Dear Council Members:

We have sought to distill the priority ranking decisions made by the Council at its June 20 meeting. The three priority areas that follow, although they depart from the wording of the recommendations, include all that gained the most support.

- √ Please review them and offer any comments;
- √ Flag the area (or areas) that you would like to focus on; and,
- √ For the work that needs to be done before our next meeting on October 17, indicate whether you would prefer to meet with your colleagues face-to-face, talk with them by conference call, or submit work independently.
- √ Please indicate if you would like to assume a leadership role such as chairing a subcommittee.

The next task will be identifying specific action items to promote the priority objectives, using the template that was distributed at the meeting.

Priority Area: Care planning for patients with a life threatening condition

- The Council should identify ways in which public policy and the culture of clinical care in Maryland can better enable:
  - Patients with capacity to communicate goals of care consistent with their own values, including the use of advance directives as one mode of communication; and
  - Proxies to identify goals of care for patients without capacity.
- Palliative care should be understood by health care professionals to be an integral part of ongoing clinical care and planning, instead of being introduced only at the very end of life.
- For every patient, the goals of care should be reflected in a physician's order. The order should be in a standardized format (similar to the POLST form used in other states) that is clear, comprehensive, and honored across care settings.
- Health care facilities should have systems in place that are supportive of advance care planning, the use of a POLST form, and the skillful implementation of each plan of care.

Priority Area: Care for disadvantaged and vulnerable patients

- The Council should examine those aspects of public policy and the culture of clinical care in Maryland that present barriers to excellent end-of-life care for disadvantaged and vulnerable patients. This category includes:

  - Any ethnic or cultural group who have experienced the lingering consequences of historical patterns of exclusion

  - Patients with dementia, whose complex and uncertain clinical course and special caregiving requirements have often not been addressed adequately

  - Children, for whom quality palliative care often is unavailable or is begun too late to be meaningful

  - "Unbefriended" persons who may not have family or friends to take care of them

  - Prisoners and others in State custodial facilities including the mentally ill, the developmentally disabled, and children in the foster care system

  - Those who, by reason of economic disadvantage, immigration status, or lack of fluency in English may have difficulty gaining access to palliative care services, including services under the Medicaid program

Priority Area: Enlisting the faith community

- The Council should examine ways to encourage the clergy, parish nurses, and lay congregational leaders to make improving end-of-life care an ongoing part of the work of their communities. This work should include creating opportunities for advance care planning, advocacy for dying patients, and support of caregivers.