairman Alan Eason opened the meeting. The December 9, 2021 minutes were approved pending receipt of any corrections.

Paul Ballard discussed the workgroup regarding Senator Kramer's legislation to increase the use of advance directives that was passed by the Senate but stalled in the House during the 2022 legislation session. The House Health and Government Operations Committee asked the Maryland Health Care Commission to gather stakeholders and look at the issue over the interim period between legislative sessions and issue a report with recommendations. The Commission held several meetings and issued a report. The report contained four recommendations, including:(1) insurers putting a link to a health care agent registry developed by CRISP, the State-designated health information exchange, on their member portal, whether through legislation or voluntarily; (2) health care providers collecting information on health care agents and promoting the completion of advance directives; (3) increasing the number of nursing homes connected to CRISP because only about ½ of them are now connected and this would provide another means for people to put their advance directives in the CRISP database; and (4) creating a pilot project for ambulatory practices and health systems similar to the WellSpan health advance care planning initiative to get more advance care planning documents into CRISP, and developing best practices on how to do that.

Peggy Funk said she participated in the workgroup. They had four meetings and there was a lot of good discussion and they tried to build some consensus, which is what she thought they did. She said that at any one time there were 60 to 80 people attending, so there was good representation on the workgroup. She said they did a good job but that some of the recommendations raise questions as to how to fund them. Because the final report was just issued the week prior to the Council meeting, people have not had a lot of time to digest it.

Tiffany Callender Erbelding agreed with Peggy Funk that the goal of the workgroup was to build consensus and to move forward in some way. She said there was a lot of discussion about focusing on the health care agent, but that it is important not to forget about the living will. The point is to start somewhere, get consensus, and build off this consensus. She is excited to see forward momentum on the issue. Although some people may not see the report's recommendation as being enough, she sees the report as a step in the right direction.

Harold Bob said that speaking as a provider in the nursing home industry and in the primary care industry, there are a lot of mandates in CRISP and sometimes as a provider they become confusing and disorganized. CRISP is very effective but a lot of the new mandates have not all flowed smoothly. Providers love the concept of CRISP. All nursing homes have mandatory reporting on Covid vaccination status so it is possible there could be some piggybacking on that. But there needs to be funding.

Alan Eason introduced the topic of Senate Bill 48 and House Bill 14. Paul Ballard said that SB 48 is identical to the bill that Senator Kramer introduced in the 2021 legislative session and that Delegate Cullison (who participated in the interim workgroup) introduced HB 14, an identical cross-filed bill.

Tiffany Callender Erbelding discussed the Honoring Choices Coalition. She said the Coalition was established to support the legislation introduced by Senator Kramer and Delegate Cullison, to support the implementation of the recommendations made by the Council in 2020, and to support the recommendations made recently in the interim workgroup's report.

Paul Ballard brought up the issue that had been discussed at prior Council meetings regarding the denial of visitation with a dying inmate by a hospital chaplain. The fact that the prisoner was denied spiritual care at the time was very troubling to everyone on the Council but the Council had not made any specific recommendations for action. He wished to explore possible options, including writing a letter containing the Council's recommendation, but he was not sure to who the Council would send such a letter. Perhaps the letter could be sent to a hospital association or to correctional officials.

Alan Eason said he recalled from the discussion of this issue in past Council meetings that someone had said the issue arose more frequently in local detention centers than in State correctional facilities, which if correct, would make it more difficult to reach out to all the local detention centers given that each county has its own detention center. He agreed it would be a good idea to reach out and communicate about the issue but he does not know often this situation occurs. It may not occur that often at local detention centers because people incarcerated at those places are serving shorter sentences.

Paul Ballard asked whether there might be a correctional services association with a newsletter that people might read. Alan Eason said that would make sense but he didn't know off-hand because he has been retired so long. He invited Paul Ballard to investigate whether such a group might exist with a newsletter. Paul Ballard said he would explore that issue and perhaps fashion something for the Council to review at its next meeting.

Michelle Ross said she had some recent experiences with these sorts of situations so she offered to talk further about how the Council might be able to help. She suspected this problem is happening more often than we know about. All the counties are different even from one facility to another in terms of what their wardens will or will not allow. And she has even seen some differences between how inmates are treated. She is really not sure how these decisions are being made but she thinks they are not necessarily being made with input from hospitals. She will email Paul Ballard and Alan Eason to discuss the issue further.

Jeff Zucker asked whether the Council is looking at inmates actually declaring their wishes, looking to confirm that the wishes we have for them on file are still accurate, looking for medical providers to find the wishes and respect them in the event of a crisis, or looking for all three. Paul Ballard responded that specifically for this issue the Council is looking at ensuring that should an inmate welcome spiritual or supportive guidance from a chaplain at the end of life, that they at least be given the opportunity to choose whether they want such support, that is, not to have the chaplain barred from the door to enter the room. Alan Eason said that in the newsletter article the issue was really about what happens when an inmate is terminally ill in a hospital setting and wasn't allowed to see a see a religious person that they wanted to see. He said the issue is not so much about advance care planning but is instead about whether a warden of a local facility may bar an inmate who is terminally ill from having access to a religious person if they want one.

Jack Schwartz said the question for the Council is how broadly or narrowly the issue is to be framed. When the issue arose, it was a quite narrow issue, that is, everyone accepted the proposition that anyone in the hospital, including a prisoner, ought to get palliative care services as needed, especially near the end of life. And hospital chaplaincy is an integral part of effective palliative care services for those patients who want spiritual, religious support from chaplains. That is a narrow issue. Jack Schwartz said the slightly broader issue alluded to by Alan is whether someone has a right to a visit from a religious person from the outside rather than from a hospital chaplain, such as the patient's own priest, rabbi, or imam for example. This raises a somewhat different issue concerning security. Jack Schwartz said there is the broader issue that Jeff Zucker raised regarding the circumstances in which a prisoner has previously expressed treatment preferences, which touches on the broader issue of what does end-of-life care look like for people in custody. Jack Schwartz said the Council could take on any or all of these issues but the broader the issue, the more complicated it is. While the Council may wish to engage on broader issues later, it may be advisable to start small and narrow and just try to figure out who to communicate with on this issue to convey the message that hospital chaplains need to be able to see patients, including prisoners, as part of effective patient care.

Jeff Zucker agreed and said he has experience with prison systems, though not in Maryland. The process, breakdown, and goals of advance care planning are no different in prison populations than in the non-prison population. There are a significant number of lawsuits brought against states and you would think Maryland would not want financial exposure created by not honoring a patient's treatment wishes. If the patient moves between facilities and the paperwork reflecting those wishes does not travel with them so there is timely access to them, or if no one bothers to check the medical record to see if the patient has declared their wishes, the family members are even more grieving and more upset when the patient's wishes were not honored. So, there are multiple facets to this issue within a correctional institution just like there is in regular society. He would recommend that the Council suggest that upon admission to any correctional facility, there would be a normal medical intake that by law has to happen within 24 or 48 hours, that during the intake physical there would be a review of the medical chart, and that in that process someone would ask "where is your advance care plan" and "who have you named as a health care agent," and if the inmate hasn't done it, to give them the ability to do it in whatever form is used that can be attached to CRISP so that it is accessible for any inmate in the State of Maryland. The more that people do it, the more likely it is that there's going to be a more top-of-mind attitude on part of the health care provider to check it and maybe respect it in the event of a crisis. But you are never going to get there unless you ask for the patient's input in the first place. So, he would recommend there be a normalized workflow in the correctional system during intake to ask these questions, just as such a normalized workflow was envisioned by Senator Kramer's original legislation that asked payors to do this in the private sector.

Pat Alt asked about the impact of Covid on this issue, that is, the restrictions on visitors. Jeff Zucker said that was a great comment and that society has groped over the past two years as to what to do in these scenarios. We do see virtual conversations between inmate patients and some members of the clergy, some chaplains. The first step is to find out what that patient's treatment wishes are. There is also literature regarding addenda to advance care planning documents in the Covid experience, that is, there are people who have said what they want in the normal course of health care but if it were Covid they might make different treatment choices. But it is not effective unless a provider knows about these wishes. It should be normalized upon any intake, upon any transfer, of an inmate from one facility to another, to verify their medical chart, verify their health care agent and if they don't have one, let them name one. To get an expression of their goals of care and if they don't have one, to let them describe them and to make sure this information is accessible so there is no excuse for not carrying out their treatment wishes. Susan Lyons responded on Chat: "Jeff, this is a great proposal. We call the prison to determine if any decision maker documents one on file, but it would be great if this was part of a routine process on the prison side. Thanks."

Christopher Kearney said during the pandemic in the last 2 years palliative care has often taken place virtually. For an inmate who is a hospital patient, there is usually a guard outside the hospital room who is not interested in letting anyone in the room. This virtual option does exist and could mitigate any security risk.

Susan Lyons said her hospital, Meritus Medical Center, sees a lot of State prison inmates on the acute inpatient side because there is a large correctional facility nearby in Washington County. Their chaplains are considered to be part of the care team and go into the inmate's room, and they always have a guard at the bedside and one in the hall. So, anything the inmate is saying to the chaplain is not privileged information because the guard is sitting there listening. But they don't restrict visits by chaplains, even throughout the Covid pandemic for the last two years. They have a palliative care chaplain who is mask-fitted with a N95 and puts on isolation gear and then goes into the room. They also have the ability for catholic priests to come in and administer sacraments and annoint people who are dying, and to do the same for any inmates who identify as catholics. They have not had any problem with this issue and she does not know whether they are an outlier among hospitals because they are the only hospital in town where the prison is. But they just manage to make this happen to respect all of their patients, whether or not they are incarcerated. Gail Mansell agreed with Susan Lyons and said her hospital on the Eastern Shore, Atlantic General, follows the same policies and have also done so throughout the Covid pandemic.

Peggy Funk said she believes the State prison system contracts out the medical care that prisoners receive. So, a good place to start would be to find out who has that contract and what their policies are. Michelle Ross from Frederick Health noted that there is confusion as whose decision takes priority when the medical team wants to allow access by the chaplains who are part of the treatment team when there is resistance from the local prison or the State correctional facility. Gail Mansell said sometimes ignorance is bliss where the chaplain says to the guard that they are in the hospital facility and that they will follow the hospital's rules for now. And she does not get pushback from that approach, which in retrospect might be surprising. Susan Lyons said the correctional facility does post orders regarding who is allowed in the room as far as family or visitors. They have the same visiting restrictions they would have if they were in the penitentiary. But anyone who is member of the health care team is not considered a visitor. Sarah Oliveira questioned that if the prison system is not considering the chaplain to be part of the health care team, then why would the prison system be making that determination rather than the hospital. Gail Mansell said this looks like an opportunity to educate prison systems that chaplains are considered by hospitals to be part or the health care team because the prison systems may not know this.

Alan Eason said that advance care planning is already complicated for a person who is not incarcerated and it is very difficult to have a thoughtful exchange with an incoming inmate about choosing goals of care during a prison intake process. An inmate is not in the position where they can get on the telephone with potential health care agents. While it would be great to have advance care planning completed during the prison intake process, he said there are a lot of challenges that would make it difficult to accomplish.

Dan Morhaim talked about wrongful life lawsuits. He said this may be another motivator for people and health care institutions to honor a patient's treatment wishes. He provided the Council with examples of wrongful life lawsuits where health care institutions did not make the effort to get the advance directive, or got the advance care plan and didn't honor it, etc. Medical malpractice lawsuits take years to filter through the system, so this is just the beginning. He knows experts who are getting more and more calls to provide expert testimony in these lawsuits. He provided a slide deck for the Council members to review regarding these cases. To prevent liability, institutions need to train their staff to honor a patient's treatment wishes even if there are stresses placed on them for honoring them.

Jane Markley said Fred Mirarchi and she spoke about this issue at the American College of Healthcare Executives because they are the people who will be dealing with this litigation and trying to convince them they need to better educate their health care workers as to advance care planning and advance directives. This education includes how to read advance directives and how to use them They also need to be educated that just because you have an advance directive, that doesn't automatically mean you are a DNR, which is a misunderstanding that is happening more and more. Shahid Aziz said on Chat: “Wanted to second what Dan and Jane said. We had cases at least 5 years ago in the big centers in town. Can find info. on cases.”

Christopher Kearney said that from a clinical standpoint this wrongful life issue often starts in the emergency room department and that’s where things happen and decisions have to be made quickly. It is a very difficult environment to be respecting wishes when someone is either going to be dead or alive in the next several minutes. That’s where the issue needs to be addressed because that is where patients are resuscitated or where interventions are provided that may not be wanted or needed because there is not enough time to figure it out. Jeff Zucker said this also happens in the home, it happens with the paramedics, and it happens in the whole continuum of care, but the majority of the wrongful life cases occur in the hospital’s emergency room. Shahid Aziz said on Chat: “EOL issues are not necessarily where one must die. At least not die immediately or so. I agree. I often talk about our EOL Living goals and plans.”

Harold Bob said one of the problems is that the mandate of the Council is the end of life and a lot of decisions in the emergency room are decisions where a reasonable person could disagree whether it was actually an end of life situation. An ER team could say this is not end of life, that this is not a life-sustaining procedure, this is instead a curative procedure, for example. This is what happened to him personally. He had Covid pneumonia, he was hypoxic, he was in an emergency room, and they wanted to intubate him but he refused to be intubated because he knew that the odds of his recovery were better if he wasn’t intubated. And they just decided that even though he knew what was going on, they decided he didn’t, and they asked his wife to make the decision. Fortunately, his wife is a nurse and he and she had talked about these things and she understood what he was trying to do which was to get his best chance for survival. But he said we need to understand that there is a distinction between when someone has a disease from which they are dying and when someone has a disease process for which an emergency room is afraid they might die. But the emergency room sees this as a curative situation rather than an end of life situation.

Alan Eason responded that it’s amazing that Harold Bob’s story tells so much about one very specific aspect of the system. Jeff Zucker added that just to be clear this happens millions of times a day in every hospital around the world and its one of the reasons why the industry has separated the advance care plan that is created by the consumer from the medical order that is created by the doctor. And regardless of what the consumer says in their advance care plan, if the doctor believes he or she can create a better outcome, they have the Hippocratic authority to do no harm and to what they think is right. So, when we use unfortunate language that consumers have MOLST documents and consumers are creating or updating those documents, we create more room for confusion because they are not supposed to come from the consumer in the first place. Those medical orders are completed by the authorized providers. There are certain people in hospitals that shouldn’t be creating those documents either and they do so just because of the chaos. But Harold Bob had an expression of a wish, his health care agent was his wife, and she knew his expression of his wish. A great doctor even in a chaotic environment, is supposed to hear those wishes and then make a medical treatment based on his or belief about what would get a patient the better outcome desired by the patient. So, the consumer shouldn’t be as proscriptive about saying what treatment they should or should not get as opposed to expressing their goals of what they want their quality of life to be on the other side of the event. It’s a subtle distinction but he said that even in the legislation that we’ve seen coming from Senator Kramer and Delegate Cullison, the words are not on purpose but by accident mixing up the MOLST with the advance care plan and that can lead to confusion. He is thrilled with the outcome because Harold Bod is doing really well.

Harold Bob said he made a full recovery. What happened at the end was that his wife and his primary care physician moved him to another hospital and he was assessed by another critical care practitioner who said he didn’t need to be intubated. 4 days later he was out of the hospital and a few weeks later he was back to work. 2 weeks previous, for his 75th Birthday his wife took him to Disney and 4 days in a row they walked 11 miles per day. But he was in the ER and was told he would die if he wasn’t intubated and they were wrong. Alan Eason asked if he had mental capacity at that time to decide that he did not want a certain treatment. Harold Bob said the hospital decided he didn’t have capacity even though he thought he had mental capacity, and indeed in retrospect he remembered everything. But the hospital thought he didn’t have mental capacity and asked his wife to overrule him because they believed that he didn’t understand what he was saying. And it was really bad that because of Covid his wife couldn’t come in to meet with him. But she is a nurse with a Master’s degree and she couldn’t be bullied by the doctors. She called his primary care physician who called the doctor at the ER.

Harold Bob said another example is the whole g-tube issue where we spend a lot of time talking about g-tubes as a life-sustaining procedure even though there is evidence that for advanced dementia patients, they are not life-sustaining procedures and they don’t help, and the mortality is at least as high or higher when a g-tube is placed for people who are dysphagic. He said it is a very complicated issue.

Alan Eason said he likes Harold Bob’s story because it has to do with communication about a patient’s preferences and about a patient’s mental capacity. A patient as in his case who understood the risks and benefits of the treatment has the mental capacity to choose the treatment regardless of whether it is the best choice after having been provided the information about the treatment’s pluses and minuses.

Harold Bob said back in 1986 when he was representing the State Medical Society and he was advising then Delegate Hickson about the Natural Death Act, he went down to Annapolis with representatives of the Grey Panthers who said to the House Committee that it wasn’t about how we died but how we lived knowing that our rights will be respected that matter. What they said has stuck with him and guided him throughout the years in teaching physicians about the importance of autonomy and respecting their patient’s decisions.

Jane Markley asked Paul Ballard to explain what happened to proposed changes to the MOLST form that the Council had considered several years ago that had since been shelved. Paul Ballard explained that after the proposed changes had been approved by the appropriate State entities, the Governor put a stop on all regulations at that time. Because it is a Department of Health regulation, the Department had a lot of competing priorities and the MOLST regulations just went to the back of the line. So, the regulations went into limbo.

Paul Ballard asked whether people were clamoring for them to be revived because the Council could then ask the Department to put them on the priority list. He recalled that the proposed changes would have included a voluntary patient signature because it was agreed that people did not want a repeat of the previous experience with the MIEMSS EMS/DNR form where for a period of time a patient or authorized decision maker's signature was required. During that time, there were instances where pending receipt of the signature for a DNR order that had been verbally approved by the authorized decision maker, the patient would have a crisis and CPR would be administered because there was no signature by the patient or authorized decision maker on the DNR order form. Such a result was contrary to the patient's wishes. He explained that when the MOLST legislation was debated in the legislature in 2011, the huge issue was the patient's signature on the MOLST form and to avoid a repeat of the previous situation with EMS/DNR order forms where CPR was inappropriately administered while awaiting the signature of a patient or authorized decision maker, the legislature required that a patient or their authorized decision maker be given a copy of the MOLST form within 48 hours after its completion or sooner upon transfer or discharge rather than requiring that there be a signature by the patient or authorized decision maker.

Paul Ballard noted that several years ago a legislator who was responding to the concerns of a constituent asked whether a patient signature could be added. So, after many stakeholders reviewed the issue, to avoid the original problem a compromise solution was proposed that would allow a patient or authorized decision maker to sign a MOLST form, but the signature would not be required for the MOLST form to be valid. But that could still result in confusion regarding the validity of a MOLST form where there was no patient signature. And there were also minor tweaks that would have clarified some parts of the MOLST form, for example, changing one of the certifications that read "other legal authority in accordance with the provisions of the Health Care Decisions Act…" to instead refer to medical ineffectiveness. He asked Jane Markley if she was getting pushback about the fact that the proposed regulation changes had not happened and she said she hadn't heard anything about it. She just wanted to know what happened to the proposed regulation and did not have a preference one way or another.

Jeff Zucker said that at the risk of frustrating everyone going back to the MOLST issue, the evidence across the country is incredibly clear that if we have a great quality advance care plan that's been updated or confirmed and it is accessible in the EHR, the need for the MOLST or POLST goes way down. He said the only reason why the State of Oregon many years ago even created the POLST in the first place was because society hadn't figured out a way to do an advance care plan. So, the work that this Council is doing and all the effort over the last few years to do the harder work will eliminate the need to do new work on yet another MOLST document. This is because the only person who can object to the treatment plan is the patient or the family member if they don't believe the wishes have been carried out effectively. So, when doctors have to guess and the ER doctors that call him they say "Jeff, I went to medical school and not divinity school, so I don't want to play God, I can't guess what people want, they just need to tell me. And then I will do my best efforts to honor those wishes."

Jeff Zucker said we should focus on getting an advance care plan for everyone readily accessible through CRISP, and to ask people on a routine basis "are these still your wishes, are these still the people that speak for you?" Then, all they have to do is check the box and say Yes, I'm confirming and nothing has changed, or thank you for reminding me, I'm going to update it. As long as we have something that the doctors can feel is relatively current, there should be no objection to the doctor doing what she or he thinks is the medically appropriate thing to be done to honor those goals of care, and then there's no need for the MOLST or the POLST in the first place. There is so much work to be done on so many other topics that he would hate to see more work being done on a stopgap when the real work that needs to be done is to get an advance care plan done for everyone and to make it readily accessible, and we're very close to that with Senator Kramer's and Delegate Cullison's legislation.

Christopher Kearney talked about the recent commentary in the New York Times titled "What's wrong with advance care planning" by Sean Morrison, Diane Meier, and Robert Arnold that was also published in October 2021 as an editorial by the Journal of the Medical Association. The authors are leading palliative care experts in the United States and they point to extensive evidence over the years that advance care planning has not done anywhere near what we had hoped it would do. They discussed a 2018 review of 80 systemic reviews which found no evidence advance care planning was associated with influencing medical decision making, enhancing the goals of care, or improving the patient's or family's perception of quality care at the end of life. Although he does not want to be associated with this article because he has done advance care planning daily for the last 30 years, the article is concerning given the expertise of the authors and that their comments were published by JAMA. The authors went on to say "no association of advance care planning with subsequent health care use, including emergency department visits, hospitalization, and critical care, etc." The authors go on to say that successful advance care planning depends on 8 steps and they enumerate the steps, and then they go on to say there are many things that follow up this process. He will share the commentary with the Council for discussion at the next Council meeting. He noted that although the authors' conclusions are counter to the Council's discussion of how to increase advance care planning, he does not agree with their conclusion because to prove something works or doesn't work is very difficult, for example, it took decades to prove that cigarette smoking was actually bad even though everybody knew it. He said that just because something is true does not necessarily mean that it is easy to prove.

Jeff Zucker said that the authors have been very consistent over the years. He said bad advance care planning does not create great results. Good advance care planning should create better results. Good advance care planning is defined by the criteria that the Maryland Health Care Commission has created: it is one that can be updated, that's owned by the consumer so that it doesn't sit siloed inside a medical record, and it is one that proves consensus from the family members to avoid disputes later. A good advance care plan also asks consumers to enumerate goals rather than medical treatments because the medical experts can tell the patient how best to achieve their goal medically. If instead the patient tells the medical expert how to get there, then we have a bad advance care plan. Unfortunately, the authors have regurgitated the notion that bad advance care planning doesn't help the case for advance care planning. Good advance care planning can help Maryland citizens get their voices heard.

Harold Bob said on Chat "But we know in the nursing home industry that when we do health care discussions and MOLST it impacts return to hospital rate."

Shahid Aziz said on Chat: "ACP is done all ways all times and Q comes up in 100% of cases!"

Jack Schwartz said that Alan Eason and Paul Ballard agreed it might be good to discuss this issue at the next Council meeting. Jack Schwartz said the point of discussing the authors' critique is not to agree or disagree with them but to see if aspects of their critique merit further thought and discussion. For example, he is not at all sure that Maryland policy does enough to support the in-the-moment decision making that is inevitable even when there are good advance care plans, but especially when people haven't prepared such plans. Support is needed for health care agents and surrogates in real time decision making. The critiques that the authors are making is their view that there is a misallocation of resources but that's too stark because one can do two sound public policy initiatives at the same time. He believes it is worth the Council's time to engage with this issue more fully. He said Paul Ballard had circulated a report by the National Academies' Workshop on Advance Care Planning and he directed people's attention to pages 19 through 21 in particular where Sean Morrison speaks in some detail for the basis for his conclusion and concern. This is a fuller explanation than what he and the other authors included in the JAMA viewpoint piece. Alan Eason liked the idea of discussing this issue at the next Council meeting. The Council can get input from everyone that will help it focus on all the different aspects of advance care planning.

Jane Markley said that the Hastings Center had written a rebuttal to the JAMA commentary. Christopher Kearney said that the JAMA commentary authors were not altogether pessimistic, saying advance care planning was necessary but not sufficient. He disagreed with their conclusion that it was distracting from other health care initiatives. The authors fully supported appointing a health care agent. In his work he has told people that if they do nothing else, they should at least appoint a health care agent. The authors also wanted to promote shared decision making and real-time pain and symptom management.

Paul Ballard wondered whether there has been a study of the Gunderson Health System patients in La Crosse, Wisconsin, because such a great percentage of them have advance directives. Jane Markley said they have done studies regarding how effective it has been at Gunderson and they are in the literature. 98% of their population has a plan in place. The impact this has had on the patient population there is fairly well documented. Jeff Zucker said there is a 13-day end-of-life bed savings for a person with an advance care plan versus a person without one in La Crosse, Wisconsin.

There being no further business, Alan Eason adjourned the meeting