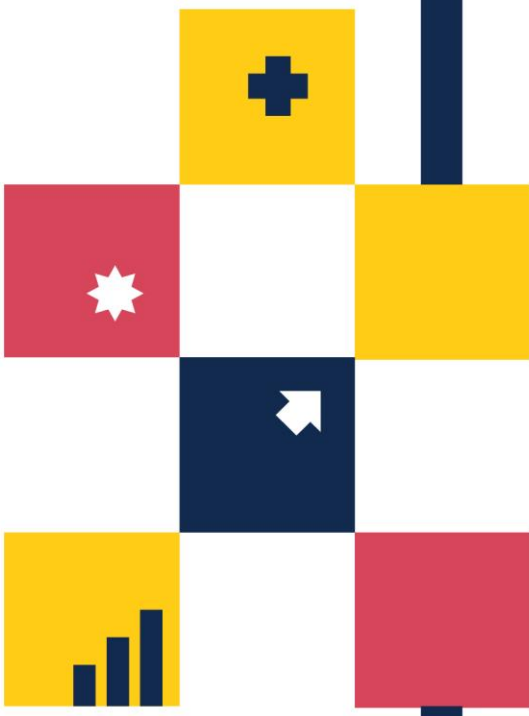
Advance Directives Workgroup Report

January 2022



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Background

Advance Directives (AD) are a key tool to help with advance care medical planning. Generally, advance directives are utilized across the health care continuum, in settings such as hospital Emergency Rooms (ER) and Intensive Care Units (ICU), long-term care facilities, nursing homes, assisted living facilities, and ambulatory care practices.

Maryland law supports residents' advance care planning and enables health care professionals to assist patients in stating their care preferences.[1] The key documents for making individuals wishes known are advance directives and medical orders for life sustaining treatment (MOLST). An advance directive communicates important treatment preferences during an emergency or near the end of life, through written or electronic instructions. Maryland MOLST is a portable and enduring medical order form for life-sustaining treatments.

Advance Directives and MOLST Explained

An advance directive includes vital information for continuing or withdrawing health care. The Maryland advance directive is composed of three parts:

- Part I of a Maryland Advance Directive allows an individual to designate a health care agent who will make medical decisions on behalf of the individual when the patient is not able to communicate.
- Part II of a Maryland Advance Directive provides for an individual to define the medical circumstances and individual's preferences for care that will guide the health care agent in making decisions on behalf of the individual.
- Part III of a Maryland Advance Directive contains the individual and witness signature fields. Note that witness signatures are not required for an electronic advance directive.

The MOLST form is a standard medical order form that travels with the patient and is designed to carry out a patient's treatment wishes regarding their current medical condition. A completed MOLST form allows for a complete range of options for care, from choosing all available life-sustaining treatments to limiting or refusing those treatments. The MOLST form simplifies the process for health care providers and helps to avoid errors by creating one standardized form to be used across health care settings. The MOLST is a major element in advance care planning, but this form has not generated as much focus. Advance directives and the MOLST are essential elements of advance care planning activities that are completed in consultation with family members and trusted providers. Medicare, Medicaid, and many private payers now reimburse providers for providing these consultations.

[1] Health General Article, § 5–601. Available online at: https://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/HCDAtext.PDF

The Maryland General Assembly passed legislation in 2016 (2016 Laws of Maryland, Chapter 510)[2] that established a foundation for advance directives, made promoting the use of advance directives a priority, and clarified that certain electronic advanced directives have the same credibility as traditional (written) advance directives.[3] The legislation expanded advance directives outreach and education activities by the Maryland Department of Health (MDH). The legislation also required the Maryland Department of Aging and the Maryland Health Benefit Exchange (MHBE) to disseminate MDH materials on advance directives.[4] The 2016 legislation included a requirement for MHCC to develop a State Recognition Program for electronic advance directives services. COMAR 10.25.19 *State Recognition of an Electronic Advance Directives Service* defined program procedures for State recognition, which is a prerequisite for connecting to the State-Designated HIE (Health Information Exchange).[5, 6]

The Maryland Office of the Attorney General (OAG) continues to serve as the State's trusted source for information on advance directives.[7] The Attorney General provides basic templates for Maryland residents interested in creating this document and promotes the use of advance directives in the State.[8, 9, 10] The Office of Health Care Quality (OHCQ) develops educational programs on the use of advance directives and MOLST. The OAG worked with MDH, the State Advisory Council on Quality Care at the End of Life, and the Maryland Institute for Emergency Medical Services Systems to develop a MOLST form. OHCQ, in collaboration with the OAG, the State Advisory Council on Quality Care at the End of Life, and the Maryland Institute for Emergency Medical Services Systems developed a website (marylandmolst.org) that makes advance care planning and MOLST

[2] The General Assembly passed legislation in 2017 that clarified certain security requirements that third-part advance directive vendors must meet to obtain MHCC recognition (2017 Law of Maryland, Chapter 667).
[3] Public Health – Advance Directives – Witness Requirements, Advance Directives Services, and Fund. House Bill 188. Available online at: https://mgaleg.maryland.gov/2017RS/bills/hb/hb0188E.pdf
[4] MHBE is the independent State agency responsible for operating the State's health insurance marketplace. MHBE is required to offer information to residents that enroll through the Maryland Health Connection.
[5] COMAR 10.25.19: State Recognition of an Electronic Advance Directives Service. Available online at: http://mdrules.elaws.us/comar/10.25.19
[6] MyDirectives is the only vendor to receive State Recognition for its advance directive services (2018 and 2021).
[7] "Advance Directives." Maryland Attorney General. Available online at: https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/AdvanceDirectives.aspx
[8] "Maryland Advance Directive: Planning for Future Health Care Decisions." 2019. Available online at: https://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/adirective.pdf
[9] "Report to the Joint Committee Chairs: State Policy Recommendations to Increase Electronic Advance Directive Registrations." 2020. Available online at: https://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/SAC/Inc_Elect_Adv_Dir_Reg.pdf
[10] "Health Care Decisions Act: Text and Education Materials." Available online at: https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/hcda.aspx

materials available to the public. Table 1 summarizes the roles of the State agencies engaged in promoting advance care planning and the use of advance directives.

Table 1. Government Agencies Roles in Promoting Advance Care Planning

Agency	Responsibilities	Statutory Authority and Links to Online Resources
Office of the Attorney General (OAG)	Operates the Office of Health Policy Decisions. That Office serves as the trusted source for information on advance directives.	https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx
Department of Health	1. Develop an Information Sheet on advance directives in consultation with OAG. 2. Encourage the use of advance directives through public outreach.	Health General Article, §§ 5–602-5-607, 5-611—5-615; 5-619-5–623; 5–625, 5–626 Health General Article §13–406, and §15–109.1
Department of Aging	Work with seniors to encourage use of advance directives as directed by MDH and OAG.	Health General Article §5-615.1
Motor Vehicle Administration	1. Make an applicant for a driver's license or an identification card aware that an advance information sheet exists. 2. Provide a method for noting that the applicant has an advance directive on driver's license.	Transportation Article §12–303.1 https://mva.maryland.gov/Documents/Advance-Directive-Information-Sheet.pdf https://mva.maryland.gov/Pages/form/driver-licensing.aspx
State Advisory Council on Quality of Care at End of Life	Council advises the General Assembly, Office of Attorney General, Department of Aging, and the Department of Health on matters related to the provision of care at the end of life.	Health-General Article §§13-1601-13-1604 https://www.marylandattorneygeneral.gov/Pages/HealthPolicy/sac.aspx
Maryland Health Benefit Exchange	Provide advance directive information sheet: 1. In the Exchange's consumer publications; 2. On the Exchange's website; and 3. At the request of an applicant.	Insurance Article §31–108(G) https://www.marylandhealthconnection.gov/?s=advance+directive
Office of Health Care Quality	Serves as MDH's responsible organization for developing MOLST in collaboration with the State Board of Physicians, OAG and MIEMSS.	Health General §5–608-5-610 https://marylandmolst.org/index.html
Maryland Health Care Commission	Recognize advance directives vendors that meet state standards. The MHCC may issue grants to advance directives vendors to support the development of APIs needed to link to Chesapeake Regional Information System for our Patients (CRISP).	Health General §19-144 and COMAR 10.25.19- State Recognition of an Electronic Advance Directives Service
Maryland Insurance Administration	Directs carriers to provide information sheet in: 1. Member publication; 2. On carrier's Web Site; and 3. On request f a member.	Insurance Article 15–122.1

Agency	Responsibilities	Statutory Authority and Links to Online Resources
Maryland Institute for Emergency Medical Services Systems	Developed MOLST in collaboration with the OAG and MDH. Implements MOLST preferences if a MOLST form exists. In the absence of MOLST forms, EMS responds to patients that cannot communicate by providing restorative interventions under the statewide Maryland Medical Protocols for EMS Clinicians.	https://www.miemss.org/home/molst

Many electronic health record (EHR) systems include advance care planning features. EPIC and Cerner, the two largest EHR systems implemented in most hospitals and a number of ambulatory practices, enable consumers to develop or upload their advance directive via a patient portal. It is notable that Johns Hopkins Medicine and the University of Maryland Medical System, which have EPIC, have activated the advance directive features. Health systems using the Cerner's EHR are in the process of operationalizing the advance directive feature. The capability to upload or create an advance directive varies among smaller EHR systems used in ambulatory practices.

The Insurance Article requires carriers[11] to make available information on advance directives to members in printed form and on their websites. An MHCC review of a small sample of health plan websites confirmed that advance directives information is available on health plan websites. The links are to the OAG, consumer-oriented sites, and third-party advance directive sites, which enable consumers to create advance directives. Carriers include information links on their website rather than supplying actual planning documents and assert that enrollees may be skeptical about carrier efforts to promote advance care planning due to their misperception that advance care planning helps the plan avoid costly care.

Despite the efforts of State agencies and others to promote the creation of advance directives, progress has been mixed. An issue brief released in September of 2021 by MHCC found that small percentages of Maryland Medicare beneficiaries met with a trusted provider to discuss advance care planning.[12] In a 2020 Joint Chairman's Report, the State Advisory Council on Quality Care at the End of Life

[11] Carriers includes insurers, non-profit health plans, health management organizations, and any person that provides health benefits subject to regulation by the State. It does not include dental benefit organizations, which are defined as carriers under MD Insurance Article § 15-141 (a)(2)

[12] "ACP: A First Look." Presentation. Maryland Health Care Commission. 2021. Available online at: https://mhcc.maryland.gov/mhcc/pages/home/commissioners/documents/20211021/Ag7A_ACP_A_First_Look_Presentation_102021.pdf

estimated that about 1.4 million adult Marylanders had created advance directives.[13] Efforts to promote the use of electronic advance directives, which was a direct outcome of the 2016 law have been disappointing; approximately 2,500 Maryland residents have created electronic advance directives. Low uptake may be due in part to only one standalone third-party vendor obtaining MHCC certification. Use of EHR systems to store advance directives is more widely used than standalone third-party applications. One EHR vendor reports that upwards of 50,000 Marylanders have uploaded an advanced directive through their EHR patient portal. Conversely, MHBE reports that about 18 percent of Qualified Health Plan (QHP) enrollees and 14 percent of active Medicaid beneficiaries have designated an authorized health care agent, the MHBE's terminology for health care agent.[14] These percentages are somewhat promising because QHP enrollees and Medicaid beneficiaries are typically under 65 years old. The lesson from this experience is that steady encouragement from multiple trusted entities is needed, and the willingness to accept limited information, such as the name of an authorized agent, is the appropriate starting point for enrollees to understand the importance of advance care planning.

Advance Care Planning Legislation in 2021

During the 2021 legislative session, *Senate Bill 837 – Health – Advance Care Planning and Advance Directives* was introduced to the General Assembly. SB 837 addressed issues with accessing electronic advance directives in Maryland.[15] The bill required MHCC to coordinate implementation of advance care planning programs in the State, including development and implementation of quality metrics[16]. The bill

[13] "Report to the Joint Committee Chairs State Policy Recommendations to Increase Electronic Advance Directive Registrations." State Advisory Council on Quality Care at the End of Life. 2020. Available online at: https://www.marylandattorneygeneral.gov/Health%20Policy%20Documents/SAC/Inc_Elect_Adv_Dir_Reg.pdf

[14] Reports are based on MHBE's queries of their enrollment systems as of December 2021.

[15] Health – Advance Care Planning and Advance Directives. Senate Bill 837. Available online at: https://mgaleg.maryland.gov/2021RS/bills/sb/sb0837T.pdf

[16] The Workgroup did not discuss the development and implementation of quality metrics even though it was included in SB 837. It is suggested by a few members of the Workgroup that MHCC add the following to its on-going clinical quality indicators program: A quarterly (or semi-annual) report of the number and percentage of advance care plans that were created by individuals within the entities monitored by the MHCC quality indicator program, and the number that were uploaded into the state's Health Information Exchange (HIE).
MHCC conducted a careful and thorough review of the National Quality Forum on quality indicators for advance directives. The National Quality Forum (NQF) is an independent, nonprofit, membership organization that brings together diverse organizations and individuals from across the country dedicated to improving health and healthcare through quality measurement. NQF maintains an exhaustive portfolio of endorsed performance measures that can be used to measure and quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high-quality care. Once a measure is endorsed by NQF, it can be used by hospitals, health care systems, and government agencies like the Centers for Medicare & Medicaid Services for public reporting and quality improvement. As of January 2022, NQF had endorsed one measure (NQF-0326) developed by the National Committee for Quality Assurance for physicians and group practices that measures use of advance directives. The measure captures the

included requirements for carriers to offer electronic advance directives to members and enrollees during open enrollment and periodically throughout the year, and to receive status notifications about enrollee completion or updates of advance directives. The bill authorized carriers to contract with an electronic advance directives service provider recognized by MHCC. The Maryland Motor Vehicle Administration (MVA) was required to submit a report to the General Assembly that provides a status update, a timeline for implementation, a description of barriers to implementation, and measures taken to resolve obstacles for implementation. Senate Bill 837 did not pass and at the conclusion of the 2021 legislative session, the Health and Government Operations Committee Chair requested that MHCC convene a workgroup to develop compromise recommendations for legislation that could be considered in the 2022 legislative session.

Workgroup Approach

MHCC convened the Advance Directives Workgroup (Workgroup) with over 40 stakeholders representing consumers, providers, nursing homes, hospice and palliative care, carriers, technology vendors, the Maryland Insurance Administration (MIA), Maryland Department of Transportation, and the legislature. The Workgroup met four times between August and December (2021) and four recommendations were identified. Two subgroups were convened to discuss the proposed recommendations: the Technical Subgroup and Policy Subgroup. The subgroups consisted of a small number of Workgroup representatives and met once in September and October.

The Technical Subgroup focused on opportunities to include advance directives in the EHR workflow using applications native to the EHR. The Workgroup discussed creating a link to MyDirectives, the MHCC State Recognized Advance Directives Service, in carrier consumer portals. The Workgroup considered the value of a health care agent registry developed by the Chesapeake Regional Information System for our Patients (CRISP) that could be made available in carrier and provider

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percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. See NQF# 326 and NQF Advance Care Plan. MHCC believes collecting data on advance directives consistent with the NQF 346 specification will be challenging regardless of whether the measure is collected in aggregate from practices or Medicare Advantage plans. Extraction from Medicare medical claims may be easier to operationalize. The denominator for the measure is all individuals over 65. NQF 326 (Quality ID #47) is designated as a Merit-based Incentive Payment System (MIPS) measure under the Medicare Quality Payment Program (QPP). MHCC believes that overtime clinicians will become more comfortable assisting patients in completing an advance care plan, especially if advance care planning is part of the QPP.

consumer portals. The Policy Subgroup deliberated on policy changes that would be necessary to implement these recommendations. A summary of the Workgroup and Subgroup meetings can be found in Appendices E.

Recommendations

Recommendation 1- Actions by Carriers to Collect Health Care Agent Information and Increase Promotion of Advance Directives

The Workgroup recommends that a carrier place a link on their member portal home page to a health care agent registry (CRISP developed) for consumers to identify a health care agent to complete an advance directive. Placing the links in the portal would require users to complete the carrier's authentication process and these credentials would be forwarded to CRISP. Enrollees will be encouraged via member publications, the carrier's website, and public education campaigns to periodically update and maintain their health care agent information and/or advance directive using the link on the insurer's website or directly with their health care provider.

Limitations and Concerns

Carriers expressed concerns about the placement of such a link on their member portal. Most carriers preferred placing a link to upload health care agent information in front of the portal. Placing the link behind the enrollee logon would not be technically difficult; however, carriers expressed concerns about enrollee challenges when navigating back to their website after being routed to another third-party website. Enrollees would likely need to reenter their user authentication credentials upon return rather than in the location on the site where they left the member portal, which was viewed as burdensome by most carriers. Enrollees log into carrier portals to do insurance business and while they may have an interest in health care agent or advance directives information the process to direct them to this information should not hinder their access to the carrier's portal by redirecting them back to the member portal to log in a second time to continue doing business with the carrier. The Workgroup did not conclude with a strategy to address this concern. Additional conversations with stakeholders are needed to determine the best approach to navigate interested enrollees to a health care agent registry in a way that they can be redirected back to their member portal without having to log in again.

Carriers also noted that this recommendation would impact only a small proportion of the Maryland population. Roughly only 17 percent of the population is covered

through commercial insurance subject to Maryland insurance law. [17] The remainder are covered through products by self-insured private employers that are protected from state regulation by the Employee Retirement Income Security Act (ERISA)[18], Medicaid, Medicare, or are uninsured. The Workgroup expressed the need to develop strategies to engage self-insured employers to voluntarily institute the same measures as the commercial carriers for the collection of a health care agent and promoting advance directives.

For the most part, carriers believe they can implement this recommendation without a legislative mandate. However, the MIA noted that legislation would be preferable because it ensures consistency across payers on implementation and enables the MIA to enforce the requirements.

Recommendation 2- Actions by Providers to Collect Health Care Agent and Promote the Completion of Advance Directives

Nearly all Workgroup participants support uploading or entering the identification of a health care agent and/or advance directives into the electronic health record (EHR) patient registration/encounter workflow. The leading EHR vendors operating in Maryland include advance directive modules for the collection and storage of this information. Advance Directives should be available where clinicians go to look for health information: within the patient's electronic health record and the State's designated health information exchange, CRISP. The Workgroup agreed that providers have an important role to play in increasing consumer awareness and the use of advance directives and/or identification of a health care agent. Information made available in the provider workflow is less likely to be overlooked during an encounter than information stored in a third-party application. CRISP participating providers would have access to this information. Additionally, it is recommended that CRISP create a tab on their website labeled "Advance Care Plans" or "Advance Directives/MOLST," that would allow providers to more easily locate health care agent information as well as the advance directives.

[17] It should be noted that the 17 percent quoted reflects the coverage of the entire Maryland population. In the private insurance market, insured products not ERISA protected represent about 50 percent of the market.
[18] Employee Retirement Income Security Act (ERISA) U.S. Department of Labor. Available online at: https://www.dol.gov/general/topic/retirement/erisa

Limitations and Concerns

The advance directive functionalities and identification of a health agent is different across EHR systems. This may pose challenges for providers that access different EHR systems. Availability of this information is also limited as not all providers are connected to CRISP. Only hospitals are required to connect to CRISP. Approximately half of all ambulatory practices and nursing homes have integrated with CRISP. Advance directive and health care agent information stored in EHR systems that are not interoperable will impede access to this critical information stored in the EHR.

Recommendation 3- Actions by HIEs: Connect Nursing Homes to CRISP

The Workgroup recommends that nursing homes in Maryland integrate with CRISP. Two vendors account for about 90 percent of nursing homes statewide. Integration will allow nursing homes to capture advance directives and/or health care agent information in the patient care workflow. Integrating nursing homes with CRISP will enable hospitals to have electronic access to this information during care transitions. Expanding the recommendation to include assisted living facilities was supported by the Workgroup. Timely access to health information in the continuum of care is critical to support high quality care.

Limitations and Concerns

The Workgroup acknowledges the need to engage nursing homes and assisted living facilities in obtaining advance directives and/or health care agent information via CRISP integration. However, sustainable funding to support connectivity remains an impediment. Currently, funding is available to support CRISP connecting the two EHR vendors under existing financial agreements between CRISP and the Maryland Department of Health and CRISP and the Health Services Cost Review Commission that leverage federal Medicaid Enterprise System certified technology funding. These funds are not guaranteed each year and a long-term funding plan is needed.

Recommendation 4- Proposed Pilot Project: Ambulatory Practices and Health Systems

The Workgroup proposes that MHCC establish a pilot project for ambulatory practices and health systems, similar to the WellSpan Health (WellSpan) Advance

Care Planning Initiative.[19] The WellSpan initiative successfully implemented team-based advance care planning processes within primary care practices in their health care network to promote patient completion of advance care planning. The MHCC project would be an adapted version of the WellSpan initiative. A leading goal would be to improve the collection of health care agent information and increase completion of advance directives. The project would use a change management model, which is a framework for achieving organizational change through the adoption and acceptance of new methodologies. Similar to the WellSpan initiative, the project would require the creation of a leadership team to oversee the project, manage systemwide collaboration between providers and patients, and to promote the use of an electronic health records system.

About the WellSpan Initiative

WellSpan is an integrated system of eight hospitals and more than 170 outpatient locations. WellSpan adopted a systemwide approach to implement team-based advance care planning (ACP) processes and during the pandemic created a remote response team to help high-risk patients with Covid-19 with ACP. WellSpan found that systematic ACP, leading to proactive decision-making for treatment preferences by patients and their family members, can reduce unwanted medical interventions and the cost of care.

A strategy for consideration is a voluntary pilot project under the Maryland Primary Care Program. Participating ambulatory practices would develop processes to capture patient health care agent information and promote the completion of an advance directive during the patient registration or the patient encounter that could be broadly shared with practices. Information from pilot participants would be made available by CRISP to treating providers. The pilot project would include a post-intervention efficacy assessment.

Limitations and Concerns

Collaboration with ambulatory practices and the Maryland Hospital Association is needed to effectively design, develop, and implement such a pilot. A funding source for the pilot has not been finalized. Funding is required to offset participating practice expense in implementing changes in workflows and for the post-intervention efficacy assessment.

[19] Bhatia V, Geidner R, Mirchandani K, Huang Y, and Warraich HJ. "Systemwide Advance Care Planning During the COVID-19 Pandemic: The Impact on Patient Outcomes and Cost." NEJM Catalyst. 2021. Available online at: https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0188

Conclusion

The Advance Directives Workgroup identified four recommendations to increase the collection of health care agent information and the completion of advance directives. Additionally, the Workgroup agreed that greater emphasis needs to be placed on the identification of the health care agent and the completion of advance directives. Although consensus on all the recommendations was not achieved, the recommendations proposed in this report represent a laudable effort among stakeholders to increase the collection and availability of advance directives.

Workgroup participants observed that greater emphasis on awareness building is an essential underpinning to increase the number of Marylanders with an advance directive or minimally the identification of a health care agent. The Workgroup acknowledged the need to normalize discussion about advance care planning and address stigma associated with advance directives. It was observed by the Workgroup that a multi-dimensional approach is required: community engagement; increasing health care provider awareness on the importance of health care agent information and the completion of advance directives; and media strategies to educate the public about the value of advance care planning.

More work is needed to build consumer awareness about the value of advance directives as technology alone cannot solve all of the existing challenges. To accomplish routine completion, acceptance, and use of advance directives, all stakeholders have an important role to play. Each stakeholder should take active and continuous steps to promote advanced care planning. This includes:

1) State and local governments
2) Health care institutions (e.g., hospitals, nursing homes, clinics, long-term care facilities, hospices, etc.)
3) Insurance companies and other coverage providers (e.g., Medicaid, HMOs, ACOs, etc.)
4) Providers of all levels (physicians, nurses, pharmacists, physician assistants, paramedics, social workers, counselors, and all other health professionals)
5) Faith-based organizations
6) Businesses and labor unions with outreach to employees and members
7) Academic institutions, especially public health schools
8) Non-governmental organizations (e.g., charities, advocacy organizations, non-profits organizations, membership and professional organizations)
9) Residents initiating one-on-one conversations
10) Active recognition of National Healthcare Decisions Day (April 16)

The Advance Directives Workgroup supports continued efforts from all stakeholders including the Maryland Department of Health, the Maryland Department of Aging, the Maryland Insurance Administration, and the Maryland Health Benefit Exchange to improve access to and utilization of advance care planning and advance directives throughout the State.

Acknowledgment

The MHCC extends our thanks to all participants on the Workgroup. We are grateful for their engagement in formulating the recommendations. Special thanks to Senator Ben Kramer and Delegate Bonnie Cullison for their leadership on the Workgroup.

APPENDICES (A, B, C, D, E)

A. Letter from Chair Pendergrass

SHANE PENDERGRASS
CHAIR

JOSELINE PEÑA-MELNYK
VICE CHAIR

THE MARYLAND HOUSE OF DELEGATES
HEALTH AND GOVERNMENT OPERATIONS COMMITTEE

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Steffen:

The Health and Government Operations Committee requests the Maryland Health Care Commission (MHCC) convene a workgroup over the interim to review Senate Bill 837 and make recommendations on feasibility of legislation to encourage Maryland residents to utilize and providers to access advance directives and other advance care planning approaches including the designation of a health care agent.

The Committee supports expanding the use of advance directives and other advance care planning approaches. MedChi, the Horizon Corporation, and End of Life Council have been forceful advocates of the benefits of these tools to patients. The Committee has heard from the Maryland Health Association (MHA) and payers about the challenges they would encounter should Senate Bill 837 pass in its current form. MHCC has also been clear about the limited benefit standalone advance directive registries would offer consumers. The Committee would prefer to resolve the differences among stakeholders in subcommittee however, with only two weeks remaining, there is not enough time to debate and incorporate changes to SB 837 and return an amended bill to the Senate.

One approach to resolve issues with SB 837 is for the MHCC to convene a workgroup to review SB 837 and make a recommendation on the feasibility of developing legislation that would be ready for consideration by the House and Senate in 2022. The Committee requests that the workgroup include all stakeholders that have taken positions on SB 837. Please let the Committee know as soon as possible if MHCC would be willing to undertake this task.

Sincerely,

Delegate Shane Pendergrass, Chairman, House Health and Government Operations Committee

Delegate Joseline Peña-Melnyk Vice-Chairman, House Health and Government Operations Committee

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C. Advance Directives Technical Subgroup Roster

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Tracey DeShields, JD, LLM	Maryland Health Care Commission	Director, Policy Development and External Affairs
Cathy Grason, JD	CareFirst BlueCross BlueShield	Director, Government Relations
Sean Hubber	Epic Systems, Inc.	Senior Software Development Manager
Shadae Paul, MPH, MPA	Maryland Health Care Commission	Program Manager, Government Relations and Special Projects
David Sharp, PhD	Maryland Health Care Commission	Director, Center for Health Information Technology and Innovative Care Delivery
Justine Springer	Maryland Health Care Commission	Program Manager, Health Information Technology and Innovative Care Delivery
Allison Taylor	Kaiser Permanente	Director of Government Relations
Dan Wortman	Epic Systems, Inc.	Software Development Manager
Jeff Zucker	MyDirectives	Former CEO

D. Advance Directives Policy Subgroup Roster

Name	Affiliation	Title
Matthew Celentano	Funk and Bolton, P.A.	Government Relations Specialist
Tracey DeShields, JD, LLM	Maryland Health Care Commission	Director, Policy Development and External Affairs
Tiffany Callender Erbelding, MSW, PMP	The Horizon Foundation	Senior Program Director
Cathy Grason, JD	CareFirst BlueCross BlueShield	Director, Government Relations
Christine Karayinopulos	Maryland Health Care Commission	Administrative Officer
Neal Karkhanis, JD, MA	Funk and Bolton Law	Government Relations Specialist
Traci LaValle, MPH	Maryland Hospital Association	Senior Vice President, Quality and Health improvement
Dan Morhaim, MD	Former Maryland State Delegate	Advocate
Michael Paddy	Maryland Insurance Administration	Director of Government Relations
Shadae Paul, MPH, MPA	Maryland Health Care Commission	Program Manager, Government Relations and Special Projects
Deborah Rivkin, Esq	CareFirst BlueCross BlueShield	Vice President, Government Affairs
Steve Salamon	The Salamon Agency	Owner
Glenn Schneider, MPH	The Horizon Foundation	Chief Program Officer
David Sharp, PhD	Maryland Health Care Commission	Director, Center for Health Information Technology and Innovative Care Delivery
Ben Steffen	Maryland Health Care Commission	Executive Director
Dee Stephens	Maryland Health Care Commission	Special Assistant to the Executive Director

E. Workgroup and Subgroup Meeting Agendas and Summaries

WORKGROUP MEETING 1 – August 4, 2021
Agenda

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 - Health - Advance Care Planning and Advance Directives Workgroup (Advance Directives Workgroup)

August 4, 2021

Meeting Agenda

- **Welcome and Introductions** – Ben Steffen, Executive Director
- **Statement and Purpose of the Workgroup** – Ben Steffen, Executive Director

  -Request from HGO

  -Goal/Objective of Workgroup

- **Overview on Advance Care Planning and Directives**

  - State Advisory Council on Quality Care at the End of Life – Summary of Council's Report to the General Assembly – Paul Ballard, Assistant Attorney, Counsel for Health Decisions Policy, Attorney General's Office

  - Review – SB837 – Health – Advance Care Planning and Advance Directives – Tracey DeShields, Director, Policy Development

- **Progress in Deploying Advance Directives**

  David Sharp, Director, Center for Health Information Technology and Innovative Care Delivery and Nicole Majewski, Chief, Health Information Technology

- **Discussion**
- **Next Steps – Next Meeting (Dates, Topics)**

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MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 - Health - Advance Care Planning and Advance Directives Workgroup (Advance Directives Workgroup)

August 4, 2021

Meeting Summary

Workgroup Participants in Attendance (29)

Mr. Matt Celentano; Mr. Jeff Zucker; Dr. Dan Morhaim; Mr. Brian Sims; Ms. Lindsay Rowe; Mr. Paul Ballard; Dr. Elizabeth Clayborne; Senator Kramer; Mr. Steve Salamon; Ms. Tiffany Callender Erbelding; Ms. Tammy Bresnahan; Mr. Ted Meyerson; Ms. Deb Rivkin; Mr. Alan Eason; Delegate Bonnie Cullison; Ms. Cathy Grason; Mr. Neal Karkhanis; Mr. Michael Paddy; and others.

MHCC Staff

Mr. Ben Steffen; Mr. David Sharp; Ms. Tracey DeShields; and, Ms. Shadae Paul

Welcome and Introductions

Mr. Steffen, Maryland Health Care Commission (MHCC) Executive Director, opened the meeting with welcome and introductions.

Statement and Purpose of the Workgroup

Mr. Steffen provided a brief overview with the purpose of the Advance Directives Workgroup. He outlined the goals and objectives of the workgroup.

Overview on Advance Care Planning and Directives

Mr. Ballard presented a summary of the State Advisory Council's report to the General Assembly. Ms. DeShields presented an overview of SB837-Advance Care Planning and Advance Directives.

Current Lay of the Land on Advance Directives

Mr. Sharp presented on the progress with deploying advance directives.

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Discussion

Distinction was made between systems, carriers, and providers (e.g. Gundersen is an integrated health care system and Kaiser is a staff model HMO).

Wrongful life suits were discussed, and a resource was provided.

The challenge of paper advance directives were discussed. Many physicians are proponents of e-records that can be uploaded to CRISP and accessible when medically necessary.

Advocates and consumers believe health care systems and insurance carriers have a key role to play in advance care planning and state recognition programs. The health systems and payers are less certain they can play a leading role.

Target population has been aged >65 years. There are opportunities to engage the younger population (aged 18-35) in discussions and utilization of advance directives.

Legislation shouldn't be the "end all, be all" solution here. Other ideas for how to promote advance directives should be explored.

MHCC Perspective
MHCC argues for a multipronged approach, the growth of patient interfaces into EHRs (patient portals) make EHR and important solution for making advance directives readily available at the point of care.

Looking Forward
There was conseneous that coordination from all stakeholders is necessary to identify the multiple best ways to support use of advance directives.

Three important questions were posed to the workgroup: What is the role of payers? What is the delivery method? And, who can serve as a data repository?

Next Steps

The next workgroup meeting will be held on September 14, 2021.

WORKGROUP MEETING 2 – September 14, 2021
Agenda

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 - Health - Advance Care Planning and Advance Directives Workgroup (Advance Directives Workgroup)

September 14, 2021

Meeting Agenda

- **Welcome and Opening Comments** – Ben Steffen, Executive Director
- **Recap of the August 4th Meeting** – Shadae Paul, Program Manager
- **Who's Paying for Advance Care Planning and Directives**
- **A Preliminary Look at the Data** – Shadae Paul and Mahi Nigatu
  - JAMA – Medicare: Are Results Promising
  - Private Insured in Maryland – Who is Paying
  - Pairing AD with Care Transformation Initiatives MDPCP or Value-Based Programs
- **Testing Ideas for Increasing Adoption of Advance Directives**

  -Elevating Standalone AD Registries and EHR Patient Portals

  -Expanding Payers' Patient Portals

  -Capturing the Name of a Healthcare Agend- Horizon Foundation

  -Via a Payer Patient Portal or Provider HER Portal

  -Open Access through CRISP and other HIEs

  Requiring Reimbursement for Advance Care Planning – Ben Steffen

  Initiatives in other States – Tracey DeShields

  -WellSpan in Pennsylvania

  -West Virginia
- **Other Options**
- **Next Steps – Next Meeting (Dates, Topics)**

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MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 - Health - Advance Care Planning and Advance Directives Workgroup (Advance Directives Workgroup)

September 14, 2021

Meeting Summary

Workgroup Participants in Attendance (37)

Mr. Alan Eason; Ms. Cathy Grason; Ms. Catherine Johannesen; Mr. Craig Behm; Delegate Bonnie Cullison; Dr. Dan Morhaim; Ms. Danna Kauffman; Mr. Glenn Schneider; Ms. Heather Shek; Mr. Kenneth Weaver; Dr. Laurence Polsky; Mr. Matthew Celentano; Mr. Michael Paddy; Ms. Pam Kasemeyer; Ms. Peggy Funk; Ms. Deborah Rivkin; Mr. Steve Salamon; Mr. Ted Meyerson; Mr. Steve Wise; Mr. Tony Ellis; Mr. Jeff Zucker; Ms. Jen Witten; Dr. Yvette Oquendo Berruz; Senator Ben Kramer; Ms. Allison Taylor; Mr. David Smulski, Ms. Tiffany Callender Erbelding; Mr. Wayne Brannock; Ms. Traci LaValle; Mr. Brian Sims; and Mr. Neal Karkhanis

MHCC Staff: Mr. Ben Steffen; Mr. David Sharp; Ms. Nicole Majewski; Mr. Oseizame Emasealu; Ms. Mahlet Nigatu; Mr. Ken Yeates-Trotman; Ms. Shadae Paul; and Ms. Tracey DeShields

Welcome and Introductions

Mr. Ben Steffen, Maryland Health Care Commission (MHCC) Executive Director, provided opening remarks

Meeting Recap

Mr. Steffen provided a summary of the August 4th Advance Directives Workgroup meeting.

Preliminary Look at the Data

Shadae Paul, Program Manager for Government Relations and Special Projects at MHCC, discussed the literature review and fielded questions from Delegate Cullison and Senator Kramer about the data and interventions presented in the articles.

- Delegate Cullison asked questions about patient responsiveness and health care provider billing for advance care planning (ACP).

- Senator Kramer asked about resources that provide guidance for moving forward on advance directives (ADs).

Ms. Paul introduced the MHCC Data Project and reviewed preliminary findings from the data analysis. Mr. Steffen and Ms. Paul responded to questions from Ms. Cathy Grason, Mr. Matt Celentano, and Delegate Cullison regarding the findings.

- Ms. Cathy Grason suggested a pivot in the analytic strategy; the assessment should explore availability not only uptake and claims (her team found over 17K claims when they conducted their analysis).

- Delegate Cullison asked about UnitedHealthcare's (UHC) volume and if UHC was doing something that encouraged utilization. Mr. Jeff Zucker reminded the group that ADVault has a contract with AARP and UHC to upload ACPs at the time, which could be the reason for the uptick in claims.

Testing Ideas for Increasing Adoption of AD – Discussion

Mr. Steffen noted that standalone registries are good; however, only a few independent AD solutions are available in the market. He further noted that there is more consumer uptake when ADs are embedded in electronic health records (EHR).

At Kaiser Permanente, patients can directly upload ACP documents to Epic. Cerner's EHR also allows users to upload ACP documents.

Questions were raised about patient knowledge and comfort with health care data sharing: Would consumers be hesitant about payers maintaining a registry of AD?

- It was noted that presently AD data doesn't go to the payer, it goes to the provider. In addition, it was mentioned that there needs to be ongoing messaging from faith leaders, payers, schools, etc. to increase knowledge and awareness about the importance completing ADs.

Discussion about legal requirements were initiated by Ms. Cathy Grason.

- Requires material about AD to be provided by the provider. It was mentioned that payers are meeting the requirements set out in law and going beyond what is required.

It was noted that CRISP can be used to access ADs.

- A question was asked whether CRISP could accept information from payers related to ADs.

- It was noted that there probably wouldn't be a difference in what exists today with ADs being uploaded to a standalone registry.

Mr. Steffen discussed payer reimbursements for ACP and fielded comments from participants.

- Delegate Cullison asked how people would feel about handing over AD to their health insurance company and she would be hesitant about having payers have advance directives.
- Dr. Morhaim mentioned that payers could just have a check off that says the individual completed an AD.
- Ms. Cathy Grason noted the law requires payers to provide information on ADs, which they make available via paper and on their website. In general, payers expressed some hesitancy about payers standing up a separate portal for capturing health care agents.

Additional Discussion

Mr. Glenn Schneider pointed out the reason we are here is because the bill is not workable as it stands. He also said that health care providers want to know a person's health care agent. Can we get more if we take out the scary parts and focus efforts on health care agents? A good place to start for patients is identifying the health care agent.

Mr. Steve Wise representing MedChi agreed with the point of focusing on capturing health care agent information.

Ms. Traci LaValle representing the Maryland Hospital Association stated that there is an advantage in starting with the health care agent because information remains stable here as opposed to starting with advance care planning and all documents.

Mr. Wayne Brannock noted he liked and believes the health care agent is important as well.

A question posed was how the health care agent information gets to the health care provider? Mr. David Sharp stated that if payer portals are used to collect consumers' health care agent, it will require payers to integrate their technical solution with the State Designated Health Information Exchange, CRISP.

Mr. Steffen observed that he hears agreement in the Workgroup on addressing the health care agent as a first step.

Next Steps

Two subgroups were established, the Technical Subgroup (led by Mr. David Sharp) and the Policy Subgroup (led by Ms. Tracey DeShields). Meeting dates and times are TBD.

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 – Health – Advance Care Planning and Advance Directives Workgroup (Technical Subgroup)

September 27, 2021

Meeting Agenda

I. Introductions

II. Purpose of the Technical Subgroup

III. HER Workflows – Vendor Perspectives

IV. Recommendations

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MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 – Health – Advance Care Planning and Advance Directives Workgroup (Technical Subgroup)

September 27, 2021

Meeting Summary

Workgroup Participants in Attendance (13)

Ms. Michelle Brough; Mr. Jeff Zucker; Ms. Tiffany Callender Erbelding; Mr. Dan Wortman; Mr. Wayne Brannock; Ms. Allison Taylor; Mr. Sean Hubber

MHCC Staff

Mr. Ben Steffen; Mr. David Sharp; Ms. Justine Springer; Ms. Nicole Majewski; Ms. Tracey DeShields; and, Ms. Shadae Paul

Welcome and Introductions

Mr. David Sharp, Director of the Center for Health Information Technology and Innovative Care Delivery at the Maryland Health Care Commission provided introductions and opening remarks. Mr. Sharp described the purpose of the subgroup and discussion topics.

Discussion

Mr. Dan Wortman from Epic discussed the current state of the workflow and the patient engagement portal. The current state has Epic exchanging information like the health care agent, code status, and scanned documents from the charts—these can be reviewed and exchanged discreetly. Patients can review documents and designate a health care agent through the MyCharts portal app on the Epic platform. When patients upload documents to the platform, it is put into a queue to be reviewed by the provider. After review it is added to the patient files. When a consumer names a health care agent or puts in an advance care plan, it is available across all systems through Care Everywhere. Effective date, expiration date,

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scanned date, and transacted dates is standard information that is included on documents. Jurisdiction is an important issue and could be a difficult to resolve, for example if an advance directive is completed in California, could it still be used in Maryland?

Ms. Michelle Brough from Cerner explained their patient portal. Their platform allows the patient to capture information discreetly and upload information. Images or paper documents can be scanned into the platform. The challenge is having pdfs scanned in because the data is fixed in the document and it is hard to extract data. Discrete data is better as long as it can be supported. Data and time stamps is standard information that included in documents when they are created and transacted; all of this is done according to national standards.

Limitations on sharing across systems was discussed. Are Epic and Cerner able to integrate with third parties? Mr. Zucker stated that ADVault is a standards-based organization; uses V2 and Fire in the US and globally. Mr. Hubber mentioned that Epic and Cerner are listed as platforms that are able to integrate with ADVault, but there needs to be follow up to see which existing customers have taken steps to set up that integration.

Data sharing was also discussed. Data sharing is possible but there needs to be assurance that the end points are decided upon and the data is reconciled. With decentralized systems, it can be difficult to make sure data moves from one place to another.

The idea of a link was shared with the technical experts and discussed as a potential solution. A link would be placed in the portal for consumers to identify a health care agent by navigating them to MyDirectives or ADVault. Ms. Brough explained that if people provide information locally, it could be used by providers. Or, the patient could provide information that gets moved to the platform that collects EHR. In the latter case, a provider would need to review patient inputs, which could increase workload for the provider. Mr. Hubber stated that a link could be added but expectations should be set for patients and providers: when the information is entered, how is it visible and how is it exchanged.

Mr. Sharp suggested that a reasonable solution would be to have a link to ADVault available by EHR vendors, which would allow consumers to input information directly. We would need to promote the link externally to health care agents. We can build on this over time but this is a start.

Ms. Callender Erbelding stated that a public information campaign would need to include providers so patients could buy in. There is potential to reimburse providers as an incentive. Mr. Brannock emphasized the importance of having information that represents the most recent patient preference in the system.

Mr. Steffen suggested focusing on getting the elder population to complete an advance directive, but Mr. Zucker respectfully disagreed stating that this approach could scare older people and deter them from engaging with the process; the topic should be normalized across age groups.

Mr. Sharp explained four recommendations that could be derived from the subgroup:

- Improve communication to consumers about the patient portal. Patient portals are a strategic way to engage patients.
- Get post-acute providers connected to CRISP. Integrate PointClickCare with CRISP so providers have necessary patient information. Reach out to and engage with the second largest vendor; CRISP will work on this.
- Promote the link among providers and patients.
- Normalize completing advance directives.

Next Steps

The Technical Subgroup will distill feedback into a comprehensive summary. The subgroup will share recommendations with the larger workgroup. A Policy Subgroup meeting will be held in the next couple of weeks.

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Advance Directives Workgroup
Policy Subgroup Meeting

October 6, 2021

Meeting Agenda

1. Review of the most likely technical option:
    - What payers/brokers will do Option 1 and Option 2
    - What health systems will do – use of EHRs
2. Will either achieved what we hope – Glenn etl al.
3. MIA prospective on payer requirements
4. Payers and health system perspectives
5. Wrap-up/Recap of consensus decision

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 - Health - Advance Care Planning and Advance Directives Workgroup (Policy Subgroup)

October 6, 2021

Meeting Summary

Workgroup Participants in Attendance (17)

Mr. Cathy Grason; Ms. Deb Rivkin; Mr. Glenn Schneider; Mr. Matt Celentano; Mr. Michael Paddy; Mr. Neil Karkhanis; Mr. Steve Salamon; Ms. Tiffany Callender Erbelding; Ms. Traci LaValle; Ms. Sarah Smith; and, Dr. Dan Morhaim

MHCC Staff

Mr. Ben Steffen; Mr. David Sharp; Ms. Justine Springer; Ms. Nicole Majewski; Ms. Tracey DeShields; and, Ms. Shadae Paul

Welcome and Introductions

Mr. Steffen, Maryland Health Care Commission (MHCC) Executive Director, opened the meeting with welcome and introductions.

Overview

Mr. Steffen provided a brief overview of the AD Workgroup and the purpose of the Policy Subgroup. The subgroup will discuss policy requirements to resolve technical issues experienced by health care providers.

Review of Technical Options

Mr. Sharp, Director of the Center for Health Information Technology and Innovative Care Delivery at MHCC, discussed technical options for collecting health care agent designations, which reviewed existing interventions in the clinical workflow, including their advantages and disadvantages:

- Brokers responsibility and legal liabilities are concerns that should be considered. Ease-of-use should also be top of mind.

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- Authenticating users is an important component—could be done outside of an application or inside of an application. Either option has implications for the authentication process.
    - The payers would have concerns about it being behind the authentication process.
    - Discussion about the format (digital, hard copy, etc.) to authenticate information.
    - Issues with asking patients, particularly seniors, to provide PII onto a digital platform.
    - Putting it behind a wall, and/or adding a referral link, adds legitimacy.
- Adding health care information in the application process—general concern that a carrier or broker agent is extracting information that would be otherwise limited to the provider.
- Legislation would have to reflect the provision of a link; providers would have to discuss this with consumers. This would have to be voluntary for consumers. Any changes in this regard would require a legislation.
- Timing is a key consideration. The workgroup has discussed the potential for carriers to do this at the point of enrollment, but that isn't the best time. The end of enrollment could be an opportunity to redirect the consumer.
    - The messaging would have to be prominent and repeated for it to be effective.

Moving Forward with Policy

Ms. DeShields led the discussion for how the subgroup can move forward with proposing policy changes.

Mr. Paddy discussed COMAR 15-122.1- Carriers have a requirement to share advance health care directive information. If they want to do it voluntarily, that would be ok.

Ms. Grason emphasized the importance of specificity as it would create uniformity.

The workgroup discussed the possibility of MDH modifying their regulations. Carriers could send out information, e.g. via a bulletin. If no modification is done, we would have to work within what exists.

Dr. Morheim supports legislation that empowers MIA to enforce policies, it should be standardized, regulated, periodic, and enforceable.

Next Steps

Consolidate feedback from the subgroup and communicate recommendations to the larger workgroup.

WORKGROUP MEETING 3 – November 4, 2021
Agenda

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 - Health - Advance Care Planning and Advance Directives Workgroup
(Advance Directives Workgroup)

November 4, 2021

Meeting Agenda

- Welcome and Opening Comments – Ben Steffen
- Recap: Technology Subgroup – David Sharp
- Recap: Policy Subgroup – Tracey DeShields
- Discussion: Rough Sketch – Ben Steffen
- Next Steps

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MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 – Health – Advance Care Planning and Advance Directives Workgroup (Advance Directives Workgroup)

November 4, 2021

Meeting Summary

Workgroup Participants in Attendance (26)

Mr. Glenn Schneider; Mr. Brian Sims; Mr. Ted Meyerson; Senator Ben Kramer; Mr. Neal Karkhanis; Mr. Tony Ellis; Mr. Larry Polsky; Dr. David Smulski; Mr. Steve Wise; Ms. Allison Taylor; Ms. Hope Morris; Mr. Michael Paddy; Mr. Jeff Zucker; Dr. Elizabeth Clayborne; Ms. Lindsay Rowe; Ms. Cathy Grason; Dr. Dan Morhaim; Ms. Deb Rivkin; Mr. Philemon Kendzierski; Ms. Tiffany Callender Erbelding; and, Ms. Pam Casemeyer

MHCC Staff

Mr. Ben Steffen; Mr. David Sharp; Ms. Tracey Deshields; Ms. Nikki Majewski; and Ms. Shadae Paul

Welcome and Introductions

Mr. Ben Steffen, Maryland Health Care Commission (MHCC) Executive Director, provided introductions and opening remarks.

Recap: Technical Subgroup

Mr. David Sharp provided a summary of the September 27th Advance Directives Subgroup meeting. The Technical Subgroup considered multiple potential workstreams. A strategy for carriers is to post a link on their website with an option to go to MyDirectives, CRISP, or another vendor within the marketplace. A strategy for providers is to advance the use of EHR for accessing and storing health care agent advance directives. Each of these solutions are in accordance with mandated standards from the Office of the National Coordinator for Health

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Information Technology (ONC). Cerner has a fragmented approach but works with health care systems within Maryland; however they are not widely deployed in all hospitals. They have agreed to do on-site education at health facilities so there is a standardized approach. In the post-acute setting, there are two vendors: Matrix Care and PointClickCare. These two vendors cover almost 89% of all post-acute care settings in Maryland. Both are certified by ONC.

Senator Kramer asked how these solutions move the ball forward with knowledge of and use of advance directives. Mr. Sharp explained these solutions create the technical infrastructure that is needed to make progress for advance directives.

Mr. Zucker emphasized the importance of having technical links for people to input advance care information but it is necessary to motivate and incentivize providers and consumers so they have the vital information they need to know about advance directives and treat patients.

Dr. Clayborne communicated the need for straight forward solutions so she has the information she needs in real time to make treatment decisions. Information needs to be up to date. From her experience, electronic platforms contain information that is more accurate than paper documents, like the MOLST form. Dr. Morhaim emphasized the need for consolidated, accurate information.

Recap: Policy Subgroup

Ms. DeShields provided a summary of the October 6th Advance Directives Subgroup meeting. The Policy Subgroup discussed potential policy changes and assessed the need for legislation. Generally, there was consensus about the need to collect information on advance care planning, but there was not consensus around needing legislation at this time.

Mr. Steffen stated there was concern from brokers and insurers about the scope of their involvement; no representatives on the call to speak from that community but it is important to consider their perspective. Senator Kramer expressed concern about including brokers in the conversation as it could be outside of the scope of the workgroup.

Dr. Clayborne communicated the need for increased public knowledge about the issue, for providers to give care that is respectful of patient needs, and for patients to maintain and updated advance directive. Mr. Sims proposed a marketing campaign to shift the culture around advance directives and to remove cultural and social stigmas.

Mr. Schneider shared progress Horizon Foundation has made on advance directives. Their foundation recently surveyed providers about their need. Many providers expressed a need to talk to someone close to the patient who could provide more detailed information than what is on a living will. Ms. Callender Erbelding added that fluidity in emergency/end of life planning deterred patients from completing an advance directive. Many patients perceived these forms as being too static, as patients might change their mind about their preferences and the form was too rigid/not able to capture their desires.

Discussion: Rough Sketch on Where We Are

Mr. Steffen facilitated the discussion on the four workgroup recommendations. Senator Kramer voiced concern about the progress the workgroup recommendations would have on increasing knowledge and use of advance directives, and communicated an intent to propose legislation in the 2022 legislative session.

Dr. Smulski stated that hospitals have a responsibility to provide services that support the public good. Hospital systems, nurses, and physicians, are well placed to support families in advance directives. All should be supportive and engaged with driving policy changes to support advance directives. Mr. Sims stated that hospitals are supportive, and emphasized the cultural shift required to get critical mass of participation across the state. Mr. Sims described the importance of health equity within the scope of advance directives.

Mr. Meyerson said it is important to communicate about this issue widely. It is important to engage with insurers and push legislation about this. Advance directives need to be normalized in the public for these efforts to work.

Next Steps

Draft recommendations will be available for further comment. The next workgroup meeting will be held on December 1, 2021. This meeting will be used to come to a final consensus on the recommendations.

MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 - Health - Advance Care Planning and Advance Directives Workgroup
(*Advance Directives Workgroup*)

December 1, 2021

Meeting Agenda

- Welcome and Opening Comments – Ben Steffen
- Discussion: Finalizing Recommendations – Ben Steffen

  1) Recommendations
  2) Description of Recommendation
  3) Limitations/Concerns

- Next Steps: Draft Report/Letter to Committees on Recommendations
  Forward to Workgroup for Comment – Tracey DeShields

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MARYLAND Health Care Commission

Andrew N. Pollak, MD, Chairman
Ben Steffen, Executive Director

Senate Bill 837 – Health – Advance Care Planning and Advance Directives Workgroup (Advance Directives Workgroup)

December 1, 2021

Meeting Summary

Workgroup Participants in Attendance (25)

Ms. Cathy Grason; Ms. April King; Mr. Brian Sims; Dr. Yvette Oquendo-Berruz; Mr. Tony Ellis; Ms. Lindsay Rowe; Mr. Wayne Brannock; Ms. Healther Shek; Mr. Ted Meyerson; Ms. Deb Rivkin; Mr. Michael Paddy; Mr. Joseph DeMattos; Mr. Jeff Zucker; Ms. Danna Kaufman; Senator Ben Kramer; Mr. Matt Celentano; Ms. Peggy Funk; Ms. Tiffany Callender Erbelding; Delegate Bonnie Cullison; Mr. Steve Wise; Mr. Larry Polsky

MHCC Staff

Mr. Ben Steffen; Mr. David Sharp; Ms. Tracey Deshields; and Ms. Shadae Paul

Welcome and Introductions

Mr. Steffen, Maryland Health Care Commission (MHCC) Executive Director provided introductions and opening remarks.

Discussion: Finalizing Recommendations

Recommendation 1

Mr. Steffen provided a summary of the recommendation.

Senator Kramer asked whether payors would want to provide a link. Mr. Steffen stated that this is something they would want to do. Mr. Celentano said that payors are required to provide information to consumers on advance directives. Ms. Grason shared the specific insurance law: IA §15-122.1, which requires carriers to provide advance directive

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information under §5-615 of Health-General Article: 1) in the carrier's member publications; 2) on the carrier's website; and 3) at the request of a member.

Delegate Cullison stated that information should be provided to payors about why advance directives are important. She asked how this gets uploaded to CRISP. Mr. Steffen clarified that payors have agreed to provide a link to a third-party site and information would be held by CRISP. Mr. Sharp stated that CRISP would provide a registry and an option for users to complete an advance directive.

Ms. Grason said the workgroup needs to be mindful of using a link due to data security. Important to nail down the details so users are comfortable using the link. Mr. Zucker said it is important to be careful which vendors are used. Vendors like ADVault exceeds those standards; vendors who don't are not recognized by the state. He thinks it is an appropriate workflow to use CRISP and a recognized vendor like ADVault.

Mr. Steffen discussed self-insured employers. A small number of the population uses these insurers. They should not be reluctant to include a link on their website. Ms. Grason stated the importance of the consumer experience. Using a single source would be easier for consumers and less confusing.

Mr. Steffen closed out the discussion; there were no changes to the recommendation. Considerations: All agree it should be behind a secure portion of the payor website. A single sign-on would be used to link users to the advance directive site without needing additional credentials. After completing the advance directive, they will be routed back to the insurer website via a secure API pathway.

Recommendation 2

Mr. Steffen provided a summary of the recommendation.

Delegate Cullison stated it is important to use all access points available. She thinks that health care practitioners are well positioned to have conversations with patients.

Mr. Sims suggested that widespread marketing, communication, and education efforts could include community health workers. Emphasized the importance of effective public messaging to increase use of advance directives.

Ms. Kaufman asked how to avoid duplication since multiple systems are being used to collect patient information. Mr. Steffen responded that since the health care system is not fully integrated, information might be collected multiple times. Duplication is possible unless

each health care provider is on the same system. CRISP could potentially de-duplicate. He noted that this is a good point but is beyond the scope of the workgroup.

Mr. Wise said they support the recommendation but it is important to keep in mind that practitioners have varying technological limitations.

Ms. Callender Erbelding, Mr. Celentano, Senator Kramer, and Mr. Zucker discussed stakeholders at the community level. Ms. Callender Erbelding stated that there are many stakeholders: faith communities, legal and financial planning, community groups, aging groups, and many more. A list can be compiled for community messaging. It is important to make sure health care information is being captured in the health care setting; this is a key consideration for community stakeholders to engage with this issue. Mr. Celentano mentioned that other agencies like MVA, nursing homes, rehab center, and brokers are key stakeholders.

Mr. Steffen closed out the discussion; there were no changes to the recommendation. There is general agreement that advance directives information should be collected at the time of patient touch using electronic patient portals, if they exist. The workgroup could look at opportunities to engage non-bill health care providers like community health workers and other community groups as they have direct knowledge of reaching specific populations of patients. There is a need to encourage providers to enable EHR to capture this information.

Recommendation 3

Mr. Sharp provided a summary of the recommendation.

Mr. DeMattos noted the varying levels of technological sophistication at facilities across Maryland. Nursing home operators and assisted living facilities aren't as connected and they are not publicly paid so getting data from these facilities could be a challenge. This recommendation is doable but there needs to be triple the communication to consumers. Small assisted living facilities need to get EHR for uptake to be widespread.

Delegate Cullison emphasized the need for open communication with assisted living facilities. Mr. Polsky said advance directives at the time of the intake process could be useful to direct families into assisted living facilities.

Mr. Steffen closed out the discussion; there were no changes to the recommendation.

Recommendation 4 (Pilot Project)

Mr. Steffen and Ms. DeShields provided a summary of the recommendation.

Mr. Zucker remarked that Maryland is at the leading edge of initiatives and discussion around advance directives. Other states are looking to Maryland as a model. The workgroup and other stakeholders are very close to resolving this issue. Normalization and awareness will fall into place. He stated that the workgroup has two legs of the stool: a safe mechanism to store data and a safe mechanism for hospitals to find it. What is missing is that people feel confident that it is worth taking time to create and upload an advance directive—this is the only thing that is missing. He applauded the progress of the workgroup.

Ben closed out the discussion; there were no changes to the recommendation.

Ms. Rivkin added that normalization is important and could be missing from the recommendations. To accomplish this, we could use flyers, commercials, leave-behinds, etc. The state has to make a commitment to provide visual and written information on advance directives.

Next Steps

A draft report will be disseminated for the workgroup to review and provide feedback. Finalized materials from the workgroup are due on January 1.

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