

State Advisory Council on Quality Care at the End of Life

Minutes from the January 31, 2023 Meeting

Meeting time and place: January 31, 2023, 10:00 a.m., the Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, Columbia, Maryland, and via video conference call.

Council members present: Christopher Kearney; Paul Ballard (Attorney General's designee); Jane Markley; Rabbi Steve Glazer; Tricia Nay (Maryland Department of Health's designee); Peggy Funk; Sara Hufstader; Gail Mansell; Tiffany Callender Erbelding; Shahid Aziz; Nicole Lopez de Victoria; Stevanne Ellis (Department of Aging's designee); Susan Lyons; Alan Eason; Don D'Aquila; Elena Sallitto.

Others present: Christian Miele; Nichole (Nikki) Majewski; Marian Grant; Jack Schwartz; Ted Meyerson; Dan Morhaim; Jeff Zucker; Jenny Kraska; Katherine Ware; Michael Munoz; Ryan Wilson; Patricia Alt; Stacy Howes; Mary Alfano-Torres; Lakshmi Vaidyanathan; Cathy Pauley.

Chairman Christopher Kearney opened the meeting. The December 8, 2022 minutes were approved. Christopher Kearney then asked Peggy Funk to present to the Council regarding the state of hospice care in Maryland.

Peggy Funk, Executive Director for the Hospice and Palliative Care Network of Maryland (the "Network") described what the Network does and the environment of hospice care services in Maryland. The Network's mission statement is "to lead and advance quality hospice and palliative care by serving as an advocate and resource for all Marylanders." The Network has many community partnerships. For example, the Horizon Foundation gave the Network a grant to work with underserved communities to understand the barriers to access to hospice and palliative care for communities of color in Howard County. Another example is that they work with RALI Maryland to distribute free drug disposal bags to members to alleviate the challenges of drug diversion when a patient has died.

Peggy Funk noted there is a lot of confusion regarding what hospice care is versus what palliative care is. The Network tries to alleviate this confusion by explaining that all hospice care (management of the symptoms of a serious illness such as pain, nausea, dizziness, etc.) is palliative care but not all palliative care is hospice care. The Network's board adopted a definition for palliative care about two years ago that is used by the Center to Advance Palliative Care (CAPC). That definition reads: "palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family." Palliative care is provided by a specially trained team in a holistic manner, provides an additional layer of support based on the needs of the patient, is appropriate at any age and at any stage in a serious illness (not just at the end of life as is the case with hospice care), and can be provided along with curative treatment.

Peggy Funk discussed the hospice benefit which is a Medicare benefit. There are conditions to be eligible for that benefit, one of which is the patient has to be considered to be terminally ill, which means that the patient's life expectancy is 6 months or less if the illness runs its normal course. Many people mistakenly believe that means they have to die within 6 months

to receive the benefit. Instead, if a patient lives longer than 6 months, they will have to be recertified. She said this happens all the time and that a patient does not have to die within 6 months. She also noted that patients can later choose to opt out of hospice care. The patient has to be certified by two physicians, usually the patient's physician and the hospice's medical director. The payors of the hospice benefit include Medicare, Medicaid, third party insurance, private pay, and community support and donations. She said that no one should be turned away from hospice because they cannot afford to pay because community support and donations cover much of that care.

Peggy Funk said that hospice care is a patient-centric approach, and everything revolves around the patient and family. The team that takes care of patients and family member includes physicians, nurses, volunteers, spiritual counselors, social workers, bereavement counselors, home health aides, and therapists.

She said that there are 4 levels of hospice care: the first level is home-based care which includes routine home care which is received in the patient's residence. Patients can receive care wherever they like but most patients choose to receive care in their residence, which residence can really be wherever they call home, which can include an assisted living program, a nursing home, their own home, or even a homeless shelter. The second level of care is predominantly licensed nursing care provided continuously at home during short periods of crisis as needed to maintain the patient's wish to remain home. The third level of care is general inpatient care for pain control or complex symptom management that cannot be managed in another setting. Then the fourth level of care is inpatient respite care where patients receive care in an approved facility on a short-term basis in order to provide respite for the caregiver.

Peggy Funk presented Medicare data which she used to compare the Maryland data to the national data. There are 21 hospice providers in Maryland which has dropped in the last few years by about two or three mainly because of mergers. 24,820 Marylanders on Medicare received hospice services in 2021 and the percentage of these Marylanders who died in 2021 that used hospice services was 43.2%, slightly below the national average of 44.9%. Maryland is 25th in the nation so she feels Maryland still has some work to do to increase hospice utilization. In 2021, 1,438,264 total hospice care days were provided in Maryland. The Maryland mean Medicare payment per beneficiary was \$10,832 and the national mean Medicare payment per beneficiary was \$13,117. In response to Christopher Kearney's question, Peggy Funk stated the hospice utilization percentage was calculated by determining how many Maryland Medicare decedents in 2021 used hospice care services.

Peggy Funk then presented a chart containing a 17-year trend of hospice utilization in Maryland in which utilization increased steadily up until 2019, after which it declined right around when the Covid pandemic started. This was primarily due to hospice providers having difficulty even getting into seeing their patients. Patients were afraid of people coming into their homes. But over those 17 years, Maryland had a 15% increase in hospice utilization, a little higher than the national average increase during that time, the national utilization rate increasing from 31.6% in 2005 to 44.9 % in 2021, and Maryland's rate increasing from 27.8% in 2005 to 43.2% in 2021.

Peggy Funk noted that cancer used to be the primary diagnosis for hospice care patients, but that now circulatory disease is the primary diagnosis, followed by cancer, nervous diseases, respiratory diseases, endocrine diseases, and then all other diseases. Maryland's percentages in this regard are similar to national percentages. Marian Grant noted that dementia is among the nervous disease diagnoses and Christopher Kearney stated that with a dementia diagnosis, it is very difficult to determine a 6-month terminal prognosis.

Peggy Funk stated that 60% of Maryland hospice patients die at home, 22% die in assisted living facilities, 15% die in nursing homes, and 2% die in inpatient hospice facilities and all other settings. These numbers are close to the national average. She said there is a lot of work to do to improve hospice utilization, including remedying the great disparities between utilization by whites versus nonwhites as shown by Maryland Health Commission statistics in 2021 showing that, for example, 66.6% of hospice utilization in Maryland is by whites and only 19.1% of utilization is by African Americans. Christopher Kearney asked what the statistic for Hispanic utilization was because it was left off the slide. [After the Council meeting, she submitted the statistic showing that only 1.6% of utilization was by Hispanics.] Christopher Kearney noted the challenges in increasing utilization by nonwhite groups, especially African Americans, because trust is important to increase hospice utilization.

Peggy Funk also spoke of the challenge of increasing the length of stay in hospice programs. She said that 33% in Maryland and 30% nationally actually have a length of stay of 7 days or less and that is just not enough time to have the full benefit of hospice care. So, the Network is trying to encourage primary care physicians and hospitals to really refer much earlier so that patients and their families can get the full benefit of hospice. Pursuant to a grant from the Horizon Foundation in Howard County, the Network did some listening sessions with communities of color and some of the barriers to accessing hospice and palliative care include cultural ones because under tradition people feel they have to take care of their parents or that extended family members care for the elderly. They also feel that people from within the community should help instead or they are uncomfortable having strangers in the home, and the listeners heard a lot of this in all the communities they were working with. Another factor was lack of information. People really don't understand what hospice is, much less palliative care. And even when they are looking for hospice care, they really do not know how to access those services. They found these problems in the Korean, Indian, and Latino communities. There is also a lack of outreach from insurance companies. A lot of people incorrectly thought hospice was very expensive and that they couldn't afford to have it.

As far as palliative care goes, especially in the Latino and Indian communities, the listening sessions revealed that these communities found out about the information way too late. There were also language barriers to consider. She was surprised at the number of primary care physicians that really did not offer any hospice information. She receives a lot of calls herself from community members asking where they can go for palliative care. There is also a lot of misinformation. People incorrectly believe they have to give up their physicians to have hospice or they need special insurance, or once they opted for hospice that they could never get out. So, there are a lot of myths that have developed. The Network developed a brochure about the top ten myths about hospice care and they do their best to dispel that misinformation. They have the

brochure available in English, Mandarin, Korean, and Spanish, and will be distributing it to various outlets so people can have this information. The Network also developed a brochure titled “What Do You Know About Palliative Care?” in which they try to dispel a lot of the myths about palliative care. They also did a social media campaign on Facebook that is a complement to the brochure. It also dispels the myths about palliative and hospice care. They will continue to educate physicians and other stakeholders in the community.

Cathy Pauley asked if there is any hope for changes to the criteria for hospice care admission with dementia as the primary diagnosis. Peggy Funk was not aware of any new developments in that regard. Marian Grant said that given the recent focus in Congress on instances of egregious fraud in hospice care, Congress is interested in modernizing the hospice benefit, which includes taking a look at the eligibility criteria and is looking at legislation to accomplish that. But any changes to the benefit eligibility criteria cannot realistically be done so as to make it more expensive to provide the benefit. So, they cannot widely increase who can get hospice care and for how long, etc., as a result of modernizing the benefit.

Elena Sallitto asked about hospice patients getting mailed morphine with written instructions only. She had heard from people that this was happening. Peggy Funk said she had not heard of that and said that typically a hospice care team visits the patient and develops a plan of care. She said they should be coming in and training the family on how to use those medications. If that is not happening, she would recommend calling the hospice lead person and ask them to come to the home. Elena Sallitto asked whether staff provides 8 hours of home care every day. Peggy Funk said that is a myth about hospice care and that it is not 24-7 care and instead the hospice determines how often they will need to come out. Christopher Kearney said that if the family is at home with the patient, the family is providing the care. More than that would not be part of usual hospice care that is covered under the Medicare benefit, but if is provided, it would be on a private pay basis. Peggy Funk did note that if a plan of care called for 8 hours per day of care as Elena Sallitto described, then that care would be provided. But they only come out as often as they need to in order to manage the patient’s symptoms.

Christopher Kearney asked Mike Munoz of ADVault to speak about the authentication process for creating an electronic advance directive on MyDirectives.com. Mike Munoz said that as a result of new legislation that passed in 2022, ADVault eliminated the identity verification requirement in the account verification workflow. Once the person provides their demographic information such as name, date of birth, address information, gender, and other items, their account is complete, and they do not have to go through the ID verification process anymore. They do have fields for social security numbers and drivers’ license numbers but those are optional. A user may want to provide this information to ease future searches by providers who may need to access their data.

Paul Ballard said that Maryland does have a requirement for witnessing an advance directive either electronically or physically. He asked whether in practice people use witnesses. Mike Munoz said it is not a requirement because they want the user to express their preferences for care and sign those documents. But he said they do have functionality in the platform to gather both witness and notary signatures. That requires them to download and print the document so that they can a physical signature on a witness page and/or a notary page and they

can upload those and append them to their existing document. They are in the process of redesigning the MyDirectives.com experience and hope to launch a new version of that in the second quarter which will reintroduce the option for an electronic remote witness and notary function. They are not going to eliminate the option to download and print and get physical signatures, but they will be adding an electronic feature to give people these options.

Marian Grant discussed the progress of the Council's prison health care workgroup. She attended a meeting in December with the former Secretary of Public Safety and Correctional Services and his staff. She was able to ask about end-of-life care for prisoners and the Secretary said they did not have time to answer questions that day but would be happy to answer further questions. Subsequently, Christopher Kearney sent a letter on behalf of the Council asking questions regarding what is in the contract for health services regarding end-of-life care and what is actually being delivered. Given the transition to a new Governor, there is now a new Secretary of Public Safety and Correctional Services and there will soon be a new chief medical officer of the Maryland prison system beginning on February 8, 2023. The new Secretary has committed to the Council being able to meet with the new medical director to ask these questions. The workgroup's plan is to also contact the new Secretaries of the Maryland Department of Health and the Maryland Department of Aging to ask the same questions because these issues concern both health and aging. The contract with the health care provider to provide health care services expires at the end of 2023 and thus the goal of the workgroup is to try to monitor those negotiations to see how the Council might help the Department to renegotiate a new contract to better meet the end-of-life health care needs of prisoners.

Marian Grant said that the workgroup is also encouraging the Council to support legislation that would amend the law regarding geriatric and medical parole so as to better enable prisoners to obtain appropriate end-of-life care in the community by being paroled on medical grounds. The Baltimore Banner has published an article about prisoners who have not been able to get geriatric or medical parole. She will be speaking with a reporter from the Baltimore Banner about these issues and the questions that the Council is looking at regarding the issue of whether the Department of Public Safety and Correctional Services' contract for health care services is satisfactorily addressing the end-of-life health care needs of prisoners. She said the people supporting the geriatric and medical parole bills feel fairly confident that these bills are going to pass. She recommended that the Council submit a letter in support of the legislation which was being heard on the same day as the Council meeting (House Bill 157) and to support its cross-filed bill in the Senate to be heard the following week (Senate Bill 98).

Christopher Kearney supported the legislation as being common sense reform. He recommended that the Council send a letter of support. Marian Grant said it is both expensive and cruel to send prisoners back and forth between prison and the hospital in their final days. Prison does not provide end-of-life care. Even though the contract requires them to provide hospice care, they are certainly not using outside hospices to do so. From talking to prison staff, she knows that they lack training in providing end-of-life care. People in these cases are so ill that they are no longer a safety risk. And so, they should be granted parole to be outside of prison, ideally die surrounded by people who matter to them rather than by strangers in the

hospital, which is the situation now. Because they do not offer hospice in prison, dying patients should be allowed to get hospice care somewhere, and that would be outside of prison.

Christopher Kearney spoke about his recent visit to Jessup Correctional Institution's infirmary where he saw a wheelchair bound and oxygen-dependent prisoner and asked him whether it would be okay if he got good hospice care in the prison. The man responded it would not be okay, that he would not want to die in prison, and no one else he knows would want to die in prison. He was clearly not much of a threat to society in his wheelchair on oxygen. His only joy in life right now is talking to his grandchildren on the telephone. It was the consensus of the Council to send a letter of support for Senate Bill 198. It was also the consensus of the Council to send a similar letter to the Secretaries of the Maryland Departments of Health and Aging that the Council had sent to the Secretary of Public Safety and Correctional Services making inquiries about the status of end-of-life care in prisons.

Paul Ballard gave a legislative update. He did not find many bills that were relevant to the Council's work. The closest bill he could find was Senate Bill 154 which is more in the area of mental health advance directives. The bill would require the Maryland Department of Health to create a public awareness campaign to encourage more people to use mental health advance directives and require the Department's Behavioral Health Administration to explore the feasibility and cost of establishing a statewide database of advance directives.

Dan Morhaim said Senate Bill 154 is well intended but he thinks all advance directives should be in one place. He said you could put the contents of a mental health advance directive in the standard advance directive. His concern is that you might have a mental health advance directive for a patient in one location and their standard advance directive in some other location. He said we have enough problems just getting people to complete a standard advance directive. He thought it should all be in the same document so that the information can be readily accessed by health care practitioners in emergency rooms and hospitals. He recommended the Council write to the legislature saying that wherever a mental health advance directive is located, it should be in the same database the legislature recently authorized for standard advance directives.

Paul Ballard noted that Senate Bill 154 does mention directing the Behavioral Health Administration to study the feasibility and costs of incorporating the mental health advance directives into the State's current advance directive registry, though he noted this is a mistake because there is no longer a requirement that there be a State advance directive registry, but rather there is a State advance directive program coordinated by the Maryland Health Care Commission. Dan Morhaim suggested that the Council write a letter of information saying the Council supports the intention of the bill but that whatever is done should be coordinated with the State's advance directive system. Paul Ballard said the Behavioral Health Administration could look at this as part of their study of the issue. It was the consensus of the Council to send such an informational letter.

Christopher Kearney gave an update on the palliative care workgroup convened by the Maryland Health Care Commission. The last workgroup meeting was held on January 9, 2023. The workgroup has selected the organization that will conduct the survey to determine the status

of palliative care in Maryland. The survey is based on a standard survey used successfully in other states to gauge the gaps and the extent to what is going well or not so well in the area of palliative care. At the meeting there were consumer representatives such as AARP who presented to the workgroup. Financing for palliative care is the major issue. There have been no formal conclusions yet. He thinks the survey will point out inadequacies and opportunities regarding palliative care throughout Maryland.

Marian Grant said that the workgroup is supposed to gather information on the palliative care services that are provided and what are the gaps. After the workgroup provides its report to the legislature regarding this information, the workgroup's mission will be completed. So, she and others are looking to how we can keep progressing. She said that other states have taken the information that the workgroup is soon to get from the survey and used it to try to figure out how they could increase access to palliative care in their states. Several states have tried to do this by making palliative care a mandated State Medicaid benefit. This is something that could make a real difference because if you mandate something in the Medicaid program, you will need an infrastructure to deliver those services. So, this is where the National Academy of State Health Policy (NASHP) comes in. They are an organization that helps states manage state affairs by sharing information across states. They are funded by the Johnny Hartford Foundation under a grant to do a specific push for palliative care. If you go to the NASHP website and look under the palliative care section, there are a lot of resources there for states that want to increase palliative care services such as model legislation, examples of Medicaid efforts, etc.

Marian Grant said the latest opportunity that NASHP has created is one she thinks we should think about for Maryland. She said NASHP is going to stand up a serious illness institute. They are going to pay for five states to get technical assistance and they are going to work with these states for a two-year period to help those states develop proposals to increase access to palliative care, most likely with Medicaid but not necessarily with Medicaid. So, they have put out a request for applications. It is not an onerous application. They are asking for the states that are interested to come forth with a team of up to four members, two of which have to be high-level state officials, and the leader of the team has to be a state official. So, she and others on the palliative care workgroup are trying to persuade people in the Department of Health and possibly in the Medicaid area to see if they could get anybody to say "Yes, I would devote time to being part of this process." She said you can go on the NASHP website and see what the application involves. They had a webinar about this opportunity last week. She was on the webinar and posted the comment (without identifying her state) that they had a palliative care workgroup that was started by a statute, we're doing a study, and asked the question whether it sounded like that state would be appropriate to apply, and they responded that such a state would be perfect to apply. This is free help and it is worth putting a little time into putting in an application. But they will need State officials as partners in the application. Christopher Kearney said that Marian's discussion of the opportunity with NASHP is for the Council's information and the Council did not need to take any formal action.

Dan Morhaim stated that National Healthcare Decisions Day is coming up and suggested the Council tackle it head on. He will be writing the same letter that he writes to the Governor and his County Executive every year to acknowledge the day. Christopher Kearney asked Paul

Ballard what the Council traditionally does with regard to National Healthcare Decisions Day and he responded that the Council encourages people to promote it. Dan Morhaim said that health care institutions should step up to do activities on this day because they are the leaders in health care. Christopher Kearney suggested the Council may be able to take a more active role in the future and Paul Ballard suggested discussing possible future actions at the Council meeting after the legislative session ends. Dan Morhaim said because the day is on April 16, you want to get information out to the public in February or March, not on April 10 when the legislative session ends.

Christopher Kearney brought up the likely reintroduction of the medical aid in dying legislation and said the Council will likely just monitor such legislation rather than offering testimony because it cannot add much to the debate. He talked with former Council member Steve Levenson and invited him to make some comments about the legislation. Steve Levenson said that in his lengthy discussion with Christopher Kearney, he updated him on his past participation as an individual regarding prior introductions of essentially the same legislation over the previous seven years.

Steve Levenson said he understands from sources that the medical aid in dying legislation is likely to be reintroduced again in the 2023 legislative session. Several states and countries have passed similar legislation. It has been approximately 26 years since Oregon first passed legislation. He did an extensive review of all of these laws over the years. He looked into how we know people are capable of making these choices and how we know what happens to the drugs once their dispensed, etc. He has always opposed the legislation for all the years it has been introduced and never passed. He knows that not everyone on the Council agrees with him and that is okay. He is just explaining what he learned over the years, which is all the laws that have been passed are more or less the same, that is, when someone has an incurable terminal illness they have a right to choose to die when they want to and pick a particular day if they want to and do it taking medications, typically long- or medium-acting barbiturates which are tremendously expensive. Death generally occurs with a few hours.

Steve Levenson said that the argument for medical aid in dying legislation is that you have a right to die when you want to die if you have an incurable illness. He said the evidence is overwhelming that most of this medication is being taken by middle-aged males that have a philosophical predisposition to want to die when they want to die whether they are seriously ill or not. It is rarely used around the country. Most doctors don't participate in it. The laws are all written so that scrutiny and disclosure of abuse is next to impossible because of all the protections. Because of nondisclosure, there is no way to know whatever becomes of the drugs after they are dispensed.

Steve Levenson said that as a physician with 43 years of experience across the spectrum of nonacute care, including long term care and assisted living, he has watched the drug problem go absolutely berserk in the United States, Fentanyl being the latest fiasco. He said there were the other opioid fiascos. He said there is CBD which supposedly should not be illegal, but it is nothing like what it has been cracked up to be and is not the salvation of health care issues, and it has a lot of issues associated with it, including psychosis and other major mental illness problems. So, his conclusion was we already have a drug fiasco in the United States of massive

and monumental proportions that is killing a lot of people increasingly and doing a lot of harm. Given all the factors, he agrees people should have the right to die if they have an incurable illness and we have put a lot of things in place in the last 40 years to make it possible to do so. He said that short of being given massive doses of dangerous drugs that we don't really know what happens to them, he couldn't see what problem this legislation is really fixing other than the philosophical one.

Steve Levenson said that the push for this type of law all started with the Hemlock Society whose philosophical predisposition was that "when I say want to die, I want to die, and you're not going to stop me." His view is that the pros of the legislation simply didn't outweigh the cons. He said that when he was a Council member for many years that there were great discussions among Council members pro and con and it was concluded that the Council wouldn't take a position. But he was filling the Council in on what has happened and what is likely to happen, and that this has certainly been presented in the legislature to state that without enacting it you are depriving people with terminal illness of their right to die. But he said we're not depriving people of their right to die.

Steve Levenson believes the legislation is fraught with difficulties and legal problems and he believes that the legislature understood that, although it has gotten closer and closer to passage with each passing year. However, there is a great push to get this across the goal line so that Maryland can be in line with the others that did pass this legislation. However, the virtues of this legislation are not likely to be any greater than they have ever been, and the drawbacks are just as problematic as they've ever been. He is not saying the Council should take a vote or take a position, but he did do a lot of background work and he wrote it up and if anyone is interested, he is more than happy to supply it. He went through all the laws and medical literature about how the physicians even know if someone is of the right mind to make decisions. The medical literature indicates that physicians' ability to make this determination about a person's decision-making capacity is not very good.

Christopher Kearney said he does not think the Council should not take a vote on the issue but instead should continue to focus on its mission to improve the quality of care at the end of life. He thanked Steve Levenson for his thoughts. Don D'Aquila stated that if the Council does want to look at the medical aid in dying issue, there is a nonprofit organization, Compassion and Choices, that specializes in this issue. They propose robust legislation in this realm and offer some clinical perspectives. He said there have been updates to the pharmacology associated with medical aid in dying that overcomes some of the barriers that Steve Levenson discussed. So, that could be a resource for the Council if it wanted to discuss the issue further.

Christopher Kearney thanked Don D'Aquila and said that Don D'Aquila is a pharmacist who is quite involved in end-of-life care and knows a great deal about the issue. Steve Levenson said he appreciates that and said that Compassion and Choices has been the organization that has been behind the legislation throughout the country and stated that Compassion and Choices never answers any of the concerns and objections to the legislation. He said they are the Hemlock Society under a new and nicer sounding name.

Dan Morhaim said he was a legislator when these bills were introduced and there were many hours of testimony both pro and con presented, and they were all sincere and serious, and thus he wouldn't disparage any group regarding this issue. The things that proponents feared generally were pain, isolation, and dependency. He said all those things could be managed by hospice and palliative care. He would ask everyone who came to lobby him whether in the story they told him if an advance directive had been completed. And generally, their answer was that no advance directive had been completed. He would ask whether they got palliative care or hospice care, and the answer would generally be that they did not. Advance directives, palliative care, and hospice care might have addressed a lot of the concerns. Increasing access to these services would address a lot of the things that people worry about when they endorse medical aid in dying legislation. That said, he would have voted for the bill because there are always a few outlier cases, and he thought the bill was structured in a sufficiently cautious way. But because people are not taking advantage of the services already available to them, they are going to have anxieties about end-of-life care.

Peggy Funk said the Hospice and Palliative Care Network does not take a position on this issue. She did note that Oregon has been doing this for a very long time and she offered that her counterpart in Oregon would likely be willing to speak with the Council about what happens in Oregon. While this person's organization does not take a position, they do participate in these cases.

Kathy Ware had the experience of being involved in writing regulations regarding medical aid in dying while she was in California. 93% of patients in California were in hospice when they asked for medical aid in dying. There were less than 700 individuals who accessed this option even though the population in California is huge. About 80% of the requests were from people with neoplasm, 10% with neurological conditions, and the rest had a variety of conditions. Peggy Funk said that is consistent with the experiences of other states with medical aid in dying, that is, that very few of those who request medications to end their life actually use them. They just want the medications as security. Marian Grant said having the medications gives them a feeling of control.

Jane Markley talked about National Healthcare Decisions Day. She said that the Montgomery County End of Life Coalition has put together a program for April 18, 2023 at the Silver Spring Civic Center that is similar to what they have done in the past. The program will focus on advance directives and the MOLST form. Cathy Pauley also has a program happening in Baltimore. She is sure the Horizon Foundation is doing the same thing. The Council has never done anything except to push the Governor to proclaim National Healthcare Decisions Day.

There being no further business, Christopher Kearney adjourned the meeting.