State Advisory Council on Quality Care at the End of Life

Minutes from the May 31, 2024 Meeting

Meeting time and place: May 31, 2024, 10:00 a.m., via video conference.

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

Others present: Dan Morhaim; Marian Grant; Kathrine Ware; Stacy Howes; Tammy Turner; Jackie Ogg; Jenny Kraska; Jack Schwartz; Liz McDonell; Tashi Taliaferro; Sarah Oliveira.

Chairman Christopher Kearney opened the meeting. The March 4, 2024 minutes were approved.

Christopher Kearney discussed House Bill 461, which bill Delegate Ashanti Martinez introduced at the Council's request to change the name of the Council to the "State Advisory Council on Serious Illness Care." Delegate Martinez successfully obtained passage of the bill and Paul Ballard said the law changing the Council's name would go into effect on October 1, 2024. Christopher Kearney said the Council had thanked Delegate Martinez for his work on the bill and will continue to work with him on other legislation in the future. Christopher Kearney said that he and the Council believe that the new name more accurately describes what the Council does and is a name that is more acceptable than "End of Life" care. He thought the new name is consistent with what is happening nationally.

Christopher Kearney next introduced the topic of the National Academy for State Health Policy (NASHP) grant and asked Peggy Funk and Marian Grant to talk about it. Peggy Funk said that Maryland was one of six states that was chosen to participate in the Institute. The program runs for two years, and they are a couple months into the second year. She said they have made some progress. The goal has been to provide information that will help Maryland develop and fund a palliative care benefit. The numbers they have been working with are based on Medicaid figures, but they now know that the Medicaid route is not going to be the way to go due to the shortage Maryland's Medicaid budget. However, knowing the Medicaid numbers will still help them to figure out alternative ways to at least make a palliative care benefit possible. The last meeting was April 28, 2024.

Peggy Funk said the NASHP team has begun to work on a cost calculator as the next step in their project seeking the establishment of a palliative care benefit. A cost calculator looks at things like who the providers are for each state, how they are organized, what the division of labor is, what services will be provided, where and when the services will occur, provider wages and employee benefits, and all the things that would go into such a benefit, including the direct costs, maybe chaplaincy services, administrative costs, and overhead costs. So, once they can really gather the answers to a lot of these questions, the team (the actuaries that are working with them), are going to work together to crunch the positive cost and avoided cost together to calculate the final ROI (Return on Investment) figures. The next steps are to get the answers to those questions, and they are going to do that by working with some of their key supporters in

Maryland to see if they can get these answers, and also to look at developing some alternatives to going through the Medicaid program. So, the project is moving forward, and they have another year to work on it. Overall, she thinks it has been a pretty positive experience. Christopher Kearney said that the next meeting for the group is tentatively scheduled for August 5, 2024.

Marian Grant said that the Medicaid population in Maryland with a "serious illness" (using a definition that other states have used), would be about a quarter million people. The Maryland Medicaid program annually spends about two billion dollars in emergency department and hospital utilization. She said that other palliative care expansions have been able to save a substantial amount of that kind of utilization. So, the group believes that a palliative care benefit can save perhaps hundreds of millions of dollars for the State of Maryland. They met with Secretary Laura Herrera Scott of the Maryland Department of Health who agreed and who is a big fan of palliative care, but who told them there is no money in the budget to add formal palliative care services. In the meantime, Hawaii got approval to add palliative care services, not a benefit, but services, to their Medicaid program. This is a project they have been working on for years. They did this by modifying their State Plan Amendment (SPA) and that is the route that Maryland could also take that would not involve legislation and would not involve officially adding a palliative care benefit.

Marian Grant said that the other thing about Hawaii that is exciting is contained in the approval letter that Medicaid sent out https://www.medicaid.gov/sites/default/files/2024-05/HI-22-0013.pdf , because they use the CAPC (Center to Advance Palliative Care) definition for "palliative care" which is used universally. They included a list of services that the NASHP workgroup would consider to be palliative care services and they included a very lengthy list of the players on a palliative care team, which included everyone that the workgroup believed should be on the list, including chaplains. Interestingly, federal Medicaid has designated palliative care in Hawaii as a preventive service, meaning that palliative care helps to prevent suffering and unnecessary hospitalization and utilization. She said this is a really interesting idea because palliative care practitioners have trouble talking about palliative care to the public, to clinicians, and to patients because many people think palliative care is only for dying people. But now, if you can describe palliative care services as a new preventive benefit, that sounds like a benefit you can get in addition to curative healthcare services. The approval for Hawaii clearly says that palliative care is care provided throughout the course of an illness, and it is based on a person's needs and not on their prognosis. So, she thinks this is an amazing development in Hawaii and creates a precedent for Maryland. So, other states, including Maryland, could take this language and craft a revision to their SPA. But this is not going to happen in Maryland for a few months or another year until issues are sorted out.

Christopher Kearney agreed that the designation of palliative care services as preventive services is kind of revolutionary, although as a palliative care physician he believes that every day he is working in preventive care. He found it to be interesting that Hawaii lumps palliative care in the same category as smoking cessation and vaccines for preventative care, which is quite a change in terms of how people think about palliative care. He wondered how the federal/State relationship works for the Medicaid program and how many people in Maryland in addition to those on Medicaid have serious illnesses. Marian Grant said states can have a certain amount of

leeway in what they offer in their Medicaid programs but there is a ground floor of what all Medicaid programs need to offer because every state gets money from federal Medicaid to do that. So, states can't just do their own thing without federal Medicaid approval. Regarding the Maryland Medicaid population, she said it is about 2 million people and 14 % of them have a serious illness, and that is how you get to the figure of 250,000 people with a serious illness in the Medicaid program. They would need to do a calculation for the rest of Marylanders with a serious illness, including the Medicare population and the private insurance population for people who are neither Medicaid or Medicare, and said this is some of the work that ideally will need to take place as next steps.

Christopher Kearney said that even though Maryland cannot move ahead with a Medicaid palliative care benefit at this time, there is a new way to achieve this through the total cost of care model discussed at the last Council meeting. Marian Grant said CMMI (Center for Medicare and Medicaid Innovation), was founded as part of the Affordable Care Act to test care and payment models because CMS can't change anything without data or legislation. And federal legislation is difficult to pass at this time. Thus, they are testing new models and one of these new models they announced recently was a total cost of care model for other states because since 2014, Maryland already had one. But CMS wanted CMMI to try this model in other states. And CMMI encouraged Maryland to apply because it is getting logistically difficult for CMS because Maryland has its own separate total cost of care model and now there are going to be other people that are going to have this model called the All-Payer Health Equities and Development (AHEAD) model. The purpose of the AHEAD model is to promote health equity.

Marian Grant said that Maryland applied to participate in the AHEAD model. There will be eight states chosen in three cohorts. The first cohort was about to be announced soon and the group believes Maryland is likely to be selected as one of the states along with possibly Hawaii and New York. She thinks that states that have applied have gotten a heads up that they have been selected but their selection hasn't been formally announced. She said that if you look at the materials on the CMI website, they list palliative care as one of the things the states might be interested in doing to improve quality of care and equity, and to reduce costs. When she and others talked with Secretary Scott, the Secretary said she was not going to try to get a Medicaid palliative care benefit but was instead hoping that the AHEAD model could accomplish the same goal.

It has not been clear to Marian Grant from their conversations with State officials just who in the State government would manage the AHEAD total cost of care model, but whoever does so will have to start preparing their participation in June, 2024, because the model would be scheduled to launch in January, 2026. So, she, Chris Kearney, Peggy Funk, and other persons interested in forming a serious illness coalition are planning to meet with whoever in the State will talk with them over the next few weeks because they believe this is probably the way that Maryland is going to be able to get palliative care services offered more broadly for all Marylanders rather than being limited to Medicare and Medicaid patients. Thus, if incorporating palliative care into the AHEAD model is successful, palliative care benefits will be available to many more people than if just the Medicaid program included a palliative care benefit.

Dan Morhaim said he met Dr. Sadie Peters of the Maryland Department of Health at a Maryland Cancer Collaborative's Advance Care Planning Workgroup, and that she seems to have been assigned end-of-life care issues and may therefore be a good person for the Council to contact. Christopher Kearney thanked Dan Morhaim and said they had previously talked with her, and that she is clearly someone the Council needs to be connected with. Christopher Kearney said she was very new on the job in January when he and Paul Ballard spoke with her and Brian Mattingly (also with the Department and the Maryland Cancer Collaborative). Christopher Kearney had invited them both to attend a Council meeting.

Christopher Kearney said the idea of a serious illness coalition is not new and people have been involved in that project for approximately 5 years off and on. The idea is to have a coalition of stakeholders as California, Hawaii, Maine, and other states in order to make something move forward. It has to be a broad coalition with a financial base and a full-time commitment to make it happen. So, now they are trying to at least gather a group to meet regularly and to move the project forward. Marian Grant is the Chair of this Serious Illness Coalition. On June 10, 2024. they invited many stakeholders to a virtual meeting to talk about this project and the cost calculator, including representatives of various health systems such as MedStar, Johns Hopkins, the University of Maryland Medical System, Kaiser Permanente, and other friends of palliative care in Maryland.

Marian Grant agreed with Christopher Kearney and said that most of the states that have made real progress have had a broad-based coalition that was not made up of just policy people, providers, or patient advocacy groups, but included all those people. She said they needed to start gathering palliative care supporters in the State while the Medicaid and AHEAD model options are being considered in order to update everyone about what is going on, and then to try to form a true coalition. Doing so would enable them to see if they can align on what they want to try to do, who is going to try to do what, and who is doing what already. She said this is because if you have a policy initiative, but the community affected by the policy is not aligned with the policy, it won't succeed. In addition to letting the AHEAD team know about some of these numbers they have gotten, they also need to try to see if there is alignment among the people involved with this issue. So, they started initially with inviting 15 or 20 people to the meeting, which is not a closed meeting, but they wanted it to be small enough that people could really talk, and they are going to ask people if they are willing to join this coalition even though there is no financial commitment. They want to see how many organizations or institutions or individuals would want to join the coalition.

Marian Grant has talked to a few people who have already agreed to join the coalition. She thinks if they can come up with a list of these key organizations in the State of Maryland, and then talk to the AHEAD team or talk to the Medicaid people or whomever, it will just have more power because at the end of the day the AHEAD model is an equity-based model and consequently the State of Maryland is going to have to show that they did a lot of work with communities across Maryland. She said this isn't a model that can just be imposed on people and that there's going to be a lot of listening sessions where representatives of various communities of color and various advocacy groups are going to be asked to weigh in. And so, the coalition needs to have a corresponding group of people that are aligned around the palliative care advocates.

Christopher Kearney wondered whether it would be fair to say that the Maryland Health Services Cost Review Commission (HSCRC), which has been running the State of Maryland's existing total cost of care program would likely be the agency that operates the AHEAD program, though he did not know this. Marian Grant agreed that is unknown and that speculation is probably not a good use of the Council's time, and it will all be known very shortly. In the meantime, the coalition is just trying to get their information together in the most powerful way so that whomever in the State is running it, if the coalition and the Council can meet with them, they can make their best case to the agency that ultimately runs it. In Chat, she provided information on the AHEAD Model from CMMI. Here's info on the AHEAD model from CMMI https://www.cms.gov/priorities/innovation/innovation-models/ahead

Donald D'Aquila noted that Marian Grant's description of Hawaii's legislation included hospice team members in a listing of providers of palliative care services. From his perspective in the palliative world, Maryland's larger health care organizations from a business perspective can typically leverage resources of pharmaceutical experts such as pharmacists and therapeutic experts but when it comes to the palliative care home-based model, programs are typically challenged because it's a fee for service type reimbursement. So, they usually do not have the funds to gain access to a pharmacist or a pharmaceutical expert. And the CMS guidelines in hospice say that the drug experts should be on the interdisciplinary team. First, he wondered whether there was a pharmaceutical piece within the Hawaii legislation regarding palliative care services. Second, he wondered whether the palliative care project in Maryland will include those types of services in any reimbursements.

Marian Grant said that pharmacists were on Hawaii's list and that the list is quite comprehensive because it is no longer a fee for service model. Instead, Hawaii is going to get a member per month payment that is going to fund all the members of the palliative care team that are needed for each individual patient because not every patient will need to see every member of the palliative care team. She also clarified that Hawaii accomplished this through regulation rather than through legislation. She said that Medicare is going to shift everyone into value-based payment arrangements, that is, bundled payments arrangements, and their goal is that everyone in Medicare and Medicaid will be included in such payment arrangements by 2030. So, the end result will be reimbursement for every member of the palliative care team if this approach is taken for a palliative care benefit. And so, that monthly payment will be directed to the particular provider services needed by the individual patient.

Donald D'Aquila and Christopher Kearney liked that approach. Donald D'Aquila said he wants to be a stark advocate because sometimes pharmacy services get overlooked even though it is a very important piece in palliative care. He said that anyone that works with pharmacists that are specialty-trained in hospice/palliative care pain management knows the special tools that they can bring to the team. Christopher Kearney agreed and recognized Donald D'Aquila to be one of the leading palliative care pharmacists in the State of Maryland and was glad he was joining the coalition. Christopher Kearney said he anticipated that the June 10, 2024 coalition meeting would be helpful and said the NASHP meeting would be held in August, 2024. He said Maryland Department of Health Secretary Scott is still willing to meet with the Council's representatives and asked them to come back in June of 2024. He is trying to be mindful of the difference between the coalition and the Council and to keep that distinction straight when

meeting with Secretary Scott. But they did ask her and the Department of Aging Secretary Roques to join them for the June 10, 2024 coalition meeting.

Christopher Kearney asked Marian Grant to update the Council on the prison healthcare project. Marian Grant said that for the past several years the Council's workgroup has been monitoring the healthcare provided to incarcerated individuals with serious illness at the end of life. She said it has been a very murky area and they have tried to insert themselves into this process and that has not been easy to do. The State had a five-year contract with a company called Corizon that declared bankruptcy and rebranded as YesCare, which according to press reports and Senator Elizabeth Warren, was done to evade liability in Maryland and in many other states. They are losing contracts in other states and their contract with the State of Maryland was going to expire at the end of 2023 but a new contract did win out very late and so they were not able to award it in time. So, they extended the contract until the end of 2024. So, YesCare is going to get extended to a six-year contract with the State. Just a few weeks ago, the State of Maryland decided on who would be the next contractor. YesCare reapplied and Wexford Care applied which had previously had a contract with the State and lost 5 ½ years ago.

Marian Grant said that the State awarded the new contract to Centurian who had already been providing the mental health services for the State. Now, they are going to provide both the physical health and the mental health services for the jails and pre-detention facilities. The contract is worth billions of dollars. Centurian is a for-profit organization because unfortunately that is who does prison health in our country these days. Because they are located in Virginia, they are being pitched in the media as a local entity. And people say good things about the mental health services they have provided for the State. Centurian is scheduled to take over providing healthcare services in January, 2025, though both YesCare and Wexford are appealing the decision to award the contract to Centurian. But it is most likely that Centurian will be the new contractor. She said the workgroup has not reengaged with the Department of Corrections but at some point, they will try to do that to offer to the Department their services in orienting the new contractor to end-of-life, palliative care, and hospice care, etc., and what the contractor is contractually obligated to do in those areas. But those conversations are probably not going to take place until it is confirmed that Centurian will be the new contractor.

Christopher Kearney thanked Marian Grant for the update and said that the Council has made the offer to help consult and they will see what happens next. He wondered whether the essential staff would remain to provide the health care services. It would seem unlikely they would replace all the staff. Instead, they will probably just take over the operation with the same group of healthcare providers. He finds it is hard to be optimistic. Marian Grant said that the Council doesn't know what is going to happen. She said there has been so much staff movement in healthcare between prison and long term care facilities and hospitals since the pandemic, it is hard to know who controls the staff they have now. Christopher Kearney noted that care is always going to be problematic in the prisons when provided by for-profit organizations.

Kathrine Ware asked whether the data being gathered in the NASHP project regarding the return of investment for a palliative care benefit might be helpful in showing a for-profit entity that they could potentially save money by doing the right thing. Marian Grant said that those in the field of palliative care have been hesitant to tout the cost savings of palliative care

because you cannot guarantee that everyone in palliative care will have cost savings for their overall care because some patients opt for every possible treatment. Marian Grant thought it would be good to talk with these for-profit providers about the merits of palliative care over a wide range of areas. The contract that Centurian has with the Maryland prison system creates a total cost of care system for Centurian because these patients do not get any other healthcare benefits. So, it is in Centurian's best interests to control costs and palliative care would be a way to do this appropriately rather than arbitrarily.

Christopher Kearney introduced the topic on the agenda regarding the Conversation Project presentation made to the Department of Aging on March 22, 2024. He said the Conversation Project has been around for some time as a national effort to improve discussions. He said the Council has been interested about how best to promote a conversation for people about their choices in healthcare and about advance directives. The Council had received a copy of the Conversation Project slide deck presentation. Christopher Kearney said the slide deck presentation was pretty good and worth looking at. He said that some people on the Council feel like it is what they are doing every day in their practices. He believed that the Conversation Project presentation is very thoughtful about how a conversation could be started or promoted.

Marian Grant said the Conversation Project is participating as one of 14 organizations in a multi-year grant project to do research on how to better introduce advance care planning, palliative care, and hospice to the general public. She posted another resource in Chat: https://seriousillnessmessaging.org ,which is the toolkit that was built as part of that project. She said if people are doing education in Maryland about advance care planning, they really should look at this toolkit because some of the things we have been saying traditionally for advance care planning have been shown by more recent research to be ineffective. So, talking about advance care planning as a gift to your loved ones is not effective. Talking about "loved ones" is problematic for people who don't have loved ones. So, there has been some really good work that's gone on regarding better ways to talk about these subjects that are appealing not just to the general public but to various different diverse groups. Kate DeBartolo, the head of the Conversation Project, is a true believer in this effort and she has revised their website. They are doing a great deal of things with social media influencers and are really trying to get better messaging out about "you can have a say in your care" (which is the way Marian Grant thinks we should be talking about advance care planning), but in that toolkit there are also ways to talk about palliative care and hospice. In 2024, the National Academies were set to conduct a series of three webinars on this effort, the second one having been held in May and the third one was scheduled to be held in June. These one-hour webinars are being recorded and will be made accessible for people. https://www.nationalacademies.org/our-work/roundtable-on-quality-care-for-people-with-serious-illness#sectionPastEvents

Christopher Kearney said he liked how the slide presentation broke people into individual categories of people such as those who are fiercely independent, worried but want to talk, etc. Marian Grant said this is the kind of attitudinal research that has been done and that many people who have been working in this area have thought they just needed to tell people they should do advance care planning. But it turns out that most people know they should do advance care planning. The research done in 2019 found that two-thirds of people have really good reasons for why they don't. And so just telling them they should plan is totally not effective. You have to

talk it about in a way that even if they have a good reason for not doing it, they start to think "well, maybe I shouldn't do that." She believes that if education is done as it has always been done, it will continue to not be very effective. Marian Grant said that Dan Morhaim did a study about 15 years ago about the level of advance direction completion in the State of Maryland and it was 30% then and is probably 30% now. She said we have been approaching education on this topic in the same way for 40 years and it has not been helping. So, this is new information and she encouraged people to review because she thinks it could help.

Christpher Kearney invited Liz McDonell of MyDirectives to talk about what she was doing. Liz McDonell said she has been on calls with Brian Mattingly of the Maryland Cancer Collaborative's Advance Care Planning workgroup on a monthly basis. She has taken over for Scott Brown for those meetings. She is a project and account manager for MyDirectives, mostly in post-sales integration. She dabbles in a lot of different fields, and she attended the Council meeting to learn, and to answer any questions. She was excited to learn about some of the projects the Council discussed at the meeting. Christopher Kearney asked what the challenges were for MyDirectives in promoting electronic advance directive going forward. Liz McDonell replied that the biggest challenge is that people in the older demographic they are targeting are not always willing to love technology, which obviously is a challenge because their entire platform is digital. And getting healthcare providers to use a stand-alone product when it isn't always integrated is also challenging because integration costs money. So, convincing providers to use this extra stand-alone product is challenging but they are making some headway in getting healthcare providers to join. Christopher Kearney thanked her and said he was guessing the problems were on all sides, including among the providers and the families and patients who don't understand technology, in addition to the integration with health systems.

Tiffany Callender Erbelding mentioned that the Horizon Foundation in the Speak(easy) Howard Project added a question about advance directives to a county-wide survey of health status done every two years. The question was about completing an advance directive, appointing a health care agent, and having a conversation with your health care agent. They did this survey in 2016, 2018, 2021, and in 2024 they are doing it again. The project has been working with a student at the University of Maryland to look at the question of whether the increase in advance directive completion they saw in Howard County is statistically significant. Tiffany Callender Erbelding said it turned out to be statistically significant, and they are now working with the student on an academic paper regarding the Speak(easy) results, which paper will add to the research base that will be available for persons in the greater community. She will be happy to share that additional resource with the Council when it is published. Christopher Kearney thanked Tiffany Callender Erbelding and said the Council would be interested in seeing that study's results.

Dan Morhaim said he did grand rounds at MedStar's Franklin Square Hospital on April 16, 2024, National Healthcare Decisions Day. After giving his talk, he went with a staff member there to test if they could access his advance directive on MyDirectives through CRISP (Chesapeake Regional Information System for Our Patients), the State-designated health information exchange. They found Dan Morhaim's name on the computer system but one time his first name was not correct. When he talked to CRISP to ask them how to fix the problem, CRISP told him that he had to find out who entered his misspelled name, but Dan Morhaim said

he wouldn't know who entered his misspelled name. Secondly, his advance directive was not there. So, obviously he had filed his advance directive electronically, filed it with MyDirectives, and had done everything he could possibly do, so he was distressed that if he had a sudden need at Franklin Square, they wouldn't be able to get his advance directive and all the contact information contained therein. Although his case is only one case, he would have to imagine that his case is not the only one with this problem and that while the advance directives are being and have been forwarded to CRISP by MyDirectives as intended, these are not getting from CRISP into the health records system and hospitals as expected. Christopher Kearney agreed this was disappointing.

Marian Grant said that the last time she worked at a hospital where she is on the palliative care team, she got called to see a patient and the first thing she did was to look at the chart to see if there was an advance directive. And indeed, there was one there that had been completed in 2022. And it said that the patient did not want any kind of life support if she was seriously ill. There was an intake note in the social worker's chart that said she did not have an advance directive. And no one else on the team had looked. So, when she went up to the floor, the patient was in one of the Intensive Care Units (ICU. Marian Grant told the staff that the patient did have an advance directive and that she had just printed it out and this is what it said. Everyone was surprised. The patient had been in the ICU for several days and no one had thought to look for an advance directive. The patient had lost capacity but had previously told staff the patient still agreed with the advance directive. The family had been insisting on life-sustaining treatments, but fortunately the advance directive and the confirmation that the patient had recently affirmed with staff that she still agreed with her advance directive convinced the family to consent to following the patient's wishes in accordance with her advance directive, and they changed her goals of care accordingly. So, the advance directive was in the records, but no one had looked for it.

Christopher Kearney said he is working in a small hospital, and they are pretty good in this area, and that there are a surprising number of people showing up with an advance directive. It is an opportunity for the patient to revise their advance directive if appropriate because being in the hospital is a good time to review the advance directive to make certain it continues to reflect the patient's treatment wishes. So, he said it is not hopeless, it is a project that is moving forward, but there is always more work to be done.

Christopher Kearney discussed the future of the Council. He and Paul Ballard were asked to be part of a webinar sponsored by the National Academy of State Health Policy (NASHP) regarding the Council and similar councils in the nation. Of the three councils that presented, Maryland's Council is one of the oldest in the nation and he noted that its longevity can create a challenge because lethargy or lack of focus can set in. He also noted that the Council's independent status was intentional but also has a drawback because there is no agency that is responsible for the Council. He has been considering how the Council could be more effective and be supported in a regular way.

Christopher Kearney said that Paul Ballard had provided him with a copy of the Council's statute that does provide for reimbursement of Council members' expenses for travel. The statute provides that the Department of Aging and the Attorney General's Office are to jointly provide the Council with staff support, though in reality, Assistant Attorney General Paul

Ballard has been the most visible and notable support for the Council. Although Christopher Kearney appreciates that support, he has wondered out loud whether at some point this Council might be better aligned within the Department of Aging or even the Department of Health. To that end, he informally brought the topic up to both of these Departments' Secretaries and didn't get a negative response. He did note that in the statute, the Department of Aging is already legislated to be part of the staffing support for the Council. So, he hasn't really pressed Secretary Roques about what that means but he reminded the Council that Paul Ballard is about to retire.

On behalf of the Council, Christopher Kearney thanked Paul Ballard for all the tireless work he has done for the Council for many years and wanted to recognize his work holding the Council together, and wished him the best in his retirement, a sentiment echoed by Council members and others in attendance. Paul Ballard thanked Christopher Kearney and the Council and said it had been an honor to serve with members of the Council and said it has been an amazing journey over his 16 years with the Council. He felt privileged he could in any small way help to keep the work of the Council going. He said a lot of the challenge over the years has been for him to make sure the Council's work carries on and that the Council stays in place. It was always fascinating for him to see the variety of very impressive Council members over the years and the different areas about which they are passionate in seeking positive changes, and how those different interests change the focus of the Council as their membership changes.

Paul Ballard said he was not certain how extensive the future involvement of the Attorney General's Office would be with the Council but noted that the Attorney General's Office is obligated to provide staff support under the Council's statute in addition to the Department of Aging. And both the Attorney General's Office and the Department of Aging are required to designate representatives to the Council. But he doesn't know any details yet. He is also trying to figure out why it has been so difficult to get people appointed to the Council. He has found another contact person with the Governor's Appointments Office to talk with before he is to retire on July 1, 2024, and hopefully those appointments can get back on track. He told the Council that Senator Ben Kramer, who he said had been very helpful to the Council, left the Council and that the Senate President would have to replace him.

Paul Ballard said he found it very interesting that the original bill creating the Council as introduced had the Maryland Department of Health (then the Maryland Department of Health and Hygiene) as the agency that would provide staff support to the Council but at the last minute during the legislative session this was changed to joint support provided by the Attorney General's Office and the Department of Aging. This led him to speculate that the Department of Health got cold feet at the last minute and did not want to take on that staff support role at the time. He was sorry to have to leave the Council in a state of uncertainty, but he will do his best to make things more certain before he retires. He thanked all the Council members and interested persons for all their help and support over the years. He said that this is a very impressive group of people and that he cannot say enough good things about them.

Christopher Kearney said that Paul Ballard does not have to feel guilty about leaving because the Council will figure out a way forward. He said Paul Ballard should not have any regrets, having led the Council very well and far, and thanked him for his work for the Council.

Jack Schwartz said he doesn't remember exactly how it happened that the bill replaced the Maryland Department of Health with the joint support of the Department of Aging and the Attorney General's Office, though Paul Ballard's account that the Department of Health got last-minute cold feet seemed right to Jack Schwartz, though this was more of a reconstructed memory than an actual memory. The idea that the Department of Health might have basically said "Hey AG's Office, this is your idea, you staff it" was how Jack Schwartz thought it worked out. And the inclusion of the Department of Aging reflected his view at the time that there ought to be a stake in this Council other than simply the Attorney General's Office because especially as he neared retirement, he was concerned as to what would happen to the staffing of the Council. That is, it was easy to imagine an Attorney General who is not particularly interested in this subject, who would have staffing on paper but not in reality. And indeed, there was such an Attorney General. So, he viewed it as a minor miracle that Paul Ballard stepped forward and did the superb job he had done over the years. But Jack Schwartz believed it was time for the Council to think about, as Christopher Kearney suggested, the possibilities for reconstituting the Council so that staffing is less dependent on the Attorney General. He said that finding someone as dedicated and talented as Paul Ballard to do this work is hardly a guarantee.

Christopher Kearney thanked Jack Schwartz for his thoughts. Christopher Kearney said that because the Department of Aging is already in the statute as one of the agencies providing staff support to the Council, that there would not be any need for new legislation as would be the case if the Maryland Department of Health were to instead take on this staffing role. In light of that, he wondered if Jack Schwartz had an opinion as to what avenue the Council might take at this time to help ensure adequate staff support and technical assistance for the Council. Jack Schwartz said that a lot would depend on the willingness of senior people in the respective agencies. He said there is logic in choosing the Department of Aging in that the renaming of the Council to the "State Advisory Council on Serious Illness Care" reflects the demographic and the health reality that the incidence of serious illness is much greater among older people. There is a built-in interest at stake for the Department of Aging in dealing with the topics addressed by the Council. So, at least as a first impression, the Department of Aging seems like an avenue to pursue. and built-in interest at stake. Jack Schwartz didn't think that the Council should count on the Attorney General's Office. The Council arose because former Attorney General Joe Curran had a personal interest in this topic and allowed Jack Schwartz to work on this topic. And that is not easily replicable. The difference between having someone who is nominally assigned to staff Council and having ten other things to do, all of which are more important to their boss than the Council, is a real prospect. He said the Council should not count on having another Paul Ballard.

Kathrine Ware said she was at a fundraiser for Senator Pam Beidle who is Chair of the Senate Finance Committee that hears a lot of the healthcare bills, and she mentioned at that meeting that one of her legislative priorities for the 2025 legislative session was the improvement of long-term care. Kathrine Ware doesn't know all the details, but she is assuming there will be a lot of work with the Maryland Department of Aging in that regard. She could do some more fact-finding but there may be some influence that can be exercised through that process. Christopher Kearney agreed that the topic of improving long-term care is well within the Department of Aging's province.

Marian Grant said it did not seem to her that Secretary Roques was opposed to the idea of having the Council within the Department of Aging when they met with her. Christopher Kearney replied that he did not know how firmly she understood the discussion and he did not remember if they specifically discussed that issue. Christopher Kearney said that Secretary Roques is certainly a supporter of palliative care as is the Maryland Department of Health Secretary Scott, who has a very sophisticated understanding of palliative care and has been interested in the Council's activities. He said that the idea of working with Dr. Sadie Peters at the Maryland Department of Health is intriguing because she has been involved with the Department's Maryland Cancer Collaborative and with their advance care planning workgroup. But he noted that the Department of Aging is already mandated in the Council's statute to provide the Council with staff support and technical assistance jointly with the Attorney General's Office. So, that may be the route that is most expeditious for the Council to pursue at this point. He does not know what level of support the Attorney General will continue to provide. So, the Council is wise to be seeking other agencies to provide support. Of course, the potential downside is that coming within an agency can also carry with it being subject to their bureaucracy and potentially diminishing the Council's independence. So, the Council will have to consider whether that trade-off is worth getting an agency's support for the Council's activities.

Christopher Kearney said he will speak further with Paul Ballard before his retirement and that Council representatives will be speaking again with the Maryland Department of Health Secretary Scott. At that meeting with Secretary Scott he could float the concept of the Health Department providing staff support and technical assistance to the Council. And he can also float the same idea with Secretary Roques when they meet with her.

Christopher Kearney said that replacing Council members also remains of interest to him. He will discuss this further with Paul Ballard to see how that can be moved forward.

Sara Hufstader said although it may be slightly off topic, she wondered if there are any updates for the status for palliative care and symptom management via telehealth, especially for those who are not able to leave their home in the state of Maryland. She said her palliative care team has essentially lost its ability to do home visits through telehealth, which they were doing heavily during the Covid pandemic. Paul Ballard asked whether this was a reimbursement issue and she replied that it was a reimbursement issue at times. So, now she is primarily providing these services at the clinic and over the last few months she was told that they might not be able to offer telehealth services to the patients who are not able to get to the clinic but who are needing management, particularly pain management. And she wasn't sure if anybody on the Council was aware of anything regarding the reimbursement of telehealth services. Christopher Kearney invited Sara Hufstader to reach out to him after the Council meeting because he may know some people who she could contact who are still providing telehealth services. He doesn't know the ins and outs at this point, though he said her concerns are valid. He said that the projects the Council is talking about for the future would hopefully help to solve that problem.

Shahid Aziz thanked Paul Ballard for all he had done and for putting together some of the best organized and well-run video meetings he had ever attended. While the Council was meeting, Dan Morhaim notified Senate President Bill Ferguson of the need to replace Senator

Ben Kramer on the Council and Senator Ferguson promptly responded he would take care of it. Christopher Kearney and Paul Ballard thanked Dan Morhaim for notifying Senator Ferguson.

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