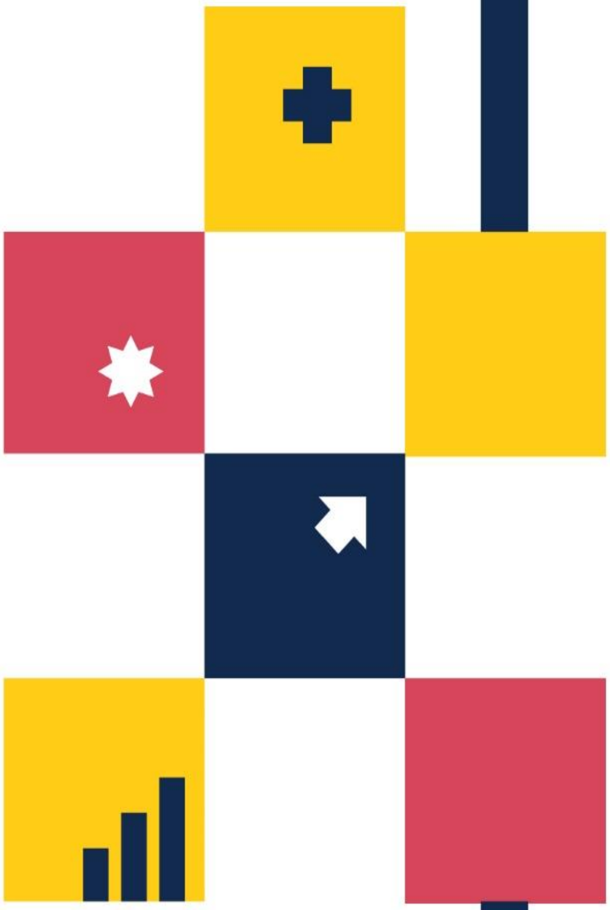
HB 378 (2022) Palliative Care Services in Maryland: Final Report



Report to the Legislature
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This report was developed on behalf of the Maryland Health Care Commission by Swain Eng and Associates, L.L.C. (dba SEA Healthcare) (www.swainengassociates.com) with data analysis assistance from Tenacity Solutions.

Executive Summary

MARYLAND LEGISLATIVE BACKGROUND

In response to HB 378 (2022 session), codified as Chapter 301, Acts of 2022, the Maryland Health Care Commission ("MHCC") assembled a Palliative Care Services Workgroup ("Workgroup") to address the requirements of the legislation to assess the state of community-based palliative care services in Maryland, and to make recommendations on issues including: collaboration, financial support, data collection, engagement strategies, and other tasks as needed. The Workgroup members agreed on the selection of the definition of "palliative care" developed by the Center to Advance Palliative Care (CAPC) for use in the statewide survey and to assess gaps in services.

STUDY APPROACH

In December 2022, MHCC issued an RFP for a contractor to fulfill House Bill 378's requirements, including the Maryland Statewide Palliative Care Survey and comparative state analyses. SEA Healthcare was competitively selected in January 2023 to conduct the study, which included data collection, analysis, and reporting on various facets of palliative care in Maryland such as service availability, provider capacity, geographical gaps, financial access, quality metrics, and recommendations for improvement.

ABOUT THIS REPORT

MHCC contracted with SEA Healthcare to develop an Interim Report[1] (July 2023) and a Final Report based on its findings from the study. The Interim Report outlines the formation of the palliative care workgroup and stakeholder involvement, procedures and methodologies for the Maryland Statewide Palliative Care Survey, a comparative analysis of palliative care in Maryland and across the United States, current trends in the field, community-based palliative care practices, and preliminary themes for recommendations.

This Final Report synthesizes a comprehensive literature review and environmental scan on palliative care programs in the U.S., with a comparative analysis of 12 states including Maryland. It provides an in-depth look at Maryland's palliative care landscape, detailing existing regulations, and covers a range of topics such as legislation, education, funding, workforce development, quality metrics, and data collection. These recommendations have

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[1] Report found at: https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pc/chcf_palliative_care_Int_rpt_july23.pdf

been reviewed by the multi-disciplinary workgroup, which includes representation from key Maryland healthcare entities. Additionally, a statewide survey was conducted to identify service gaps, program staffing, and features in palliative care services in Maryland. Key findings from this survey are integrated into the report, offering a robust picture of current palliative care provisions. Complete workgroup membership details are available in the Appendices.

MARYLAND STATEWIDE PALLIATIVE CARE SURVEY

The Maryland Statewide Palliative Care Survey presents a comprehensive analysis of palliative care practices within the state, identifying key trends, challenges, and opportunities. The final dataset comprises responses from 65 organizations, all of which meet the criteria established by CAPC for designation as a palliative care provider. While all participating organizations were required to complete the survey in its entirety, it is important to note that there were varying response rates to individual questions. This variability could potentially impact the reliability of specific findings from the survey.

TOP 10 KEY FINDINGS FROM SURVEY:

1. **Geographical Distribution**: Palliative care services are primarily located in urban areas, leaving rural counties underserved.
2. **Education Gaps**: Both the public and healthcare professionals show a lack of understanding about palliative care, signaling a need for targeted education.
3. **Financing and Payer Distribution**: Medicare and Medicaid are the main funding sources, raising questions about long-term financial sustainability.
4. **Staffing Structure**: 34 percent of organizations outsource services, leading to a diversity of staffing models and potential inconsistencies in care quality.
5. **Board Certification**: 18 percent of programs operate without board-certified staff, indicating a potential quality issue.
6. **Utilization Trends**: Hospitals have seen a 17.6 percent growth in patient numbers, while hospice programs have faced a 27.2 percent decline.
7. **Service Tenure**: A significant subset of organizations has been in operation for over a decade, suggesting stability and capacity for mentorship in the field.
8. **Predominant Conditions**: Cancer, heart disease, and dementia are the most common conditions requiring specialized care.
9. **Pediatric Care Gap**: Pediatric palliative care is significantly underrepresented, suggesting a critical need for service expansion.
10. **Telehealth Integration**: Adoption of telehealth is inconsistent, with hospitals taking the lead but leaving other facility types lagging.

These key findings provide an objective overview of the current landscape of palliative care services in Maryland.

RECOMMENDATIONS OVERVIEW

Drawing on the findings from the comprehensive literature review, statewide survey, and workgroup and stakeholder feedback, this section outlines targeted recommendations to advance the state of palliative care in Maryland. As required by the legislation, the recommendations focus on public education, provider education, financing, community-based palliative care development, palliative care quality improvement, and palliative care survey recommendation areas. The appendices of this report include pertinent legislative documents, workgroup membership, state and national palliative care legislative overviews, and a palliative care organization provider directory for further reference.

1. PUBLIC EDUCATION

1a. RECOMMENDATION*[2]: Work with state partners, including the State Advisory Council on Quality Care at End of Life, community associations/organizations, and the Maryland Department of Aging, to support the development of comprehensive evidence-based education programs aimed at promoting palliative care among healthcare providers and the general public.

1b. RECOMMENDATION: Work with the Maryland Department of Aging to assure that Maryland Access Point (MAP) and other community-based providers have knowledge of palliative care services to assure referral to appropriate community-based palliative care providers.

1c. RECOMMENDATION: Build upon the Maryland Health Care Commission's (MHCC) current public education efforts on advance directives to develop further public education initiatives focused on palliative care.

1d. RECOMMENDATION*: Seek funding to launch evidence-based public awareness campaigns to educate individuals about the benefits and importance of palliative care. Collaborate with community organizations, patient advocacy groups, and faith-

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[2] * Indicates the need for legislative action and/or funding.

based organizations to disseminate educational materials and host public forums on palliative care.

2. PROVIDER EDUCATION

2a. RECOMMENDATION*: Collaborate with the Maryland Higher Education Commission to encourage relevant academic programs, such as nursing, medicine, social work, and other programs, to include education on palliative care across all levels of education, from entry level/certificates to graduate degrees.

2b. RECOMMENDATION*: To address the current and anticipated workforce shortage and ensure adequate access to specialized palliative care services, it is recommended that policies and payment reforms be implemented to promote the growth and sustainability of the specialty palliative care workforce. Efforts could include promotion, support, and expansion of physician and advanced practice nursing fellowships, including loan forgiveness at academic institutions in the state.

2c. RECOMMENDATION*: Applicable licensing boards (e.g., Maryland Board of Nursing, Maryland Board of Examiners of Nursing Home Administrators, Maryland Board of Pharmacy, Maryland Cannabis Commission, Maryland Board of Professional Counselors and Therapists, Maryland Board of Physicians, Maryland Board of Social Work Examiners, Maryland Board of Psychologists, among others) should revise initial licensing requirements and/or continuing education courses to include education on palliative care medicine. Relevant boards should collaborate with the Maryland Higher Education Commission, and Maryland colleges, universities, and private career schools to ensure that existing programs and new programs meet revised licensing standards that include education on palliative care medicine.

3. FINANCING

3a. RECOMMENDATION*: Maryland should pursue a statewide strategy to develop financing mechanisms for palliative care services, through a Medicaid State Plan amendment, modification of the Total Cost of Care Medicare model, and other insurance mechanisms.

3b. RECOMMENDATION*: Integrate palliative care services within Maryland's Medicaid State Plan and to require Medicaid Managed Care Organizations (MCOs) to provide a palliative care benefit with defined services under their managed care contracts.

3c. RECOMMENDATION: Continue work with the National Academy for State Health Policy (NASHP) Serious Illness Institute to explore ways to fund palliative care benefits statewide. This should include an exploration of funding models used successfully in other states.

3d. RECOMMENDATION*: Review the current expansion of Maryland Program of All-Inclusive Care for the Elderly (PACE) programs for the inclusion of palliative care services as a required benefit.

4. COMMUNITY-BASED PALLIATIVE CARE DEVELOPMENT

4a. RECOMMENDATION*: A broad and funded Palliative Care Coalition, including providers, consumers, MHCC, Maryland Department of Aging, and the State Advisory Council on Quality Care at End of Life should develop a strategy for the development, promotion, and sustainability of community-based palliative care services.

4b. RECOMMENDATION*: Prioritize the expansion of home and community-based palliative care services in Maryland to improve accessibility and convenience for patients. This can be achieved by building on collaborative models, including the Maryland Primary Care Program (MDPCP) that integrate palliative care with primary care and other healthcare services, ensuring seamless coordination and holistic support for patients and their families.

4c. RECOMMENDATION: The Palliative Care Coalition (4a) should explore innovative funding models, including contracted alternative payment arrangements and financial subsidies, to provide stability and flexibility for palliative care programs.

4d. RECOMMENDATION: Encourage the expansion of Community-Based Palliative Care Programs, such as in primary care, hospices, home health and other agencies.

5. PALLIATIVE CARE QUALITY IMPROVEMENT

5a. RECOMMENDATION*: Require community-based palliative care programs to meet accreditation requirements under one of the accreditation organizations.

5b. RECOMMENDATION: MHCC should continue annual data verification to update and maintain an up-to-date Palliative Care Provider Directory in Maryland.

5c. RECOMMENDATION*: Require new and existing licensed palliative care programs to meet evidence-based requirements, including the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th Edition, or any updated edition.

6. PALLIATIVE CARE SURVEY RECOMMENDATIONS

6a. RECOMMENDATION: MHCC should streamline the Palliative Care Survey to focus on key areas of interest to reduce participant burden and to ensure that it is concise and focused on gathering essential information. Collaborate with relevant stakeholders, including healthcare professionals and survey experts, to review and refine the survey instrument. Prioritize questions that yield critical data while minimizing redundancy, thereby reducing respondent burden.

6b. RECOMMENDATION: MHCC, using its existing resources, should develop a web-based survey delivery process. Increase the number of beta testers and testing sites to identify and resolve potential technical issues before the launch of the survey. Consider other web-based survey platforms for distribution of the survey.

6c. RECOMMENDATION: Work with the Palliative Care Coalition (4a) to strengthen communication and outreach efforts to hospitals, home health agencies, nursing homes, hospices, and other community-based palliative care provider organizations before launching the survey. Collaborate with organizational leaders and stakeholders to emphasize the importance and benefits of survey participation, encouraging their support and engagement.

6d. RECOMMENDATION: MHCC should conduct Palliative Care Surveys every two (2) years. Regular surveys provide a comprehensive understanding of the evolving landscape of palliative care and enable informed decision-making based on current trends and needs.

CONCLUSION

The Final Report presents data-driven strategies for advancing palliative care in Maryland, covering crucial areas such as provider education, financing, community engagement, and quality improvement. Maryland's selection for participation in a two-year National Academy for State Health Policy Serious Illness Institute Program presents a timely opportunity to enact impactful policies in palliative care.

Although implementation will require interdisciplinary collaboration and may encounter obstacles, the anticipated benefits, such as enhanced patient outcomes and alignment with principles of patient-centered care, are significant. As strategic planning progresses through 2024 and beyond, it is vital for Maryland to maintain its commitment to palliative care improvement, thereby establishing itself as a national exemplar in delivering compassionate and high-quality care for individuals with serious illnesses.

Maryland Palliative Care Legislation

In the 2022 Maryland Legislative session, House Bill 378 was passed and codified as Chapter 301, Acts of 2022.[3] This legislation directed the Maryland Health Care Commission (MHCC) to convene a Palliative Care Services Workgroup (Workgroup) to study palliative care services and make recommendations to improve palliative care services.[4] The Workgroup studied the state of palliative care services, examined opportunities to collaborate with key stakeholders, reviewed the feasibility of financial support for palliative care services, developed a plan for ongoing data collection, and recommended engagement strategies for educating the public about palliative care. This workgroup held six meetings. Details on the meetings and handouts may be found at MHCC Palliative Care Workgroup webpage.[5]

Review of Palliative Care Services Interim Report

The July 2023 Interim Report titled "Current Status of Palliative Care Services in Maryland" offers an exhaustive analysis of the state's palliative care landscape. The report starts with a foundational overview, outlining the mission and objectives of the Palliative Care Services Workgroup. It highlights the importance of diverse stakeholder representation in the workgroup and includes both agendas and summaries of workgroup meetings. Additionally, the report delves into an in-depth examination of existing palliative care research, policies, and regulations. It also provides a thorough description of the methodologies employed in a comprehensive statewide survey on palliative care.

While highlighting the importance and benefits of palliative care, the Interim Report offers both a national overview, including federal legislation and emerging trends, and a local look at Maryland, featuring data from the Center to Advance Palliative Care (CAPC) and insights from the Coalition to Transform Advanced Care (C-TAC). The document concludes with emerging themes for recommendations from the workgroup, intending to guide and shape the future of palliative care in the state.

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[3] See Appendix A for HB 378 (2022 Legislative Session).
[4] See Appendix B for the Palliative Care Work Group Roster.
[5] MHCC Palliative Care Workgroup Website:
https://mhcc.maryland.gov/mhcc/pages/home/workgroups/workgroups_palliative_care_services.aspx

State of Palliative Care in the United States

Palliative care serves as a specialized approach designed to improve the quality of life for patients with complex health conditions or serious illnesses. Delivered by an interdisciplinary team, it addresses the unique needs of these patients by integrating several key components. Palliative care specialists allocate time for in-depth family meetings and patient counseling, promoting informed decision-making about treatment options and care plans.

Palliative care specialists streamline care coordination across various providers, ensuring seamless transitions and, as some studies suggest, potentially reducing costs through fewer hospital admissions.[6,7] Palliative care teams operating within home-based programs have not only saved Accountable Care Organizations (ACOs), health plans, and health systems as much as $12,000 per enrolled individual,[8,9] but have also decreased emergency department visits, hospital admissions, managing symptoms and enhancing communication. Such comprehensive care not only bolsters patient well-being but also alleviates family stress within the healthcare system.

The United States currently has over 12 million adults and 400,000 children diagnosed with serious illnesses like metastatic cancer and heart failure. These numbers are projected to rise sharply by 2035. [10,11] Significantly, 81 percent of the aging population have multiple chronic conditions, and they will soon outnumber traditional caregivers. Despite the 2014 "Dying in America" report's clear recommendations advocating palliative care access for those with advanced illnesses, there remains a concerning shortage of palliative care specialists.[12]

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[6] Cassel, J.B., Garrido, M., & et al. (2018). Impact of Specialist Palliative Care on Re-Admissions: A "Competing Risks" Analysis to Take Mortality into Account. *Journal Pain Symptom Management*, 55(2), 581.

[7] May, P., Normand, C., Cassel, J.B., et al. (2018). Economics of Palliative Care for Hospitalized Adults with Serious Illness: A Meta-analysis. JAMA Intern Med, 178(6), 820-829.

[8] Lustbader, D., Mudra, M., Romano, C., et al. (2016). The Impact of a Home-based Palliative Care Program in an Accountable Care Organization. Journal of Palliative Medicine, 20(1), 23-28.

[9] Krakauer, R., Spettell, C., Reisman, L., et al. (2009). Opportunities to Improve the Quality of Care for Advanced Illness. Health Affairs. 28(5).

[10] Institute of Medicine. (2003) When Children Die: Improving Palliative and End-of-Life Care for Children and Their Families. Washington, DC: The National Academies Press; doi: 10.17226/10390

[11] Vespa, J., Medina, L., & Armstrong, D.M. (2020). Demographic Turning Points for the United States: Population Projections for 2020 to 2060. Current Population Reports (P25-1144). U.S. Census Bureau.

[12] Institute of Medicine. (2015). Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life. Washington, DC: The National Academies Press. https://doi.org/10.17226/18748

Furthermore, The Commonwealth Fund's report had revealed significant care deficits for this patient population: over 20 percent reported unresponsive hospital staff or received conflicting medical advice, and 37 percent exhausted most or all their savings on health expenses even though they had health insurance.[13] Caregivers were also under immense strain. This data underscored the pressing need for healthcare reform that addresses quality, affordability, and caregiver support for those with serious illnesses.

Given the urgent challenges in healthcare, there is a compelling argument for broadening the reach of palliative care beyond its conventional inpatient setting to the wider community. By incorporating it into more familiar environments such as homes and community settings in Maryland, patients can experience an improved quality of life that aligns more closely with their care preferences.[14]

This extended scope requires a coordinated effort from palliative specialists, primary care providers (PCPs), and specialty clinicians. Together, they can offer comprehensive patient management that encompasses symptom relief, advanced planning, and emotional support.[15] Moreover, such an expansion can help bridge healthcare disparities, particularly for underserved communities facing challenges in accessing hospitals. Current trends indicate a rise in PCPs adopting palliative care principles, highlighting their crucial role in catering to the holistic needs of seriously ill patients within the community.[16,17]

Leveraging this growing trend, community settings are reshaping the palliative care landscape to include locations such as office practices, medical clinics, long-term care facilities, and patients' residences. Research consistently highlights the benefits of community-based palliative care, including fewer hospital visits, reduced acute care costs, and an overall enhancement in the quality of life.

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[13] The Commonwealth Fund, The New York Times, Harvard T.H. Chan School of Public Health. (2018) Being seriously ill in America today. Retrieved from: https://www.hsph.harvard.edu/wp-content/uploads/sites/94/2018/10/CMWF-NYT-HSPH-Seriously-Ill-Poll-Report.pdf

[14] Reymond, L., Parker, G., Gilles, L., & Cooper, K. (2018). Home-based palliative care. *Australian Journal of General Practice*, 47(11), 747–752. https://doi.org/10.31128/AJGP-06-18-4607

[15] Mayeda, D. P., & Ward, K. T. (2019). Methods for overcoming barriers in palliative care for ethnic/racial minorities: a systematic review. *Palliative & Supportive Care*, 17(6), 697–706. https://doi.org/10.1017/S1478951519000403

[16] Roth, A. R., & Canedo, A. R. (2019). Introduction to Hospice and Palliative Care. *Primary Care*, 46(3), 287–302. https://doi.org/10.1016/j.pop.2019.04.001

[17] California Health Foundation. (2017). Weaving Palliative Care into Primary Care: A Guide for Community Health Centers. Retrieved June 1, 2023, from https://www.chcf.org/wp-content/uploads/2017/12/PDF-WeavingPalliativeCarePrimaryCare.pdf

A noteworthy endeavor in this direction was the three-year project in 2016 CAPC aimed at identifying community palliative care programs nationwide.[18] Their survey results revealed a diverse group of care providers, with hospitals and hospices at the forefront. The findings also indicated that a considerable portion of these programs delivered in-home care, and nearly half extended their services to office or clinical environments. However, most of these programs catered to adults, with only a limited emphasis on pediatric palliative care.

Beyond the nature and settings of these programs, the financial frameworks and quality paradigms underpinning palliative care have also undergone transformative changes. Quality improvement and value-based payment models have risen to prominence in palliative care, representing a crucial pivot from traditional fee-for-service approaches which often inadequately supported home-based care. These models emphasize the continuous enhancement of care services, aligning patient care with individual needs and preferences. Furthermore, they reward healthcare providers for achieving better patient outcomes rather than the volume of services rendered.

The shift from volume-based to value-based care has brought the significance of palliative care into sharper focus. Palliative care has consistently achieved key objectives such as enhanced quality, improved patient experience, and efficient resource utilization. It is noteworthy to highlight that of the top five percent of individuals who frequently utilize healthcare services, only 11 percent are in their final year of life. Yet, strikingly, 40 percent of this group consistently demonstrate high healthcare utilization each year, suggesting that there are patients with chronic or severe conditions that require continual care, not necessarily related to end-of-life situations.[19] By integrating quality improvement and value-based payment models into palliative care, healthcare organizations can fine-tune patient outcomes and resource use. This ensures individuals with serious illnesses receive care that augments their overall well-being.

While the value and effectiveness of palliative care are clear, national efforts are continually refining its delivery to ensure consistent and high-quality care across care settings. Several national healthcare initiatives are passionately committed to boosting the quality of palliative care. This reflects a consolidated effort among diverse organizations to

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[18] CAPC. (2019) Mapping Community Palliative Care-A Snapshot. Retrieved May 26, 2023, from: http://capc.org/documents/download/700/

[19] Aldridge, M. D., & Kelley, A. S. (2015). The Myth Regarding the High Cost of End-of-Life Care. *American Journal of Public Health*, 105(12), 2411–2415. https://doi.org/10.2105/AJPH.2015.302889

establish standardized measures, advocate for evidence-based practices, and equip professionals with tools for all-encompassing care.

Central to these efforts is the National Consensus Project (NCP) Clinical Practice Guidelines for Palliative Care.[20,21] These guidelines stress the importance of measuring palliative care quality and aim to improve access to consistently high-quality care for all individuals with serious illnesses, offering a structured framework and evidence-based processes for its provision across settings.

Concurrently, recent projects such as the American Academy of Hospice and Palliative Medicine's development of patient-reported measures and the National Quality Forum's review of performance measures further underscore the necessity for comprehensive and flexible metrics in palliative care, emphasizing patient preferences and family involvement. [22,23]

Building upon these advancements in measuring and improving palliative care quality, the organizational structure and strategies of healthcare entities also play a pivotal role. ACOs, which focus on enhancing care quality while ensuring cost-effectiveness, increasingly incorporate palliative care, especially advanced care planning (ACP). ACP engages patients in discussions about their future medical care, ensuring that their choices are respected in complex situations. Medicare data suggests that a mere 2.8 percent of beneficiaries engage in ACP discussions, indicating a vast scope for improvement.[24] For a review of federal legislation on palliative care, see Appendix D.

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[20] CAPC. (2023) Palliative Care Definition | What is Palliative Care | Center to Advance Palliative Care (capc.org) Retrieved from: https://www.capc.org/about/palliative-care/

[21] National Consensus Project for Quality Palliative Care. (2018). Clinical Practice Guidelines for Quality Palliative Care, 4th edition. National Coalition for Hospice and Palliative Care. https://www.nationalcoalitionhpc.org/ncp

[22] Ahluwalia, S. C., Vegetabile, B. G., Edelen, M. O., Setodji, C. M., Rodriguez, A., Scherling, A., Phillips, J., et al. (2021). New Patient-Centered Quality Measures for Office-Based Palliative Care. RAND Corporation. https://www.rand.org/pubs/research_briefs/RBA400-1.html

[23] National Quality Forum (2016) Palliative and End-of-Life Care 2015-2016. Technical Report. https://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=84242

[24] He, F., Gasdaska, A., Friedman, H., Wedehas, B., Kirk, A., Broyles, I., & Karon, S. L. (2020). Advance Care Planning Among Medicare Fee-For-Service Beneficiaries and Practitioners: Final Report. RTI International. Retrieved from https://aspe.hhs.gov/reports/advance-care-planning-among-medicare-fee-service-beneficiaries-practitioners-final-report-0#execsum

Comparison of State Palliative Care Programs

State-led health reforms increasingly emphasize the integration of comprehensive care for patients with serious illnesses. According to the latest data available from 2019 CAPC State-by-State Report Card, the presence of palliative care teams in hospitals with fifty or more beds has increased nationally to 72 percent. This represents a notable rise from 67 percent in 2015 and a significant growth compared to only 7 percent in 2001. These hospitals now cater to 87 percent of all patients admitted to hospitals in the United States, showing an increase from 82 percent in 2015. Ninety-four percent of U.S. hospitals with more than 300 beds now have a palliative care team, compared to 62 percent of hospitals with 50 to 299 beds.

However, regional disparities persist, with the highest concentration of palliative care teams observed in New England and the lowest in the south-central states. Notably, large nonprofit hospitals located in urban centers continue to be the primary institutions offering access to palliative care teams. Palliative care access in rural America continues to be restricted, with the majority of palliative care services concentrated in urban areas. A staggering 90 percent of hospitals offering palliative care are in urban settings, while only 17 percent of rural hospitals with 50 or more beds have reported the presence of palliative care programs.

Presented here are tables summarizing palliative care practices across 12 states, capturing developments in legislation, education, workforce, and data collection. This aggregated data serves as an authoritative reference for understanding regional palliative care nuances.[25]

By the close of 2022, legislation was enacted in eighteen states to establish education programs aimed at promoting palliative care among healthcare providers and the general public. These programs play a crucial role in raising awareness about the benefits and importance of palliative care, ensuring that healthcare professionals have the necessary knowledge and skills to deliver high-quality care, and empowering individuals to make informed decisions about their healthcare options. The legislative measures taken by these states emphasized the acknowledged significance of palliative care in advancing patient outcomes and overall care excellence.

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[25] For a detailed state by state breakdown of palliative care programs in 12 states see Appendix E.

Palliative Care Funding Models

The provision and financing of palliative care are influenced by a myriad of factors. While some factors, like patient demographics and regional characteristics, remain constant, policies, preferences, and practices, particularly of payers and providers, are modifiable and greatly influence the cost structure of palliative care services.

A recent survey by CAPC (May 2023) indicated that the predominant funding source for palliative care remains fee-for-service billing, accounting for 86 percent of programs surveyed.[26] Concurrently, 21 percent of these programs have embraced alternative payment models, such as bundled payments. Notably, financial backing from parent organizations and philanthropic efforts are pivotal, with half of the programs identifying these as possible key funding sources.

The **Medicaid 1915(c) Home and Community-Based Services (HCBS) waivers** provide personalized care to specific groups, especially older adults, and those with disabilities.[27] By 2022, over 300 such waivers were operational across various states. By leveraging HCBS waivers, states like Maryland can offer tailored palliative care services to these targeted populations, ensuring personalized care aligned with individual needs.[28]

Medicaid Managed Care is increasingly becoming an essential model in Medicaid service delivery. By July 2022, 41 states, including Maryland, have adopted Capitated Managed Care Models.[29] However, the inclusion of palliative care specialists within Medicaid Managed Care Organizations (MCO) networks varies among states. There is an opportunity for Maryland to strengthen its palliative care delivery by incentivizing the inclusion of these specialists.

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[26] CAPC and PCQC. Report-Spotlight on Home-based Palliative Care. Retrieved June 30, 2023, from: https://capc.org/documents/download/1100/.

[27] Medicaid. (2023) Home & Community-Based Services 1915(c). https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html

[28] NASHP (2023). How States Can Embed Palliative Care in Health Care Reform. Retrieved June 12, 2023 from: https://eadn-wc03-8290287.nxedge.io/wp-content/uploads/2023/03/NASHP_Palliative-Care-Health-Initiatives-HT-Fact-Sheet_FINAL.pdf

[29] Hinton, E. & Raphael, J. Kaiser Family Foundation-10 Things to Know About Medicaid Management Care. Brief. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/

Medicaid Managed Long-term Services and Supports (MLTSS) provide managed care plans that emphasize long-term services and support. These plans help in enhancing coordination of long-term care services. As of 2022, 23 states have adopted MLTSS programs specifically tailored for older adults and adults with physical disabilities.[30]

Dual-Eligible Special Needs Plans (D-SNPs) target individuals who qualify for both Medicare and Medicaid. As of January 2023, 45 states, including Maryland, have embraced D-SNPs.[31] This model promotes integrated healthcare services for dual-eligible beneficiaries, thereby ensuring efficient coordination between Medicaid and Medicare services.

The **Patient-Centered Medical Home (PCMH)** model promotes coordinated care with a primary care physician at its center.[32] By state fiscal year 2023, Maryland, along with 23 other states, had implemented the PCMH model for its Medicaid beneficiaries, suggesting its broad acceptance and its effectiveness in offering integrated care.[33]

Lastly, the **Medicaid Health Homes program** focuses on providing team-based care for Medicaid beneficiaries with chronic conditions.[34] This approach ensures comprehensive care coordination, case management, and the integration of both behavioral and physical health services. By focusing on holistic and coordinated care, the Health Homes program offers a promising avenue for enhanced patient outcomes.

In summary, while costs associated with delivering palliative care are influenced by an array of factors, there are several financing and service delivery models available to states. Maryland, among other states, has several avenues to enhance its palliative care provision,

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[30] National Academy for State Health policy (2022) States cover respite care and adult day services in Medicaid Managed Long-Term Services and Supports. State Tracker 8-23-2022. https://nashp.org/states-cover-respite-care-and-adult-day-services-in-medicaid-managed-long-term-services-and-supports-mltss/

[31] Centers for Medicare & Medicaid Services. (2023) Special Needs Plan Comprehensive Report. https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/mcradvpartdenroldata/special/1703042516/snp-comprehensive-report-2023-08

[32] The Working Party Group on Integrated Behavioral Healthcare, Baird, M., Blount, A., Brungardt, S., Dickinson, P., Dietrich, A., Epperly, T., Green, et al. (2014). Joint principles: integrating behavioral health care into the patient-centered medical home. *The Annals of Family Medicine*, 12(2), 183-185. https://www.annfammed.org/content/annalsfm/12/2/183.2.full.pdf

[33] Kaiser Family Foundation (2023) States that reported Patient Centered Medical Homes in Place. SFY 2015-SFY 2023. https://www.kff.org/medicaid/state-indicator/states-that-reported-patient-centered-medical-homes-in-place/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[34] Medicaid. (2023) Health Homes. Retrieved September 6, 2023: https://www.medicaid.gov/medicaid/long-term-services-supports/health-homes/index.html

ranging from Medicaid waivers to managed care models, each offering unique opportunities to better serve its residents.

Evolving Landscape of Palliative Care in Maryland: From Hospital-Centric Models to Community-Based Approaches

In 2015, the Maryland Health Care Commission (MHCC) conducted a study of palliative care services in Maryland's acute general hospitals, pursuant to legislative directives.[35] Data was collected from 11 hospitals across the state, and recommendations were subsequently formulated, informed by standards from the CAPC and the National Quality Forum (NQF). A total of 37 best practices were recommended in the final report, with 30 of these identified as minimum standards for providing palliative care services.[36]

In response to the Survey's findings, Maryland developed regulations, requiring that hospitals with 50 beds or more implement a palliative care program. Defined by regulations (COMAR 10.07.01.31), this care emphasizes providing palliative services to enhance the quality of life for individuals with serious illnesses, ensuring symptom relief regardless of the disease stage. Beyond pain management, the interdisciplinary palliative care teams provide education, as well as psychological and spiritual support, while maintaining a commitment to honor advance directives.

Success in the hospital environment is evidenced by Maryland's 'A' grade in the 2019 CAPC Report. [37] This grade is particularly significant for larger hospitals: 100 percent of Maryland hospitals with 300 or more beds provide palliative care services, outperforming both the South-Atlantic Region and national averages. Despite this success in the hospital setting, smaller hospitals with fewer than 50 beds faced challenges due to limited resources. The

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[35] Maryland Health Care Commission (2015) Maryland Hospital Palliative Care Programs: Analysis and Recommendations. Retrieved from: https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pcp/chcf_palliative_care_final_report_20151201.pdf

[36] Maryland Hospital Palliative Care Programs: Analysis and Recommendations report also found in Appendix C.

[37] Center to Advance Palliative Care analysis. (2019) 2019 State-by-State Report Card on Access to Palliative Care in Our Nation's Hospitals for additional details on data sources and methods for hospital palliative care. Retrieved June 5, 2023, from: https://reportcard.capc.org

grading criteria excluded hospitals with less than 50 beds and were based on the percentage of hospitals with palliative care.[38]

Expanding the lens to community-based palliative care, the hospital-focused regulations have implications for the broader healthcare landscape. The Coalition to Transform Advanced Care (C-TAC) has introduced the Advanced Care Transformation (ACT) Index. The ACT index serves as a complementary metric system, offering an expansive evaluation of palliative care quality that extends beyond the hospital environment.[39] This evidence-based tool serves to evaluate the quality of care for patients with serious illnesses. The ACT Index adds an additional set of 27 metrics across four domains that can be juxtaposed with the CAPC's assessments, offering a broader perspective on the quality of palliative care experiences, and aiding in identifying areas for improvement. Maryland's 34th ranking in the 2022 ACT Index Report underscores the need to improve care delivery across multiple settings, including community-based services.

The integration of insights from both the CAPC and ACT Index reports can guide the refinement of palliative care services, emphasizing the importance of a seamless transition between hospital-based and community-based palliative care to optimize patient outcomes. Maryland’s selection as one of six states chosen in 2023 for the State Policy Institute to Improve Care for People with Serious Illness, led by the National Academy for State Health Policy (NASHP) and The John A. Hartford Foundation, will provide Maryland with expert technical assistance for serious illness and palliative care policy, including actuarial modeling for Medicaid palliative care benefits.[40]

While Maryland has made strides in updating regulations for hospital-based palliative care, a more comprehensive assessment of community-based palliative care remains largely unexplored and is a central focus of current legislation. Emerging trends indicate an expansion of the palliative care scope beyond traditional hospice and end-of-life settings. Factors such as the integration of palliative care into primary healthcare models, advancements in telemedicine, and an increased emphasis on patient and family-centered

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[38] National Consensus Project for Quality Palliative Care. (2018) Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; Retrieved January 31, 2023, from: https://www.nationalcoalitionhpc.org/ncp

[39] Coalition to Transform Advanced Care (2022). Advanced Care Transformation Report 2022. Retrieved June 1, 2023, from: https://thectac.org/wp-content/uploads/2022/10/CTAC-2022_act-index-print-version.pdf

[40] National Academy for State Health Policy (2023) Six states selected to participate in NASHP’s State Policy Institute to Improve Care for People with Serious Illness. Blog post. Retrieved from: https://nashp.org/six-states-selected-to-participate-in-nashps-state-policy-institute-to-improve-care-for-people-with-serious-illness/

approaches are contributing to this paradigm shift. Additionally, the growing focus on multidisciplinary, team-based care, incorporating roles like physicians, nurses, and social workers, supports the ongoing evolution and potential scalability of palliative care services. Collectively, these factors not only signify palliative care's ongoing evolution but also point to its potential for scalability and adaptability across community-based care settings.

MHCC's Statewide Palliative Care Study

The MHCC issued a Request for Proposals in December 2022 to obtain a contractor to assist with the requirements of House Bill 378, including conducting a statewide palliative care survey and assessment of states' efforts on improving the delivery and financing of palliative care services. In January 2023, Swain Eng and Associates, LLC (dba SEA Healthcare[41]) was competitively selected to complete the study. The study included collection, analysis and reporting of data focused on the current status of palliative care services offered in the state, the capacity of palliative care providers to provide services, geographic areas where significant gaps in palliative care services may exist, financial accessibility to palliative care services, quality and performance measures and recommendations for additional data and work to support palliative care services.

The MHCC convened a Palliative Care Services Workgroup to study palliative care services and make recommendations to improve palliative care services. The workgroup was charged with studying the state of palliative care services; examining opportunities to collaborate with key stakeholders; reviewing the feasibility of financial support for palliative care services; developing a plan for ongoing data collection; and recommending engagement strategies for educating the public about palliative care.

Selection of Palliative Care Definition and Settings

One initial priority for the Palliative Care Services Workgroup was to reach a consensus on the definition of palliative care. Recognizing that a unified understanding was crucial before beginning the study and administering a statewide survey, the group unanimously adopted the definition formulated by the CAPC.[42]

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[41] SEA Healthcare is health services research and quality improvement consulting firm dedicated to making a positive impact on healthcare quality, data interoperability, policy, and health services research. More information is available here: www.swainengassociates.com

[42] Center to Advance Palliative Care (2022) What is Palliative Care? Retrieved from: https://www.capc.org/about/palliative-care/

“Palliative Care is specialized medical care for people living with serious illness. This type of care is focused on providing relief from the symptoms and stress of illness. The goal is to improve quality of life for both the patient and family. Palliative care is provided by a specially trained team of doctors, nurses, and other specialists who work together with a patient’s other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient’s prognosis. It is appropriate at any age and any stage of a serious illness, and it can be provided along with curative treatment.” -CAPC

Overview of the Maryland Statewide Palliative Care Survey

As part of its work in response to HB 378, MHCC conducted a survey, Maryland Statewide Palliative Care Survey (Survey), designed to provide insights into the state of palliative care services across Maryland.

Survey Methodology

The survey methodology was adapted from an existing Colorado telephone-based palliative care services survey for web-based deployment. Through collaborative efforts with the Palliative Care Services Workgroup and other key stakeholders, beta testing was conducted to fine-tune the survey instrument. Survey responses were collected from Maryland healthcare provider organizations including hospitals, nursing homes, hospices, and home health agencies.

Data collection spanned from February 22 to April 30, 2023, utilizing multiple techniques to optimize the response rate. After the data was collated, a rigorous data cleaning process was employed to ensure the inclusion of only eligible and complete responses. The data gathered was then analyzed to identify discrepancies in palliative care service provisions, encompassing aspects like geographical and financial accessibility, and staffing resources. The survey findings were subsequently integrated into this report and contributed to the establishment of a Maryland Palliative Care Provider Directory, designed as a resource for both professionals and the general public.

Survey Methodology Limitations

The 2023 Palliative Care Survey in Maryland encountered certain limitations that affected its response rate and participation. These limitations primarily revolved around the length and burden of the survey, technical issues related to email delivery, and challenges in engaging organizational staff.

1. Length and Burden of the Survey: Respondents found the survey lengthy and burdensome, potentially reducing their willingness to complete it. The comprehensive nature of the survey may have contributed to survey fatigue and time constraints, resulting in incomplete responses.

2. Technical Issues with Email Delivery: Technical problems, such as spam filters and emails being directed to junk folders, hindered participants from receiving and accessing survey invitations. Additionally, organizational firewalls and security measures posed challenges, blocking survey invitations and impeding participants' ability to engage with the survey.

3. Challenges in Engaging Organizational Staff: Difficulties were encountered in reaching and engaging organizational staff members who were intended survey recipients. Despite multiple email and phone communication attempts, some staff members did not respond, leading to incomplete surveys and lower participation rates.

4. Limited Responses Implications: The number of survey responders was limited, which raises concerns about the generalizability of the findings. It is important to exercise caution when interpreting the results, as they may not fully represent the diversity and breadth of the palliative care landscape. Therefore, further research with a larger sample size is recommended to obtain a more comprehensive understanding of the financial aspects of palliative care services across different settings and regions.

Survey Results

The Maryland Statewide Palliative Care Survey results provide a comprehensive insight into the evolving landscape of palliative care services, offering a detailed assessment of trends, challenges, and opportunities in the state within the specific timeframe of the study (2021-2023).

The following Table 1 provides an overview of both the initial sample size and the rate of participation in the survey. Organizations were directed to self-identify if they met the CAPC definition for providing palliative care services. Of the organizations that responded, 72 indicated that they did not align with the CAPC definition, thus refining the final dataset to data from 65 distinct organizations that qualified for comprehensive analysis.

Although every survey question was required, there was variability in responses to individual questions across organizations. This resulted in fluctuating numbers of respondents for different questions and a noticeable decline in participation toward the survey's conclusion. Consequently, the number of responses (N) varies by question, making it challenging to draw definitive conclusions, especially in instances of low response rates such as home health agencies represented by a single respondent.

Table 1. Palliative Care Survey Response Rates by Facility Type

Data Analysis Inclusion by Facility Type							
	Total Invited	Response Rate (of total invited)		Responses Included (of total invited)		Responses Excluded (of total invited)	
Facility Type	#	#	Percent %	#	%	#	Percent %
Home Health Agency	56	30	54%	1	2%	29	51%
Hospice	27	24	89%	12	44%	12	44%
Hospital	46	26	57%	22	48%	4	9%
Nursing Home/ Skilled Rehabilitation	227	102	45%	30	13%	72	31%
Grand Total	356	182	51%	65	18%	117	33%

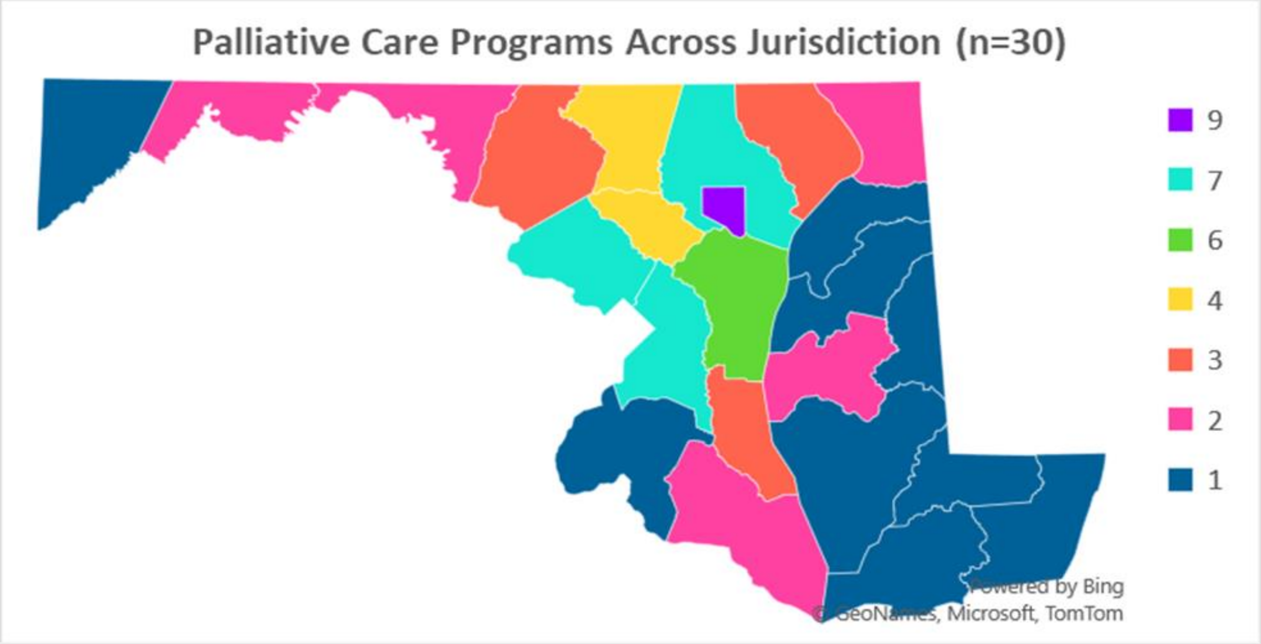
Palliative Care Services Distribution Across Maryland:
Maryland's palliative care programs are largely concentrated in the most populous jurisdictions including Baltimore City, Baltimore County, Montgomery County, and Prince George's County, each having seven or more programs. Anne Arundel, Carroll, Howard, and Calvert counties also show a robust presence with three to six programs each. In contrast, rural counties tend to have fewer available palliative care services, indicating a potential area for concentrated efforts to close these service gaps. Table 2 below presents the distribution of palliative care services by facility type and region.

Table 2. Palliative Care Survey Respondents by Facility Type and Region[43] of Maryland

Region Facility Types	Montgomery	Central	Eastern Shore	Southern	Western	Grand Total
Home Health Agency	0	1	0	0	0	**1**
Hospice Program	1	4	3	2	2	**12**
Hospital	4	12	0	2	4	**22**
Nursing Home or Skilled Rehab Facility	6	15	1	2	6	**30**
Grand Total	**11**	**32**	**4**	**6**	**12**	**65**

Map 1 illustrates a color-coded representation of the geographical distribution of palliative care programs within Maryland's jurisdictions, highlighting a greater concentration of programs in urban areas.

Map 1. Distribution of Palliative Care Programs by Jurisdiction Among Survey Respondents



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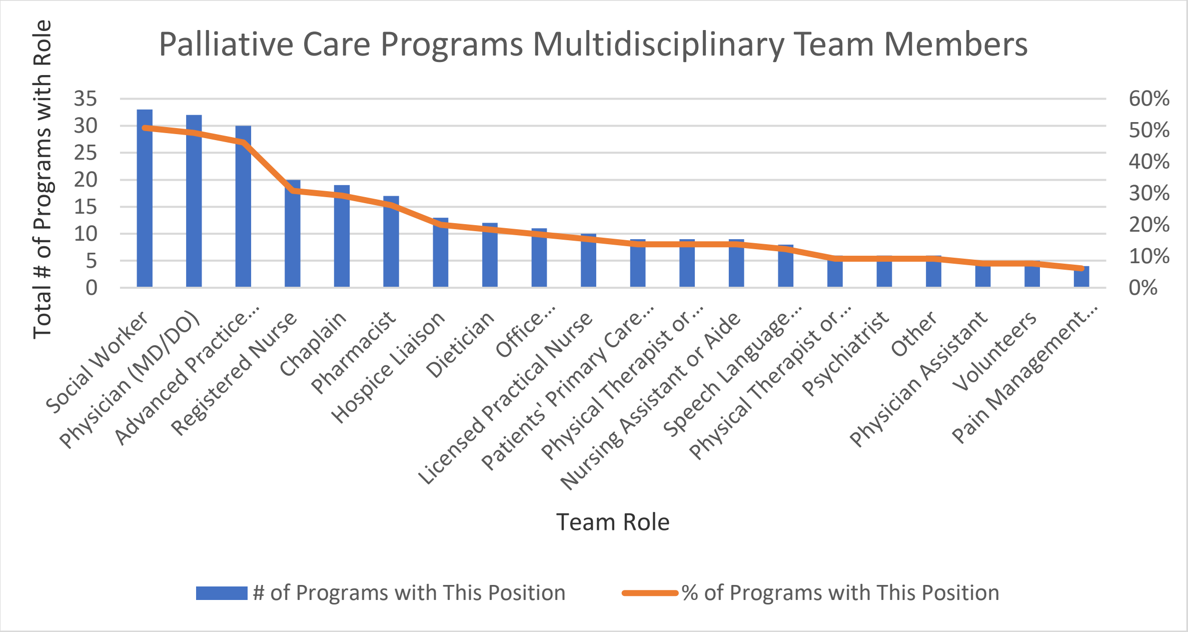
[43] Regions of Maryland: Montgomery (Montgomery), Central (Anne Arundel, Baltimore City, Baltimore County, Harford, Howard), Eastern Shore (Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, Worcester), Southern (Calvert, Charles, Prince George's, St. Mary's), and Western (Allegany, Carroll, Frederick, Garrett, Washington).

Palliative Care Staffing:

The survey results indicated a varied management structure among the 65 responding organizations. Specifically, 34 percent contracted out their services, while 25 percent managed their services in-house. In terms of the composition of multidisciplinary palliative care teams, approximately 50 percent integrated physicians, social workers, and Advanced Practice Nurses or Nurse Practitioners. An additional 30 percent also included RNs, chaplains, and pharmacists. Notably, fewer than 25 percent of the programs incorporated roles such as hospice liaisons, LPNs, physical therapists, psychiatrists, and pain management providers. (N=65)

The following Chart 1 illustrates the composition of multidisciplinary teams across palliative care programs, showcasing the prevalence of diverse types of providers, ranging from physicians to volunteers.

Chart 1. Provider Composition Across Palliative Care Program Respondents



Service Tenure:

Among Survey respondents, organizations displayed a diverse range in their years of operation from less than one year to ten years or longer. Notably, sixteen (16) organizations were operational for a decade or more, marking their extensive experience, stability, and potential role as mentors in the field. (N=65)

Board Certification:
The presence of board-certified professionals emerged as a critical metric of quality. Among the 34 programs that responded to this query, a noteworthy 27 programs reported having staff who were board-certified or had received specialized training in hospice and palliative care. Conversely, six programs indicated the absence of certified personnel. (N=34)

Palliative Care Consultations and Services Availability:
Of the 29 palliative care programs that responded to relevant survey questions, 26/29 (89 percent) offer dedicated consultation services. The availability of these services varies by facility type: 59 percent in hospitals, 27 percent in nursing homes or skilled rehabilitation facilities, 33 percent in hospice programs, and 100 percent in home health programs.

Regarding service availability hours, most respondents operate during standard business hours from Monday to Friday. However, ten programs offer uninterrupted palliative care services seven days a week and two programs offer continuous services only on weekdays. Lastly, four respondents had varied service hours, highlighting areas that may warrant further investigation. (N=29)

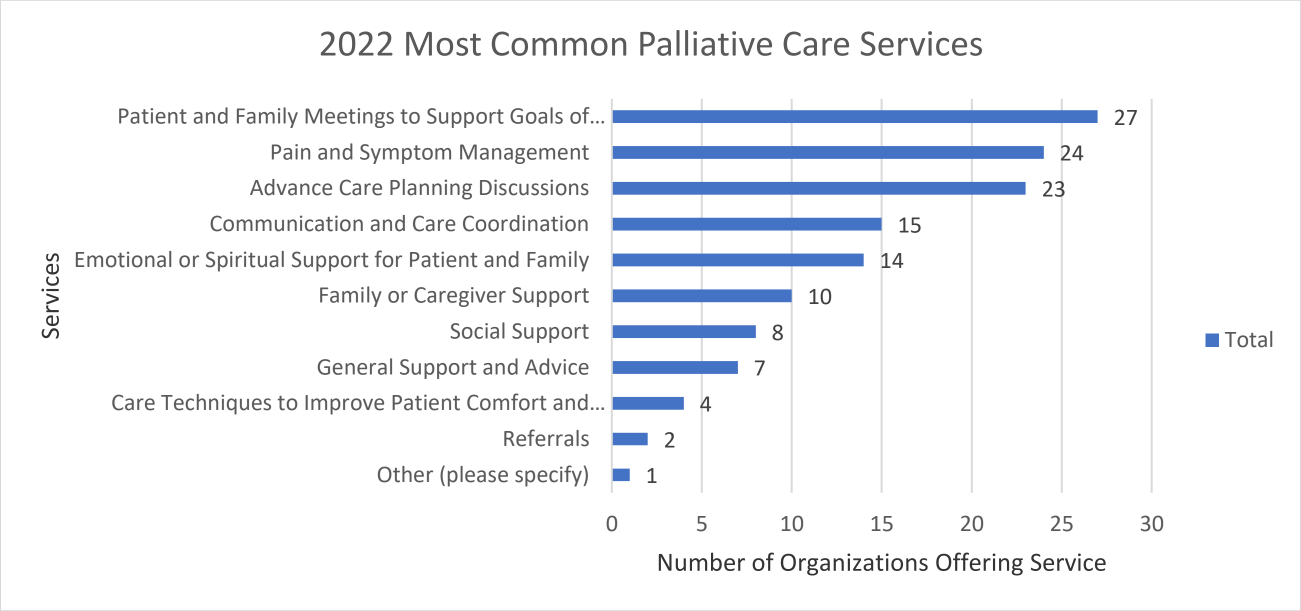
From 2021 to 2022, there was an increase in the number of patients receiving palliative care services in hospitals and home health settings, a decrease in hospice programs, and a slight increase in nursing homes. Overall, there was a net increase of 408 patients receiving palliative care services year-over-year. Table 3 below provides a comparative analysis of the number of patients receiving palliative care services in the years 2021 and 2022, disaggregated by facility type.

Table 3. Year-over-Year Trends in Palliative Care Patient Volumes: 2021 vs. 2022

Facility Type	Patients Receiving Services in 2021	Patients Receiving Services in 2022	Change between 2021 and 2022
Home Health	800	1000	200
Hospice Program	5960	4340	-1620
Hospital	10267	12072	1805
Nursing Home or Skilled Rehabilitation Facility	860	883	23
Grand Total	**17887**	**18295**	**408**

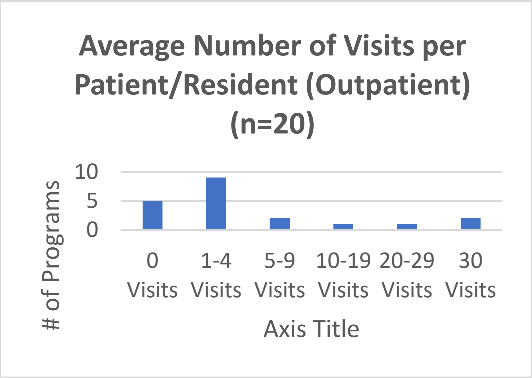
Core Palliative Care Services Offerings in 2022:
In an evaluation of the most frequent palliative care services provided in 2022, all responding 27 organizations indicated providing patient and family meetings, pain and symptom management, and advance care planning discussions. Additional services included communication and care coordination, reported by 15 respondents; emotional or spiritual support, cited by 14; and family or caregiver support, mentioned by 10. Other services such as social support and referrals were less commonly provided. (N=27). Chart 2 below provides a visual representation of the range of palliative care services offered to patients and residents in 2022, as reported by survey respondents.

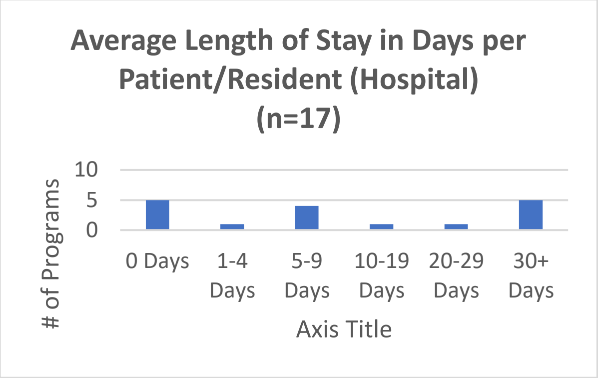
Chart 2. Most Frequent Palliative Care Services Provided to Patients/Residents in 2022



The survey respondents provided insights into the frequency and length of palliative care services provided to patients/residents.

Chart 3. Average Outpatient Visits and Hospital Days Patients Received Palliative Care Services in 2022

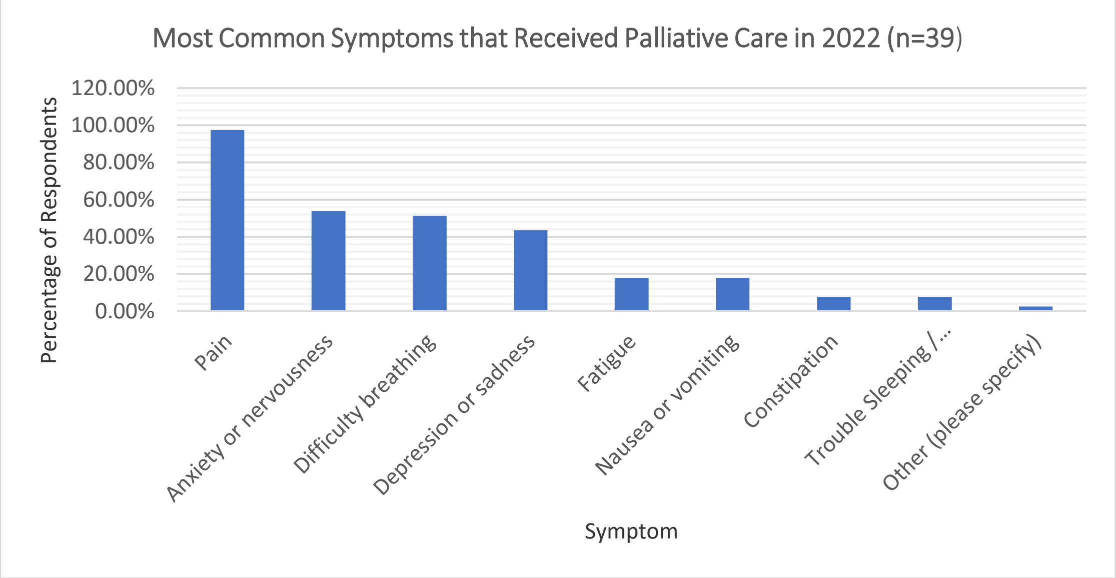




Prevalent Conditions and Symptomatic Interventions in Palliative Care in 2022:
In 2022, cancer was the most frequently reported condition for which patients received palliative care, cited by 36 programs. It was closely followed by heart disease and dementia, reported by 87 percent and 77 percent of facilities, respectively. Additional conditions such as stroke, lung disease, and kidney failure were also notably prevalent. Less commonly reported conditions like cystic fibrosis and Parkinson's disease were also included, indicating the adaptability of palliative care to diverse medical needs (N=39).

Regarding symptomatic interventions, pain management was nearly universal, reported by 97 percent of programs. Other symptoms targeted varied by facility type: hospices often addressed nausea, depression, and fatigue; hospitals primarily managed anxiety, respiratory difficulties, and pain; and nursing homes focused on depression, anxiety, and pain. The data suggest specialized approaches to symptom management across different types of facilities, thus meeting the unique requirements of their patient populations (N=39).

Chart 4. Most Common Symptoms for which Palliative Care was Offered in 2022 by Survey Respondents.



Pediatric Palliative Care:

Pediatric palliative care, essential for addressing the unique needs of children with life-limiting conditions, was notably underrepresented in the 2022 survey. Among the organizations surveyed, only one provided care to a small group of 6-10 pediatric patients, while the majority reported no pediatric palliative care services. This highlighted a potential service gap and underscored a potential growth area for healthcare services.

Family and Caregiver Support in Palliative Care Programs:

Based on 2022 data from 26 palliative care programs, there is a strong recognition of the critical role played by families and caregivers. The service structure was designed to be inclusive, with 40 percent of services focused solely on patients, 44 percent involving both patients and their families or caregivers, and 16 percent catered specifically to families and caregivers. (N=26)

Services spanned a wide array of offerings, going beyond patient-centric options like symptom management and end-of-life discussions. They included advance care planning, illness education, emotional and spiritual support, and referrals to community services, among others. This multi-dimensional approach aims to offer comprehensive support to families and caregivers, recognizing their integral role in the palliative care process.

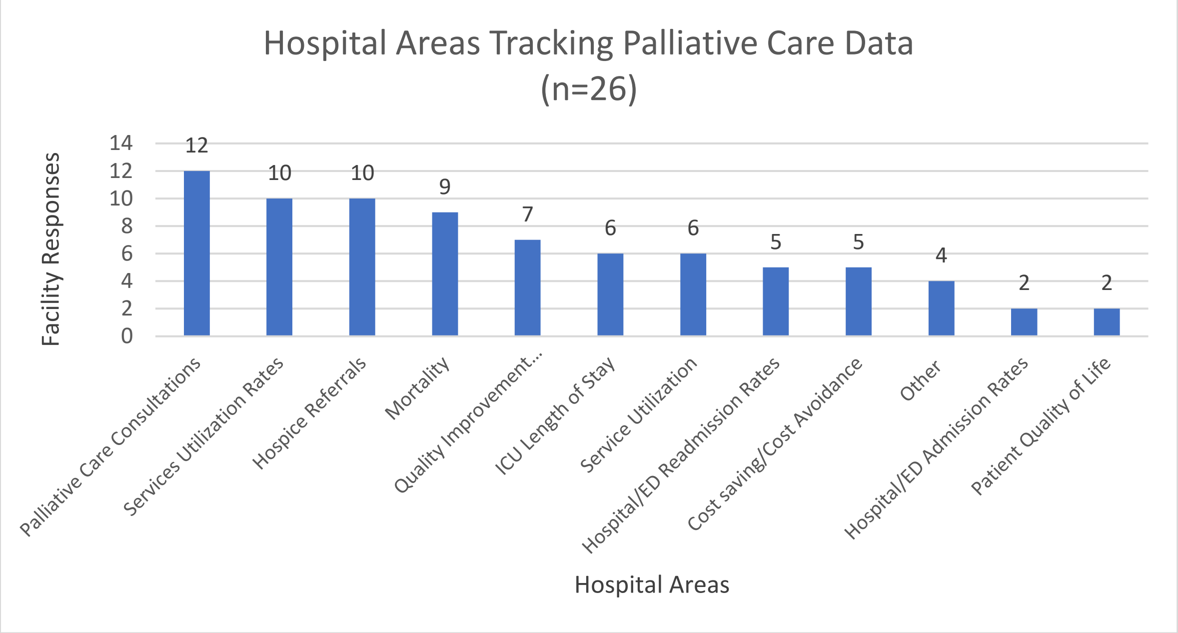
Palliative Care Program Accreditation Overview:
Based on self-reported data from 30 respondents to questions about accreditation in the survey, there is recognition of the importance of accreditation and certification as quality benchmarks, although pursuit of these standards is inconsistent among the represented palliative care programs. Specifically, 10 percent of programs are accredited by The Joint Commission Palliative Care Definition, seven percent by the Community Health Accreditation Partner (CHAP), and 17 percent by the Maryland Office of Health Care Quality (OHCQ). Notably, no programs had received the Accreditation Commission for Health Care, Inc. (ACHC) Palliative Care Distinction, while a substantial 67 percent of programs reported "Other" as their source of accreditation or certification.

Concerning future initiatives, among the thirty respondents, two non-accredited programs intend to seek accreditation within the next year. Five are contemplating this course of action without a specified timeline, while thirteen currently have no plans to achieve such accreditation or certification. (N=30)

Hospital Palliative Care Data Monitoring:
Based on the responses from 26 hospitals, data tracking in palliative care programs varies significantly across key performance indicators. The most frequently tracked metrics include Palliative Care Consultations (n=12) and Palliative Care Services Utilization Rates (n=10), followed by Mortality (n=9) and Hospice Referrals (n=10). Less commonly tracked are metrics related to ICU Length of Stay, Hospital/ED Admission and Readmission Rates, and Patient Quality of Life. These findings highlight the diversity in quality data tracking practices, signaling the need for a more unified approach to quality measurement in palliative care. (N=26)

Refer to Chart 5 below for a comprehensive list of performance or quality indicator domains.

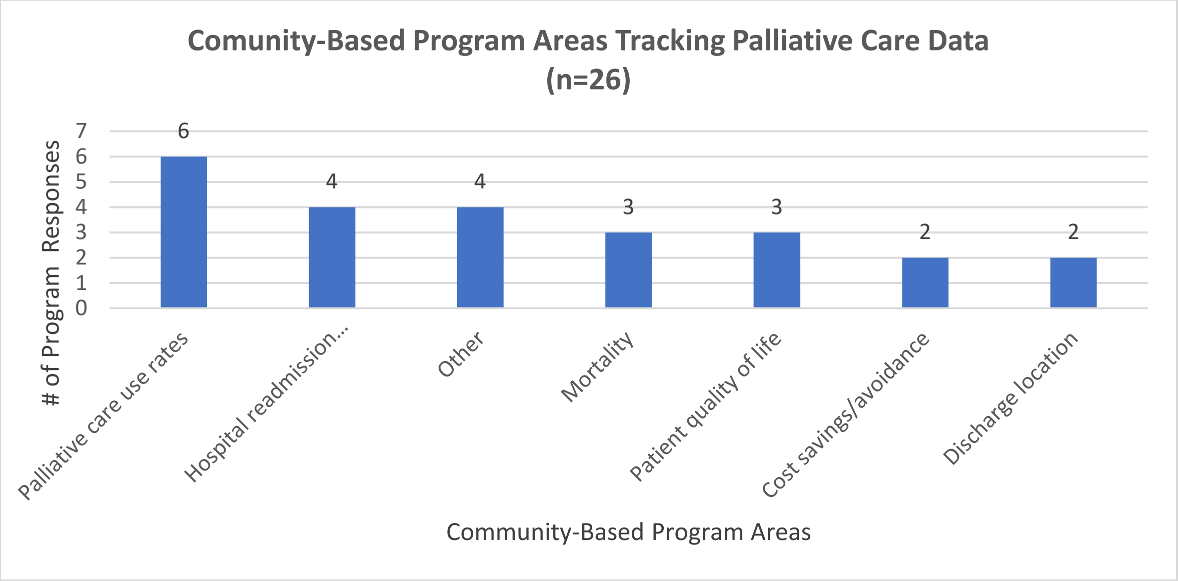
Chart 5. Hospital Palliative Care Performance Indicator Data Tracking Areas



Trends in Community-Based Palliative Care:
The survey data reveals that community-based palliative care programs prioritize various metrics for data collection. Most commonly tracked are palliative care use rates and hospital readmission rates, followed by metrics such as mortality and patient quality of life. Less frequently monitored are cost savings and discharge locations. This suggests a diverse focus in data tracking across community-based settings. (N=26)

Refer to Chart 6 below shows areas of data collection and tracking for community-based palliative care providers.

Chart 6. Areas of Data Collection and Tracking in Community-Based Palliative Programs



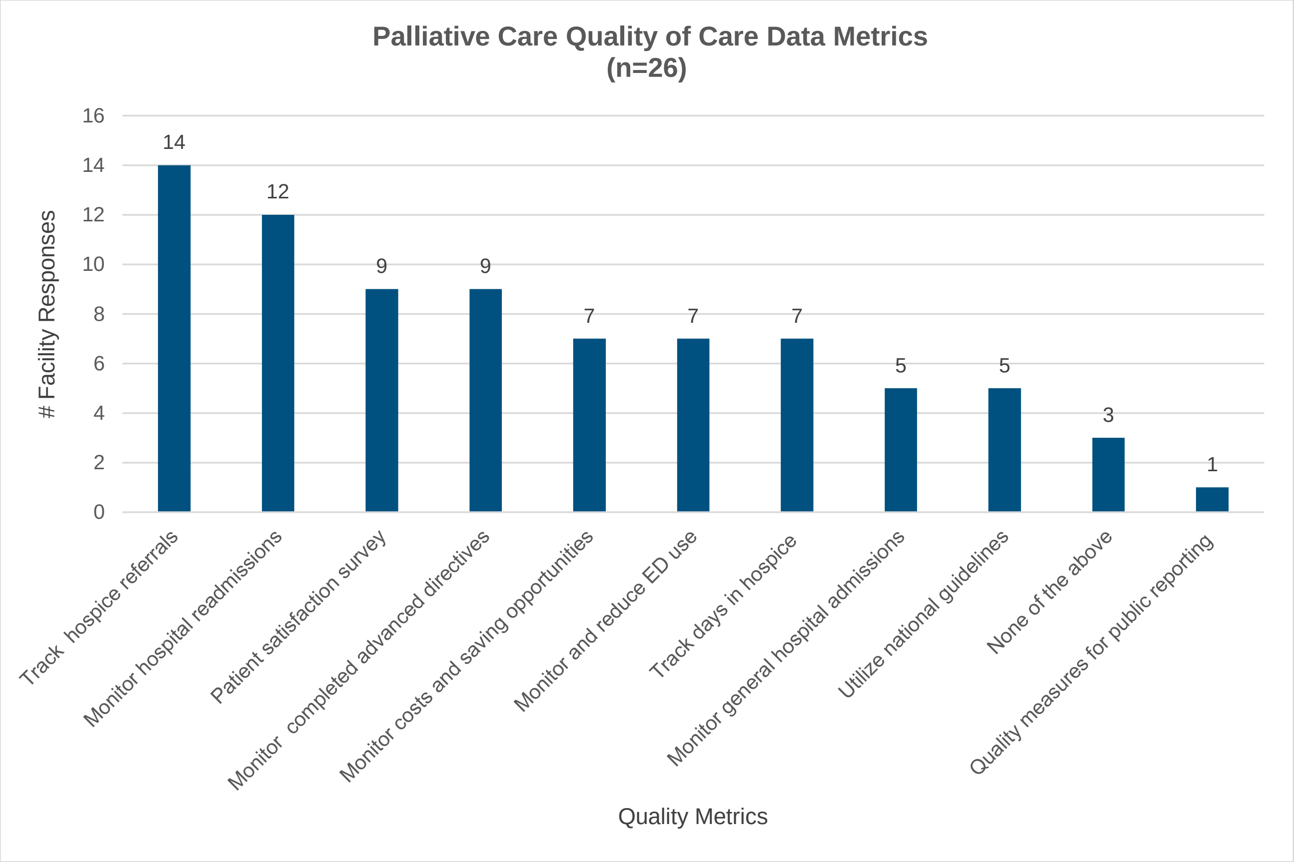
Telehealth Integration in Palliative Care Services:

Based on a survey with varying respondent numbers for different questions, several key insights into telehealth integration in palliative care programs were revealed. Of the 46 programs queried about the routine use of telehealth in their palliative care consultations, 59 percent (27 programs) confirmed its use. Further, when narrowed down to performance in the year 2022, 56 percent (22 out of 39 programs) indicated the use of telehealth to provide palliative care services. Additionally, when questioned about revenue streams, 37 respondents reported that an average of four percent of their palliative care revenue originated from telehealth services. This data collectively suggests a moderate, yet significant, level of telehealth integration in palliative care delivery.

Palliative Care Quality Measurement, Quality Improvement and Registries:

Based on a survey question regarding quality metrics used by palliative care programs, the most employed measures were tracking hospice referrals (14 respondents) and monitoring hospital readmissions (12 respondents). (N=26) Patient satisfaction surveys and monitoring completed advanced directives were also notable, each with nine respondents. Fewer programs focused on financial metrics like cost-saving opportunities. Notably, no program reported participation in the Hospice Quality Reporting Program or the CAHPS Hospice Survey. This highlights a reliance on specific, often clinical, indicators for quality assessment and a limited use of nationally standardized metrics. Chart 7 below indicates that the most frequently employed quality metrics in palliative care programs.

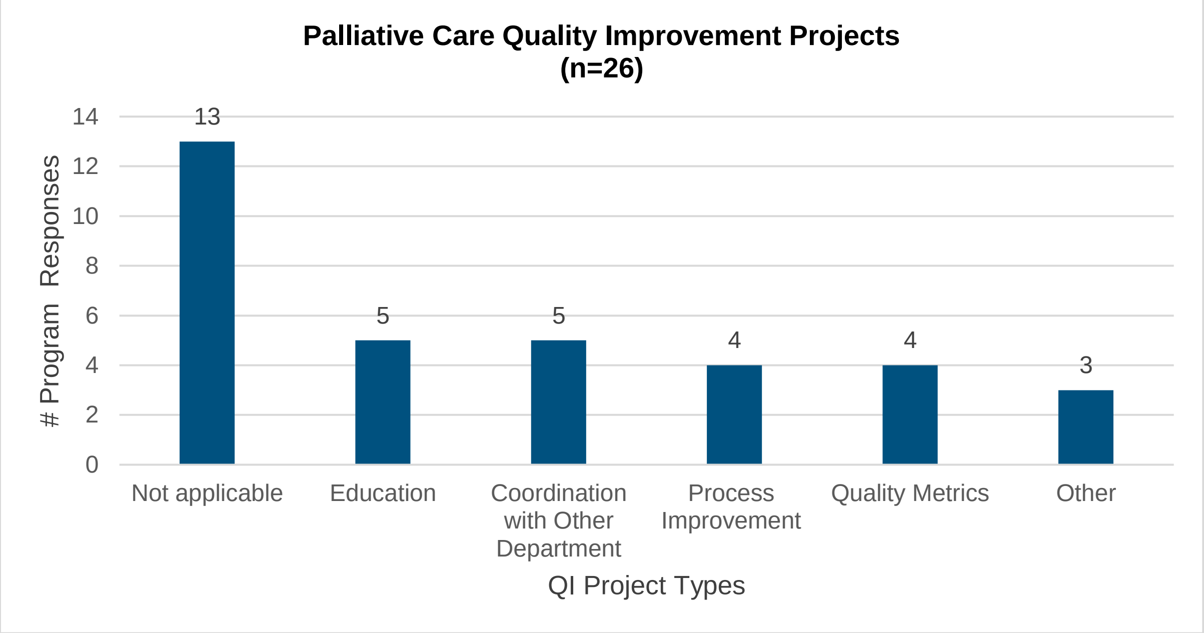
Chart 7. Usage of Palliative Care Quality Measures Among Survey Participants



The survey reveals that among the 26 respondents, the majority (13) indicated that they are not currently engaged in any quality improvement or performance initiatives. For those that are active in this area, the focus is primarily on education and inter-departmental coordination, each cited by five respondents. Process improvements and quality metrics monitoring are also areas of focus but are less commonly reported, each by four respondents. The findings depict a varied landscape where quality improvement strategies are inconsistently adopted across palliative care programs.

Refer to Chart 8 below for total number of programs who participate in each area of quality improvement.

Chart 8. Palliative Care Quality Improvement Project Areas



Survey respondents were invited to provide an overview of any quality improvement projects in palliative care that they have been involved with. The responses revealed four predominant themes: integration and education, care coordination, enhanced documentation and communication, and outcome measurement. Table 4 that follows outlines the opportunities mentioned by respondents, organized by thematic categories and respective organizations.

Table 4. Palliative Care Quality Improvement Projects

Theme	Opportunities
Integration and Education	• Embedding palliative care team members in ICU rounds. • Providing education to new nurses and physicians through meetings and modules. • Implementing palliative care huddle and coordinating care with hospice providers. • Updating electronic medical records specific to palliative patients. • Offering end-of-life education modules for staff and providers.
Quality Improvement and Collaboration	• Participating in hospital readmission reduction programs. • Tracking advance directives and utilizing assessment tools. • Collaborating with different departments and disciplines to enhance care coordination. • Working with quality departments to improve hospital outcomes and efficiency. • Conducting surveys and analyzing data to assess program efficacy and patient satisfaction
Patient Care and Symptom Management	• Focusing on goal setting, communication, and symptom management to improve patients' quality of life. • Screening patients in the emergency department and various hospital units for palliative needs. • Partnering with specialty teams to provide comprehensive care for specific conditions. • Developing partnerships with hospices and pain management services.
Program Development and Refinement	• Refining skill sets and training for the palliative care team. • Developing new initiatives, units, and partnerships to expand the program. • Engaging in diversity projects and initiatives to ensure inclusive care. • Streamlining processes such as hospice referrals and advance care planning.

Financial Analysis of Palliative Care Services:

This data analysis provides a comprehensive overview of the financial environment surrounding palliative care services, shedding light on key aspects such as payer distribution, value-based healthcare contracts, direct care billing, supplementary funding sources, and billing practices.

Payers of Palliative Care Services:

Survey respondents detailed the entities they billed for palliative care services, encompassing Medicare, Medicaid, Commercial/Private Insurance Payers, Veteran's Administration, Patients or Family Members, and other categories. This analysis provided insights into the distribution of billing practices among different payer groups.

Value-Based Healthcare Services Contract:

Organizations disclosed if they had any palliative care services covered under value-based healthcare service contracts, illuminating any specific contractual arrangements for palliative care service delivery in Maryland.

Percentage of Expenses Paid by Direct Care Billing:

Respondents furnished the percentage of their 2022 palliative care program expenses funded through direct care billing. The analysis calculated the average percentages for various facility types like Home Health, Hospice Programs, Hospitals, and Nursing Homes or Skilled Rehabilitation Facilities.

Other Financial Support or Funding:

The survey probed additional financial sustenance sources for palliative care programs, including Donations/Philanthropy, Grants, Research Programs, Academic Institution Support, and Others. The data analysis presented the prevalence of these diverse financial support channels.

Billing for Palliative Care:

The billing practices within palliative care programs were also explored. Some organizations utilized the ICD-10-CM Z-code Z51.5 for tracking and quality improvement, with 13 out of 26 organizations employing this code. Additionally, most organizations billed for Advance Care Planning (ACP) discussions using CPT codes 99497 or 99498 in 2022, emphasizing the significance of ACP discussions and appropriate billing for reimbursement purposes.

Key Findings:

1. **Direct Care Billing:** The percentage of expenses paid by direct care billing varies among facility types, with Nursing Homes or Skilled Rehabilitation Facilities having the highest average at 93 percent.
2. **Payer Distribution:** Medicare and Medicaid are the most billed payers, followed by Commercial/Private Insurance Payers. Various facilities reported billing for the Veteran's Administration, patients or family members, and other sources.
3. **Financial Support:** Donations/philanthropy and other sources are the primary financial support channels, with limited participation in grants and research programs. Academic institution support was not reported.
4. **Revenue Sources:** Primary revenue sources for palliative care programs include Provider Time Services, Medicare Part A, and Inpatient Billing-Other. Telehealth Billing is notably present, indicating its growing utilization in generating revenue.
5. **Value-Based Healthcare Programs:** Absence of reported revenue from value-based healthcare programs suggests potential future exploration and engagement in value-based care models.
6. **Billing Practices:** Some organizations utilize specific codes like Z51.5 for tracking and quality improvement, while others prioritize appropriate billing for ACP discussions, underlining the importance of these practices in palliative care.
7. **Unknown Revenue Sources:** The presence of unknown revenue sources in some facilities underscores the need for improved tracking and documentation practices to ensure transparency and accurate assessment of revenue generation.

Advanced Care Planning:

This data analysis delved into advanced care planning (ACP) practices within the responses from 27 palliative care provider organizations. It examined the types of ACP forms offered to patients, their utilization across different facility types, completion rates, and the involvement of various healthcare disciplines in ACP processes. (N=27)

Variety of ACP Forms Offered:

The most frequently provided ACP forms were the Maryland Advanced Directive Document and the Maryland Order for Life Sustaining Treatment (MOLST), offered by 22 and 25 facilities, respectively. The Maryland Power of Attorney (MDPOA) was available in eight facilities, while the Living Will and Maryland Advanced Directive Translated (Spanish) were offered by 10 and 12 facilities, respectively. Notably, none of the facilities reported offering no ACP forms.

Variation in ACP Forms by Facility Type:

The usage of ACP forms varied across different facility types. Hospitals predominantly used the Maryland Advanced Directive Document and the MOLST. Hospice programs commonly utilized the MOLST. Nursing homes or skilled rehabilitation facilities exhibited a balanced distribution across multiple forms, while home health facilities did not report the use of specific ACP forms.

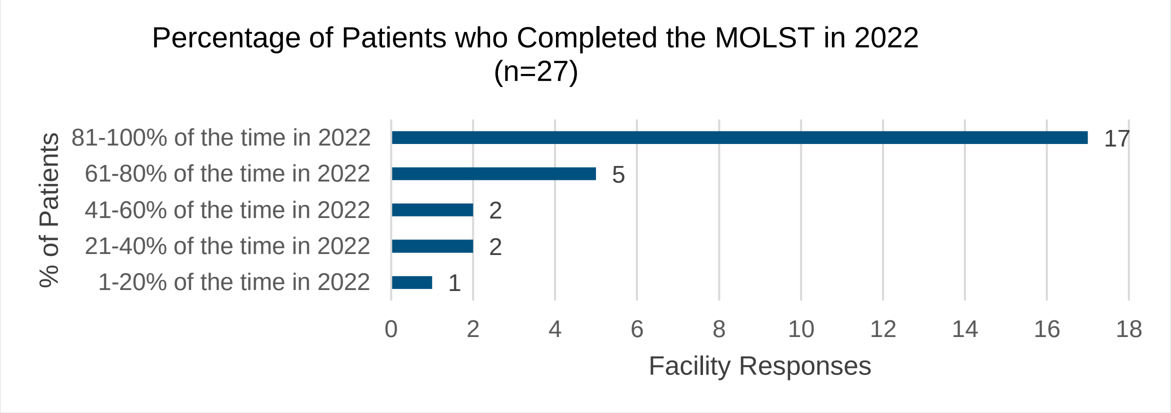
Disciplines Involved in ACP:

Several healthcare disciplines actively participated in ACP conversations and assisted patients, families, and caregivers in completing forms. Physicians and advanced practice providers were the most involved, followed by social workers. Other disciplines, such as registered nurses, chaplains, rehabilitation professionals, pharmacists, and dietitians, also contributed.

The prevalence of the Maryland Advanced Directive Document and the MOLST suggested a recognition of the importance of documenting patients' healthcare wishes and treatment preferences. The availability of these forms, along with MDPOA, Living Will, and translated versions, indicated a comprehensive approach to ACP. The presence of other specified forms demonstrated tailored offerings to meet specific patient needs. Overall, the data signified a commitment to supporting patients in making informed decisions about their healthcare and end-of-life preferences.

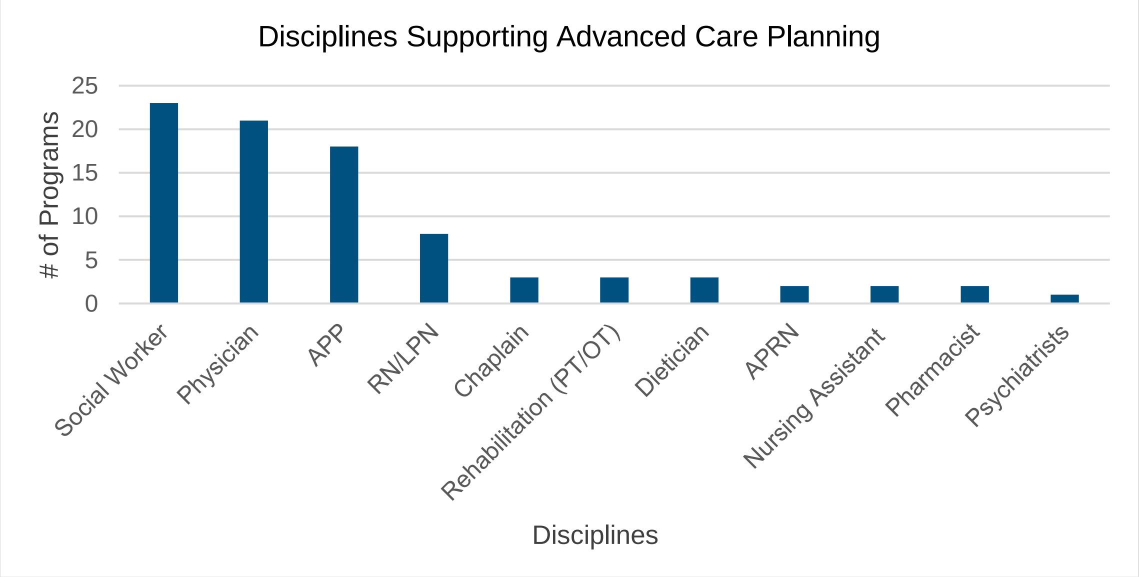
Based on the data provided, it was found that when patients enter palliative care programs, the most frequently completed advanced care planning form is the Maryland Order for Life Sustaining Treatment (MOLST), with 17 facilities reporting its completion 81-100 percent of the time. When broken down by facility type, hospitals lead in MOLST adoption, followed by nursing homes or skilled rehabilitation facilities, and hospice programs. Home health facilities reported the least utilization. No respondent indicated that the MOLST form is not used in their palliative care program. Further details on the distribution of MOLST usage are provided in Chart 9 below.

Chart 9. Utilization of Maryland Order for Life Sustaining Treatment (MOLST) by Palliative Care Providers in 2022



The survey data reveals that social workers and physicians are the primary disciplines involved in Advance Care Planning (ACP) conversations and assisting patients, families, and caregivers with completing forms, reported by 23 and 21 respondents, respectively. Advanced Practice Providers also frequently participate, as indicated by 18 respondents. Participation by other disciplines such as RNs/LPNs, chaplains, and dieticians is notably lower. Review Chart 10 below for additional information on disciplines that support advanced care planning in palliative care.

Chart 10. Disciplines Supporting Advanced Care Planning



Qualitative Feedback from Survey Responders

In addition to gathering quantitative metrics, the survey captured substantive qualitative feedback from respondents to provide a more nuanced understanding of their experiences and perspectives.

Strengths and Benefits: According to survey respondents, high-quality palliative care programs are characterized by multiple strengths that contribute to their efficacy. Key attributes include a dedicated and patient-centered team, robust support from hospital leadership, timely referrals, personalized care, and positive relationships with healthcare providers. Additional factors such as provider expertise, educational programs for patients and families, workforce satisfaction, and community recognition play pivotal roles in delivering high quality palliative care. These factors collectively contribute to the program's effectiveness and ability to provide high-quality services.

Challenges and Barriers: Respondents also highlighted several challenges facing palliative care programs. These include limited awareness among key stakeholders, financial limitations, resource allocation challenges, and paradoxically, both high demand and limited referrals. Addressing these barriers calls for multifaceted solutions that encompass educational initiatives, financial support, strategic resource distribution, staffing strategies, and enhanced communication pathways to improve the delivery of palliative care services.

Educational and Public Awareness Needs: The survey results indicate a broad consensus on the importance of comprehensive educational materials for various audiences, including the general public, patients, and healthcare providers. Respondents recommend clear delineation between palliative care and hospice services, promoting early referrals, and addressing educational gaps. Specific media for information dissemination, such as digital platforms, printed materials, and webinars were suggested, along with the need for targeted educational programs in under-served communities.

Overall, the survey data pointed to an urgent need for enhanced transparency and standardization in palliative care education. By filling these gaps, stakeholders can facilitate more informed decision-making for patients with complex and serious illness and their families, while also mitigating common misunderstandings surrounding palliative care.

Survey Recommendations

The survey experience led to insights that help inform recommendations for future work on palliative care.

1. Survey Length and Content: To address the issue of survey length and respondent burden, consider streamlining the survey by prioritizing essential questions. This will allow for the efficient gathering of key data while reducing the time required for completion.

2. Email Delivery and Communication: Implement robust email delivery solutions to ensure that survey invitations reach participants' inboxes. Additionally, work to address organizational firewall issues to facilitate access to the survey for all intended recipients.

3. Engagement Strategies: Develop targeted engagement strategies aimed at effectively reaching and involving organizational staff. Consider personalized outreach and follow-up communication to enhance participation rates and ensure that all relevant staff members are aware of and engaged with the survey.

4. Increased Outreach: Expand outreach efforts to reach a broader range of palliative care organizations. Collaborate with relevant stakeholders to promote survey participation and raise awareness about its importance within the palliative care community.

5. Frequency of Survey: Evaluate the optimal frequency for conducting the survey, considering the balance between data collection needs and respondent capacity. Periodic surveys can help track changes and trends in the palliative care landscape over time, providing valuable insights for ongoing improvement.

These recommendations collectively aim to address the identified survey limitations and enhance the quality of future iterations of the Maryland Palliative Care Survey.

Palliative Care Provider Directory

The 2023 Maryland Palliative Care Provider Directory was developed based on data provided by organizations that have self-reported the existence of a palliative care program that meets the CAPC definition of "palliative care program" from the Survey, as well as hospitals known to maintain such a program in compliance with Maryland law.[44] Please note that Maryland law mandates that all hospitals with 50 or more beds must have a

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[44] 2023 Palliative Care Provider Directory is found in Appendix F.

palliative care program. While efforts have been made to verify the accuracy of this information, the directory does not guarantee its completeness or correctness. Verification of specific program details with the respective provider or institution is advised. The directory features the following information: Organization Name, Organization Type, Address, Main Phone Number, Website, Survey Participation Status (Yes/No), and Palliative Care Provider Status (Yes/No).

Recommendations for Advancing Palliative Care in Maryland

Drawing on the findings from a comprehensive literature review, statewide survey, and workgroup and stakeholder feedback, this section outlines targeted recommendations to advance the state of palliative care in Maryland. As required by the legislation, the recommendations focus on public education, provider education, financing, community-based palliative care development, palliative care quality improvement, and palliative care survey recommendation areas. The appendices of this report include pertinent legislative documents, workgroup membership, state and national palliative care legislative overviews, and a palliative care organization provider directory for further reference.

1. PUBLIC EDUCATION

1a. RECOMMENDATION*[45]: Work with state partners, including the State Advisory Council on Quality Care at End of Life, community associations/organizations, and the Maryland Department of Aging, to support the development of comprehensive evidence-based education programs aimed at promoting palliative care among healthcare providers and the general public.

Rationale: Palliative care education programs assume significant importance as they equip healthcare providers with the knowledge and skills required to deliver high-quality palliative care. Comprehensive education programs enhance the capacity of the healthcare workforce, ultimately leading to improved patient outcomes and healthcare quality. These programs also contribute to public awareness and understanding of palliative care, empowering individuals to make informed healthcare decisions.

1b. RECOMMENDATION: Work with the Maryland Department of Aging to assure that Maryland Access Point (MAP) and other community-based providers have knowledge of palliative care services to assure referral to appropriate community-based palliative care providers.

Rationale: To streamline the referral process to appropriate palliative care providers, it is crucial that community-based providers, such as Maryland Access Point (MAP), possess comprehensive knowledge of palliative care services.

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[45] *Indicates the need for legislative action and/or funding.

Informed referral processes lead to timely access to palliative care, improving patient outcomes and efficient resource utilization. Enhanced awareness and knowledge of community-based providers contribute to more effective and patient-centered healthcare services.

1c. RECOMMENDATION: Build upon the Maryland Health Care Commission's (MHCC) current public education efforts on advance directives to develop further public education initiatives focused on palliative care.

Rationale: Expanding public education initiatives on palliative care is essential to raise awareness among Maryland residents about the availability and benefits of these services. Increased awareness empowers individuals to make informed healthcare decisions, promoting a patient-centered approach to care delivery. These initiatives also dispel common misconceptions surrounding palliative care, encouraging more patients to consider it as a viable option for improving their quality of life.

1d. RECOMMENDATION*: Seek funding to launch evidence-based public awareness campaigns to educate individuals about the benefits and importance of palliative care. Collaborate with community organizations, patient advocacy groups, and faith-based organizations to disseminate educational materials and host public forums on palliative care.

Rationale: Securing funding for public awareness campaigns on palliative care is a vital step toward impactful outreach. Adequate funding ensures that the information reaches a diverse audience, making palliative care services accessible to individuals across the state. Improved awareness allows patients and families to make informed choices regarding their care, fostering a healthcare environment that values patient-centered decision-making. These campaigns contribute to efficient healthcare resource utilization by educating the public and preparing them to navigate complex healthcare choices. Investing in public awareness campaigns on palliative care demonstrates a commitment to enhancing healthcare accessibility, patient outcomes, and the overall well-being of Maryland residents.

2. PROVIDER EDUCATION

2a. RECOMMENDATION*: Collaborate with the Maryland Higher Education Commission to encourage relevant academic programs, such as nursing, medicine, social work, and other programs, to include education on palliative care across all levels of education, from entry level/certificates to graduate degrees.

Rationale: Collaborating with the Maryland Higher Education Commission to incorporate palliative care education across various healthcare disciplines and academic levels is instrumental in cultivating a well-rounded, competent workforce in this specialized field. By embedding palliative care principles into the curriculum, healthcare professionals are better equipped from the onset of their careers to deliver patient-centered, quality care. This standardized educational approach not only enhances the skill set of future healthcare providers but also elevates the quality of palliative care services across the state. Moreover, it fosters a culture of continuous learning and adaptation, allowing for the healthcare system to stay abreast of best practices in palliative care.

2b. RECOMMENDATION*: To address the current and anticipated workforce shortage and ensure adequate access to specialized palliative care services, it is recommended that policies and payment reforms be implemented to promote the growth and sustainability of the specialty palliative care workforce. Efforts could include promotion, support, and expansion of physician and advanced practice nursing fellowships, including loan forgiveness at academic institutions in the state.

Rationale: Addressing the current and anticipated workforce shortage in palliative care demands innovative policies and payment reforms. The growth and sustainability of the specialty palliative care workforce can be achieved by supporting physician and advanced practice nursing fellowships and offering incentives, such as loan forgiveness programs, at academic institutions in Maryland. These measures encourage healthcare professionals to pursue careers in palliative care, thereby enhancing access to specialized palliative care services.

2c. RECOMMENDATION*: Applicable licensing boards (e.g., Maryland Board of Nursing, Maryland Board of Examiners of Nursing Home Administrators, Maryland Board of Pharmacy, Maryland Cannabis Commission, Maryland Board of Professional Counselors and Therapists, Maryland Board of Physicians, Maryland

Board of Social Work Examiners, Maryland Board of Psychologists, among others) should revise initial licensing requirements and/or continuing education courses to include education on palliative care medicine. Relevant boards should collaborate with the Maryland Higher Education Commission, and Maryland colleges, universities, and private career schools to ensure that existing programs and new programs meet revised licensing standards that include education on palliative care medicine.

Rationale: Revision of initial licensing requirements and continuing education curricula to include education on palliative care medicine is imperative for ensuring that licensed healthcare professionals possess the requisite knowledge and skills in this area. Involving various relevant licensing boards fosters a comprehensive approach to standardizing palliative care training across multiple disciplines, thereby enhancing interdisciplinary collaboration. Collaborative efforts between these boards, the Maryland Higher Education Commission, and academic institutions ensure alignment between educational standards and licensing requirements, thus creating a streamlined educational and credentialing pathway. Such a unified approach ensures consistency in the quality of palliative care services across the state, leading to improved patient outcomes and satisfaction. This initiative also establishes accountability mechanisms for ongoing professional development in palliative care, contributing to the sustainability and evolution of high-quality care in this field.

3. FINANCING

3a. RECOMMENDATION*: Maryland should pursue a statewide strategy to develop financing mechanisms for palliative care services, through a Medicaid State Plan amendment, modification of the Total Cost of Care Medicare model, and other insurance mechanisms.

Rationale: Pursuing a statewide strategy for developing financing mechanisms for palliative care services is a pivotal step in ensuring equitable access to palliative care for Maryland residents. This strategy should encompass Medicaid State Plan amendments, modifications of the Total Cost of Care Medicare model, and other insurance mechanisms. These efforts are aimed at securing adequate funding to support the delivery of high-quality palliative care services across the state.

3b. RECOMMENDATION*: Integrate palliative care services within Maryland's Medicaid State Plan and to require Medicaid Managed Care Organizations (MCOs) to provide a palliative care benefit with defined services under their managed care contracts.

Rationale: Integrating palliative care services into Maryland's Medicaid State Plan and mandating Medicaid Managed Care Organizations (MCOs) to provide a palliative care benefit with defined services under their managed care contracts enhances access to palliative care for Medicaid beneficiaries. This integration ensures that vulnerable populations have access to the specialized care they need, promoting equitable healthcare delivery.

3c. RECOMMENDATION: Continue work with the National Academy for State Health Policy (NASHP) Serious Illness Institute to explore ways to fund palliative care benefits statewide. This should include an exploration of funding models used successfully in other states.

Rationale: Collaborating with the National Academy for State Health Policy (NASHP) Serious Illness Institute to explore innovative funding models for palliative care benefits at the state level is vital. Learning from successful funding models implemented in other states provides insights into sustainable financing solutions for palliative care services in Maryland. These efforts aim to ensure the long-term availability and accessibility of palliative care.

3d. RECOMMENDATION*: Review the current expansion of Maryland Program of All-Inclusive Care for the Elderly (PACE) programs for the inclusion of palliative care services as a required benefit.

Rationale: The Maryland PACE program provides home and community-based medical and social services to dual-eligible, low-income seniors through an interdisciplinary team. Adding palliative care as a required benefit could enhance service quality by addressing complex care needs for this vulnerable group. A review of the program's current expansion to include such services is recommended.

4. COMMUNITY-BASED PALLIATIVE CARE DEVELOPMENT

4a. RECOMMENDATION*: A broad and funded Palliative Care Coalition, including providers, consumers, MHCC, Maryland Department of Aging, and the State Advisory Council on Quality Care at End of Life should develop a strategy for the development, promotion, and sustainability of community-based palliative care services.

Rationale: A funded Palliative Care Coalition, comprising providers, consumers, MHCC, Maryland Department of Aging, and the State Advisory Council on Quality Care at End of Life, should collaboratively develop a strategy for the promotion and sustainability of community-based palliative care services. This collaborative approach fosters comprehensive care delivery and ensures that palliative care is accessible and readily available in various community settings.

4b. RECOMMENDATION*: Prioritize the expansion of home and community-based palliative care services in Maryland to improve accessibility and convenience for patients. This can be achieved by building on collaborative models, including the Maryland Primary Care Program (MDPCP) that integrate palliative care with primary care and other healthcare services, ensuring seamless coordination and holistic support for patients and their families.

Rationale: Prioritizing the expansion of home and community-based palliative care services in Maryland enhances accessibility and convenience for patients. Collaborative models, such as the Maryland Primary Care Program (MDPCP), that integrate palliative care with primary care and other healthcare services facilitate seamless coordination and holistic support for patients and their families. This expansion aligns with the goal of patient-centered, community-based care delivery.

4c. RECOMMENDATION: The Palliative Care Coalition (4a) should explore innovative funding models, including contracted alternative payment arrangements and financial subsidies, to provide stability and flexibility for palliative care programs.

Rationale: The Palliative Care Coalition should explore innovative funding models, including contracted alternative payment arrangements and financial subsidies, to provide stability and flexibility for palliative care programs. Innovative funding models help ensure the sustainability of palliative care programs, allowing them to adapt to the evolving healthcare landscape while maintaining a focus on patient-centered care delivery.

4d. RECOMMENDATION: Encourage the expansion of Community-Based Palliative Care Programs, such as in primary care, hospices, home health and other agencies.

Rationale: Promoting the expansion of Community-Based Palliative Care Programs, particularly in primary care, hospices, home health, and other agencies, enhances the availability of palliative care services across different healthcare settings. This expansion aligns with the goal of offering diverse care options to individuals with serious illnesses, enabling them to receive palliative care that suits their specific needs and preferences.

5. PALLIATIVE CARE QUALITY IMPROVEMENT

5a. RECOMMENDATION*: Require community-based palliative care programs to meet accreditation requirements under one of the accreditation organizations.

Rationale: Requiring community-based palliative care programs to meet accreditation requirements under one of the accreditation organizations ensures the delivery of high-quality care. Accreditation promotes adherence to evidence-based standards and guidelines, leading to improved palliative care services. This recommendation emphasizes the importance of maintaining high standards in community-based palliative care.

5b. RECOMMENDATION: MHCC should continue annual data verification to update and maintain an up-to-date Palliative Care Provider Directory in Maryland.

Rationale: Continuing the annual data verification process to update and maintain an up-to-date Palliative Care Provider Directory in Maryland is essential for ensuring that individuals have access to current and accurate information about available palliative care services. This directory serves as a valuable resource for patients, families, and healthcare providers seeking palliative care options, contributing to informed decision-making and improved care coordination.

5c. RECOMMENDATION*: Require new and existing licensed palliative care programs to meet evidence-based requirements, including the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th Edition, or any updated edition.

Rationale: Requiring new and existing licensed palliative care programs to meet evidence-based requirements, including the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care, 4th Edition or any updated edition, ensures that palliative care services adhere to established best practices. This requirement promotes the delivery of high-quality and patient-centered palliative care, aligning with the goal of improving patient outcomes and healthcare quality.

6. PALLIATIVE CARE SURVEY RECOMMENDATIONS

6a. RECOMMENDATION: MHCC should streamline the Palliative Care Survey to focus on key areas of interest to reduce participant burden and to ensure that it is concise and focused on gathering essential information. Collaborate with relevant stakeholders, including healthcare professionals and survey experts, to review and refine the survey instrument. Prioritize questions that yield critical data while minimizing redundancy, thereby reducing respondent burden.

Rationale: Streamlining the Palliative Care Survey to focus on key areas of interest reduces participant burden and ensures that the survey remains concise and focused on gathering essential information. Collaboration with relevant stakeholders, including healthcare professionals and survey experts, aims to refine the survey instrument, prioritizing questions that yield critical data while minimizing redundancy, thereby reducing respondent burden.

6b. RECOMMENDATION: MHCC, using its existing resources, should develop a web-based survey delivery process. Increase the number of beta testers and testing sites to identify and resolve potential technical issues before the launch of the survey. Consider other web-based survey platforms for distribution of the survey.

Rationale: Developing a web-based survey delivery process using existing resources enhances the accessibility and efficiency of the Palliative Care Survey. Expanding the number of beta testers and testing sites identifies and resolves potential technical issues before the survey's official launch. Exploring various web-based survey platforms for distribution further improves the survey's reach and impact.

6c. RECOMMENDATION: Work with the Palliative Care Coalition (4a) to strengthen communication and outreach efforts to hospitals, home health agencies, nursing homes, hospices, and other community-based palliative care provider organizations before launching the survey. Collaborate with organizational leaders and stakeholders to emphasize the importance and benefits of survey participation, encouraging their support and engagement.

Rationale: Strengthening communication and outreach efforts to hospitals, home health agencies, nursing homes, hospices, and other community-based palliative care provider organizations before launching the survey is essential. Collaborating with organizational leaders and stakeholders to emphasize the survey's importance and benefits encourages their support and engagement. This proactive approach ensures broader participation and more comprehensive survey results.

6d. RECOMMENDATION: MHCC should conduct Palliative Care Surveys every two (2) years. Regular surveys provide a comprehensive understanding of the evolving landscape of palliative care and enable informed decision-making based on current trends and needs.

Rationale: Conducting Palliative Care Surveys every two (2) years is vital for obtaining a comprehensive understanding of the evolving palliative care landscape. Regular surveys provide up-to-date insights into current trends and needs in palliative care, enabling informed decision-making and responsive policy development to meet the evolving demands of individuals with serious illnesses and their families.

Advancing Palliative Care in Maryland: A Strategic Roadmap

The Final Report synthesizes a rigorous body of evidence, encompassing a comprehensive literature review, statewide surveys, and multidisciplinary stakeholder feedback to formulate targeted recommendations for elevating the state of palliative care in Maryland. Areas of focus include enhancing public and provider education, establishing robust financing mechanisms, cultivating community-based palliative care models, implementing quality improvement initiatives, and offering directives for future palliative care provider surveys.

Given Maryland's recent selection for participation in the two-year National Academy for State Health Policy Serious Illness Institute Program, the state is at an opportune juncture to implement evidence-based policies that could profoundly influence palliative care delivery and access. Enacting these strategies is complex and will necessitate a coordinated effort from multiple sectors, including healthcare providers, policymakers, and academic institutions.

The expected benefits of fully realizing these recommendations are considerable. Enhanced patient outcomes, reduced healthcare costs, and alignment with the principles of patient-centered and community-based care stand as notable dividends. The return on investment, both in terms of healthcare expenditure and quality of life, is predicted to be substantial, warranting the allocation of resources and political capital toward these ends.

As Maryland's strategic planning on palliative care extends into 2024 and beyond, it is imperative that the state maintain an unwavering commitment to these endeavors. Sustained focus on the recommendations outlined in this report will not only improve palliative care at a state level but also position Maryland as a national exemplar in providing compassionate, effective, and high-quality care for individuals facing serious illnesses. By doing so, Maryland has the opportunity to set a precedent for other states, influencing national policies and establishing new standards for palliative care.

Appendix A - House Bill 378

Chapter 301

(House Bill 378)

AN ACT concerning

Maryland Health Care Commission – Palliative Care Services – Workgroup

FOR the purpose of requiring the Maryland Health Care Commission to convene a workgroup to study palliative care services and make recommendations to improve palliative care services; and generally relating to the Maryland Health Care Commission and palliative care services.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

(a) (1) The Maryland Health Care Commission shall convene a workgroup of interested stakeholders to study palliative care services and make recommendations to improve palliative care services in the State.

(2) The workgroup convened under paragraph (1) of this subsection shall include representatives of:

(i) hospice and palliative care providers;

(ii) health care facilities;

(iii) patient advocacy groups; and

(iv) health insurers.

(b) The workgroup shall examine:

(1) the state of palliative care services offered in the State;

(2) the capacity of palliative care providers to provide services;

(3) any geographic areas where significant gaps in palliative care services may exist;

(4) opportunities to collaborate with key stakeholders who are positioned to develop a strategy or plan for improving and expanding the provision of high–quality palliative medicine and care services;

(5) the feasibility of financial support for a long–term expansion of palliative care services, including insurance coverage;

(6) a plan for ongoing data collection for purposes of the monitoring and improvement of palliative care services;

(7) engagement strategies for educating the public about palliative care to empower individuals to make informed decisions about an individual's preferred care when faced with serious illness; and

(8) any other strategies that would improve palliative care services.

(c) (1) On or before July 1, 2023, the Maryland Health Care Commission shall submit an interim report of the findings and recommendations of the workgroup, including the need for any legislative initiatives, to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

(2) On or before November 1, 2023, the Maryland Health Care Commission shall submit a final report of the findings and recommendations of the workgroup, including the need for any legislative initiatives, to the Governor and, in accordance with § 2–1257 of the State Government Article, the General Assembly.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2022. It shall remain effective for a period of 2 years and, at the end of September 30, 2024, this Act, with no further action required by the General Assembly, shall be abrogated and of no further force and effect.

Approved by the Governor, May 12, 2022.

Appendix B - Palliative Care Work Group Membership

MARYLAND
Health Care
Commission

Palliative Care Work Group Membership

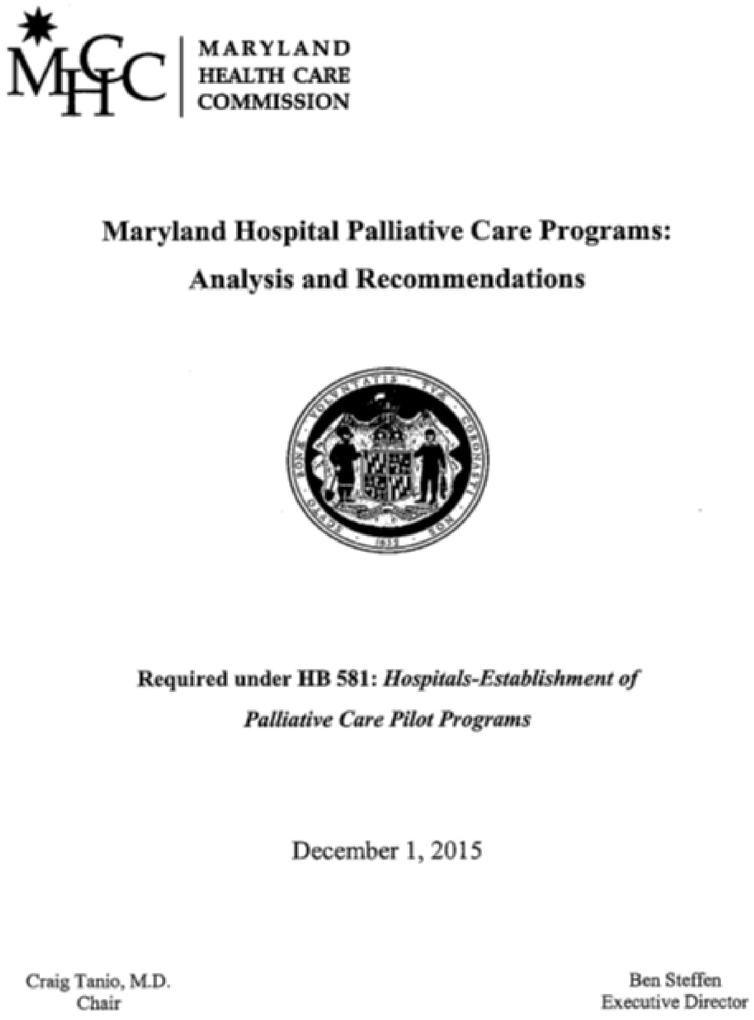
Name	Affiliation	Group Represented
Cathy Hamel **CHamel@gilchristcares.org**	Gilchrist Hospice	Hospice Provider
Scott Hanel ScHanel@accentcare.com	Seasons Hospice,	Health Facilities Association of Maryland- Nursing home representative
Chris Kearney christopher.d.kearney@gmail.com	Formerly Medstar Union Memorial Palliative Care	State Advisory Council on Quality Care at the End of Life
Marian Grant msgrant@comcast.net	Palliative Care Nurse Practitioner	Nurse provider/CAPC
Erin Davis edavis@mhaonline.org	MD Hospital Association	Maryland Hospital Association
Peggy Funk Peggy.Funk@hnmd.org	Hospice & Palliative Care Network of Maryland	Hospices in Maryland and nationally
Lisa Stone/ Mark Lovelace mlovelace1@stellamaris.org	Stella Maris	Home Health Agency

Cindy Carter cpcarter@aol.com	AARP	AARP-consumer
Cindy Massuda Cindy.Massuda@cms.hhs.gov	CMS	Federal payer
Amanda DiStefano AmandaK.Distefano@maryland.gov	MDoA	Maryland Dept of Aging
Matthew Celentano **mcelentano@fblaw.com**	Attorney; Commercial Insurers	League of Life Insurers
Cindy Baumhardt-Rivera Cindy.Baumhardt-Rivera@carefirst.com	Carefirst	Blue Cross/Blue Shield of Maryland
Joanna Ruth joannae.ruth@maryland.gov	Maryland Medicaid	Medicaid

Appendix C - MHCC 2015 Palliative Care Hospital Report

For the complete MHCC 2015 Palliative Care Hospital Report, see:

https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/pcp/chcf_palliative_care_final_report_20151201.pdf



MHCC | MARYLAND HEALTH CARE COMMISSION

Maryland Hospital Palliative Care Programs:

Analysis and Recommendations

Required under HB 581: ***Hospitals-Establishment of Palliative Care Pilot Programs***

December 1, 2015

Craig Tanio, M.D.
Chair

Ben Steffen
Executive Director

Appendix D - Palliative Care Federal Legislation 2020-2023

Senate Bill 1845 (2023-2024) -The bill would amend title XI of the Social Security Act to provide for the testing of a community-based palliative care model. The bill was introduced June 7,2023 and referred to Committee on Finance.

Senate Bill 2565 (2023-24)-Expanding Access to Palliative Care Act. This bill was introduced on June 8, 2023, and was referred to Committee on Finance. If passed, the bill would require the Center for Medicare and Medicaid Innovation (CMMI) to develop a community-based palliative care (CBPC) demonstration. The model would provide essential interdisciplinary care to people with serious illness in their home and lead to improved quality and cost outcomes.

Senate Bill 2565 (2021-22) – (Earlier version of the 2023 legislation introduced with the same number SB 2565). This bill requires the Center for Medicare and Medicaid Innovation (CMMI) to evaluate a model that provides community-based palliative care and care coordination for high-risk Medicare beneficiaries and that may replace the Medicare Care Choices Model (set to expire on December 31, 2021).

Sente Bill 2117 (2023-2024) -The bill would allow participants in the National Health Service Corps to defer their obligated service in order to receive training in palliative care services. The bill was introduced June 22, 2023, and referred to Health, Education, Labor, and Pensions Committee.

H.R.4363 – This bill addresses the health of cancer survivors and unmet needs that survivors face through the entire continuum of care from diagnosis through active treatment and posttreatment, in order to improve survivorship, treatment, transition to recovery and beyond, quality of life and palliative care... and for other purposes. The bill was introduced June 23, 2023, and referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and Education and the Workforce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

HR. 1493 (2023-2024) - HCBS Access Act. This bill would amend title XIX of the Social Security Act to require coverage of, and expand access to, home and community-based services under the Medicaid program; to award grants for the creation, recruitment, training and education, retention, and advancement of the direct care workforce and to award grants to support family caregivers; and for other purposes. The bill was introduced on March 17, 2023, and referred to the Subcommittee on Health.

Senate Bill 4260 (2021-22) - Palliative Care and Hospice Education and Training Act (PCHETA): This bill mandates that the Department of Health and Human Services (HHS) undertake various initiatives to enhance palliative care training. The bill entails providing support for Palliative Care and Hospice Education Centers to enhance the training of healthcare professionals in palliative care and establish traineeships for individuals pursuing advanced education in nursing, social work, or physician-assistant studies in palliative care. HHS is also empowered to offer support to medical schools, teaching hospitals, and graduate medical-education programs for training physicians who intend to teach palliative medicine. Additionally, HHS is required to provide career development awards, support entities operating Palliative Care and Hospice Education Centers, assist individuals pursuing advanced degrees in palliative care, and grant funds to nursing programs for palliative care training. Furthermore, the bill directs the Agency for Healthcare Research and Quality to conduct a national education and awareness campaign to educate patients, families, and healthcare professionals about the benefits of palliative care. Lastly, the National Institutes of Health is tasked with expanding national research programs in palliative care. This bill was introduced to the Senate on May 19, 2022. It was then referred to Senate Health, Education, Labor, and Pensions Committee.

H.R. 647 (2019-2020) - Palliative Care and Hospice Education and Training Act passed on 10/29/2019. This bill requires the Department of Health and Human Services (HHS) to take a series of actions relating to palliative-care training. This is an earlier version of SB 4260.

S.Res.849 (2021-2022) - A resolution designating November 2022 as "National Hospice and Palliative Care Month". The resolution was submitted in the Senate, considered, and agreed to without amendment and with a preamble by Unanimous Consent on November 28, 2022.

Appendix E - Palliative Care Programs by State

State-by-State Overview of Palliative Care Initiatives: Snapshot as of August 22, 2023

NASHP published a comprehensive table in July 2023, detailing the budgetary and legislative actions taken in 2022 and 2023 that endorse and amplify state initiatives in palliative care. The information provided encapsulates palliative care actions taken in 13 of the 50 United States. Specifically, Maryland was spotlighted for the state's palliative care workgroup who has played a significant role in supporting the development of this report.

Budgetary And Legislative Actions in 2022 and 2023 that Support and Expand State Palliative Care Initiatives (NASHP, July 2023)

State	Budget/ Legislation	Summary
Colorado	HB23-1218	Requires a health-care facility to inform patients of services the facility refuses to provide to patients when the refusal is for nonmedical reasons, including end-of-life services.
Illinois	SB 3819	Requires health plans to provide coverage for community-based pediatric palliative and hospice care starting January 1, 2024.
Indiana	HB 1457	Expands the definition of "home health services" to include community based palliative care.
Kentucky	SB 173	Allows for completion of an electronic version of a MOST (Medical Orders for Scope of Treatment) form.
Maine	LD 479	Amends the laws governing the membership of the Palliative Care and Quality of Life Interdisciplinary Advisory Council.
Maryland	HB 378	Creates a palliative care workgroup that must submit recommendations to the governor and legislature by November 1, 2023.
Minnesota	HF 4065	Updates the definition of palliative care.
New Jersey	FY 2024 Budget	Designates funds for a palliative care pilot program and a grant to expand access to palliative care.

New York	**S 8205**	Establishes a statewide advance care planning public education campaign.
	A 8880	
	J 2491	Establishes November 2022 as Hospice and Palliative Care Awareness Month.
	J 1352	Establishes November 2023 as Hospice and Palliative Care Awareness Month.
	K 649	
Tennessee	HB 952 and SB 858	Amends the membership requirements of the State Palliative Care and Quality of Life Council.
Texas	SB 739	Establishes October 10 as Supportive Palliative Care Awareness Day.
Virginia	FY 2023-2024 Budget	Designates funds for the Medical College of Virginia Palliative Care Partnership and for a contract with Edmarc Hospice for Children to expand pediatric hospice and palliative care services.
Washington	FY 2023-2025 Budget	Requires a joint legislative executive committee on planning for aging and disability issues to identify strategies to promote palliative care planning, and advance care directives through the Bree Collaborative palliative care guidelines. Designates funds to increase pediatric palliative care rates to the equivalent hospice care rates for Medicare and to design a standardized payment methodology for a palliative care benefit for the state Medicaid program and the employee and retiree benefits programs.

Assessment and Comparative Analysis of Palliative Care Initiatives: A Multidimensional Overview of Policies, Programs, and Practices Across 12 U.S. States as of August 22, 2023

The palliative care workgroup undertook a comprehensive examination of how different states across the United States were providing, supporting, and evaluating palliative care services and programs. A detailed analysis was performed on data collection programs from 12 varied states, reflecting a snapshot as of August 22, 2023. This information was methodically organized into tables, encompassing critical domains such as legislation, education (targeting both the general public and healthcare providers), workforce development, and quality and data collection standards.

By synthesizing this essential information, the tables furnished a well-rounded view of the existing landscape of palliative care, illuminating unique state-level initiatives, challenges, and potential avenues for growth. Policymakers, healthcare practitioners, and researchers may have found this compilation to be an invaluable resource for deeper understanding of state-specific trends in palliative care. It served as a significant reference point for guiding informed decisions and encouraging further examination of palliative care practices, with special attention to developments in Maryland.

The selection of the specific states included in the tables was influenced by several key factors:

1. **Geographical Representation:** States were chosen to ensure diverse representation across different regions of the country, providing a more encompassing view of palliative care practices and initiatives.
2. **Varied Policy Landscapes:** The inclusion of states with different legislative frameworks and policies enabled a comparative analysis of varied approaches, facilitating the identification of successful initiatives that might have been replicated elsewhere.
3. **Focus on Key Areas:** The tables accentuated essential aspects like legislation, education (public and provider), workforce, and quality/data collection, showcasing differing strategies and accomplishments in these domains, helping to pinpoint strengths and areas needing enhancement.
4. **Insights from the National Academy for State Health Policy (NASHP):** The tables also integrated findings from NASHP, particularly a November 2022 blog post that spotlighted states demonstrating recent progress in palliative care and the NASHP Budgetary and Legislative Actions in 2022 and 2023 that Support and Expand State Palliative Care Initiatives described earlier in the report.

STATE ISSUE	ARIZONA	CALIFORNIA	COLORADO
LEGISLATION	Senate Bill 1447(2011) defined palliative care for the state. Arizona's Long Term Care System — for older and physically disabled individuals — managed care contract requires case managers to inform members, individuals authorized to make treatment decisions for a patient, and designated representatives	SB1004, implemented in California on January 1, 2018, requires Medi-Cal managed care plans (MCPs) to ensure access to palliative care services for eligible patients. The bill was initially for adult patients and expanded to include pediatric patients in 2019. The objectives of the bill include understanding different clinical and staffing models used in delivering palliative care,	In 2019, Colorado implemented legislation (SB19-073) to establish an advance directive registry system, showcasing the state's growing emphasis on advance care planning and directives as vital elements of effective palliative care programs. This development indicates Colorado's commitment to ensuring that individuals' end-of-life preferences are documented and honored. Furthermore, in 2008, the Colorado Center for

	about person-centered planning services and end-of-life care; and aid members in accessing services. The Arizona Coalition to Transform Serious Illness Care (AZ Coalition) is a group of 40+ stakeholders in Arizona working to improve the quality of care and outcomes for people with serious illness.	considering service and contract features that impact the cost of palliative care delivery, and exploring strategies to align costs and payments. DHCS' SB 1004 Medi-Cal Palliative Care Policy specifies the minimum types of palliative care services that MCPs must authorize when medically necessary for members who meet the eligibility criteria. This includes the minimum services 1. Advanced Care Planning, 2. Palliative Care Assessment and Consultation, 3. Plan of Care, 4. Palliative Care Team, 5. Care Coordination, 6. Pain and Symptom Management, and7. Mental Health and Medical Social Services. The California Department of Health Care Services (DHCS) requires Medi-Cal managed care plans to have palliative care programs for members. Medi-Cal plans currently follow palliative care criteria as outlined in APL 18-020. Starting January 2024, DHCS will also require Medicare Dual Eligible Special Needs Plans (D-SNPs) to have palliative care programs for their dually eligible members. Specific guidance is in the 2024 D-SNP Policy Guide. CA [R] AB 567 Establishes the Long-term Care Insurance Task Force in the Department of Insurance. It is composed of stakeholders and representatives of government agencies, including a representative of palliative and hospice care providers, to examine the components necessary to design and implement a statewide long-term care insurance program. AB 1407 Regarding establishing standards for continuing education, directs the board of nursing to consider adding a course on special care needs that is included but not limited to "pain and symptom management,	Hospice & Palliative Care commissioned a survey by Hospice Analytics to assess the prevalence of palliative care services in the state. The survey aimed to provide insights into the extent of palliative care provision and its impact on healthcare in Colorado. HB23-1128 Requires a healthcare facility to inform patients of services the facility refuses to provide to patients when the refusal is for non-medical reasons, including end-of-life services.

		including palliative care; the psychosocial dynamics of death; dying and bereavement; hospice care".	
EDUCATION	The Arizona Hospice and Palliative Care Organization (AHPCO) is the statewide nonprofit membership organization of hospice and palliative care programs and professionals in Arizona. The AHPCO also has palliative care information focused on finding providers and advanced care planning for patients and families.	In April 2020, the California Health Care Foundation (CHCF) and the Coalition of Compassionate Care of California organized a series of webinars on Driving Palliative Care Improvement in Medi-Cal (SB 1004). The webinars covered various aspects of SB 1004 implementation, including updates on who is being served and how, future developments, and examining the quality of palliative care services. These webinars provided valuable information on program characteristics, care models, contracting, payment issues, program sustainability, collaboration practices, and patient outcomes. From June 2017 to July 2018, CHCF also conducted webinars and workshops to assist health plans and providers in implementing SB 1004 palliative care. These sessions focused on estimating member volume and costs, assessing care delivery costs, launching services, measuring success, and addressing implementation challenges. These resources aimed to support health plans and providers in developing sustainable palliative care programs and improving patient outcomes. The California State University Institute for Palliative Care also provides online training in palliative care for health care professions, patients and families.	Colorado has implemented various initiatives to promote and support palliative care in the state. They have a dedicated page on the Colorado Department of Public Health and Environment website that provides information and resources on palliative care. This includes an interactive provider map that allows users to locate palliative care providers in Colorado. Additionally, the website offers patient resources, such as videos and guides on what to do after a diagnosis, how to communicate with doctors, and where to find more information about palliative care. These resources are available in both English and Spanish, ensuring accessibility for a diverse population. Colorado's efforts demonstrate a commitment to educating both healthcare providers and patients about palliative care and providing access to necessary resources.
FUNDING	**Arizona's** Long Term Care System — for older and physically disabled individuals — managed care contract requires case managers to inform members, individuals authorized to make treatment decisions for a patient, and designated representatives about	All Medi-Cal managed care plans (MCPs) are required to ensure access to palliative care services for eligible patients. The cost of delivering palliative care is influenced by numerous factors, some of which can be modified while others cannot. Factors like patient population characteristics and	In Colorado, there are reimbursement limitations for palliative care services, which impact the types of services that can be provided and to which patients. Currently, interdisciplinary teams consisting of nurses and doctors can be reimbursed, but other service providers are unable to bill directly. This limitation on

	person-centered planning services and end-of-life care; and aid members in accessing services.	regional factors are fixed and need to be accounted for when estimating costs. However, there are modifiable factors related to payer and provider policies, preferences, and practices that can impact the cost. For instance, if care is being provided in a rural area, the physical distance between patients' homes can result in higher costs due to travel time for home-based palliative care services. To address this, providers may propose alternative delivery models such as video visits to reduce travel time and lower costs. While the rurality of the region is unchangeable, choices regarding allowable types of contacts in the contract can be modified. As part of California Advancing and Innovating Medi-Cal (CalAIM), a framework that encompasses delivery and payment reform across Medi-Cal, California's Medicaid program policy guide identifies the need for palliative care as part of the comprehensive health assessment. **California's** CY2024 D-SNP Policy Guide includes care coordination requirements for D-SNPs around the provision of palliative care, including guidance around eligibility, providers and settings, and services.	reimbursement has implications for the availability and accessibility of palliative care services in the state. To ensure comprehensive care, it is necessary to advance funding for non-medical team members as well, recognizing the importance of their contributions in delivering holistic palliative care. Colorado's 1915(c) HCBS waiver for children with life-limiting illness specifically for palliative care services includes: • In-home respite care that can incorporate home health, nursing, personal care, and expressive therapy. Palliative care services such as care coordination (telehealth allowed), pain and symptom management, and counseling supports
WORKFORCE DEVELOPMENT	The Bureau of Health Systems Development (HSD) supports a variety of programs and services meant to improve access to high quality primary health care, particularly for the uninsured and other vulnerable populations. HSD was established in 1995 and is the Primary Care Office for the state of Arizona. The Bureau of Health Systems Development houses the Arizona Health Disparities Center and the Cancer Prevention and Control Programs and focuses on improving	The California Hospice and Palliative Care Association (CHAPCA) is a non-profit organization dedicated to improving access to quality end-of-life care in California. They provide education and support to patients, families, the community, and healthcare professionals regarding hospice and palliative care. CHAPCA's mission is to ensure that patients and their caregivers receive high-quality care while advocating for the hospice and palliative care sector.	In Colorado, the Health Navigator Workforce Development Initiative is focused on defining competencies, standardizing training, and promoting sustainability for unlicensed Health Navigators. These individuals are trusted community members who possess a deep understanding of the communities they serve, often through shared lived experiences. Health Navigators work closely with patients, supporting and assisting them in navigating the complex healthcare system. The initiative includes the establishment of a voluntary credentialing

	access to primary health care through workforce recruitment and retention programs, health professional shortage area (HPSA) and medical underserved area/population (MUA/P) designations and community development programs.	CHAPCA serves as a resource for hospice and palliative care providers in California, offering education, tools, resources, and services. They aim to equip providers with the necessary knowledge and compliance standards to deliver exceptional care to patients and families. By becoming a CHAPCA member, providers demonstrate their commitment to serving their communities effectively. As part of their offerings, CHAPCA organizes an annual conference and provides various educational programs. They also provide a job search function for individuals interested in working in the hospice and palliative care field. Through these initiatives, CHAPCA strives to support workforce development and ensure that California's hospice and palliative care services meet the highest standards of quality.	program, a registry of competency-based training programs, and a registry of health navigators who have completed the training and passed the competency evaluation. The Health Navigators registry page provides further information on this initiative. https://cdphe-health-navigator-prod.appspot.com/
QUALITY/ DATA COLLECTION	The AZ Coalition engaged partner Discern Health to lead a Best Practices Study to determine which community-based services and supports the coalition should pursue to help people with serious illness manage health conditions and increase the number of days at home. The Best Practices Study identified many opportunities, and the coalition members prioritized the recommendation to develop a home-and community-based palliative care network for integrated patient support to help address patient and family barriers to managing conditions at home and reduce the risk of acute events.	SB1004 contains numerous provisions focused on quality and data collection for California. The California Health Care Foundation (CHCF) has developed resources to assess and improve the quality of palliative care in California. They provide an overview slide deck that discusses the information plans report to the California Department of Health Care Services (DHCS) regarding their SB 1004 programs, which focuses on palliative care. The slide deck also includes various strategies and metrics commonly used to assess palliative care quality. To assist stakeholders in selecting appropriate metrics and evaluating feasibility, the resources also provide worksheets such as the Preparing for SB 1004 Metrics Selection Worksheet and the Metrics Balance Check Worksheet. They also provide information on the Payer-Provider Partnership for Palliative Care.	In Colorado, a comprehensive survey was conducted to assess the provision of palliative care. The survey included all 95 hospitals and 76 hospices in the state. It was found that hospitals continue to provide the majority of palliative care consults, although the percentage has decreased from 72% in 2013 to 49% in 2020. Hospice-based palliative care has seen an increase, accounting for 36% of consults. Other providers, apart from hospitals and hospices, accounted for 15% of consults in 2020. The survey also revealed that 48% of palliative care providers are employed by hospitals, and on average, each provider offers 967 consults per year. While the number of patients receiving palliative care services has been increasing, the number of actual programs is not keeping up with the demand. Access to palliative care is disproportionately available on the Front Range, leaving rural areas with limited access. There are challenges related to geographic limitations and cultural perceptions of palliative care. Efforts are

		These resources and tools are designed to support the assessment and improvement of palliative care quality in California, ensuring that care providers have access to relevant metrics and information to deliver high-quality care to seriously ill patients and their families.	being made to address these challenges through state-supported conferences, statewide media campaigns, engagement in membership organizations, mentorship programs, and community-based innovations. Colorado provides state-supported resources for palliative care, which can be accessed through the published State PC Care document. However, there is a need for further development of palliative care programs, particularly in underserved areas and a focus on education and awareness to address misconceptions about when palliative care is appropriate.

STATE ISSUE	HAWAII	MARYLAND	MASSCHUSSETTS
LEGISLATION	SCR 142 was a concurrent resolution passed in 2018 that "requests the Department of Health to convene a working group to examine palliative care services and develop recommendations to expand palliative care services in Hawaii." The working group published a report in 2019 with recommendations including developing a definition of palliative care, supporting palliative care awareness through education, supporting efforts to include palliative care in healthcare insurance and managed care plans and developing a palliative care pilot program. 2019 Report to the Thirtieth Legislature, State of Hawaii In 2019, Hawaii enacted House Bill No. 722, which introduced several measures to promote and expand palliative care services in the state. This legislation established a bidding process for culturally competent palliative care pilot programs and mandated the Department of Health to provide education on palliative care.	The Maryland regulations on palliative care emphasize the importance of specialized medical care for individuals with serious illnesses or conditions. House Bill 581 (2013) directed MHCC to study hospital based palliative care pilot programs. Maryland, informed by findings from a legislatively mandated pilot study on hospital palliative care, updated its regulations to require that hospitals with fifty or more beds establish an active, hospital-wide palliative care program that provides consultation services to patients living with a serious illness. The regulations outline various aspects of palliative care programs, including staffing requirements, palliative care education and training for hospital staff, interdisciplinary plans of care, coordination of services, and continuity of care. The programs are expected to provide counseling on health options, pain management, prognosis, and the availability	The Massachusetts Coalition for Serious Illness Care gathers plans, providers, patient advocates, professional associations, and others to strategize on the implementation of statewide campaigns that improve advance care planning, clinician skills, and more. Palliative Care and Quality of Life Interdisciplinary Advisory Council consults with and advises the Department of Public Health on matters related to the establishment, maintenance, operation, and evaluation of palliative care initiatives in Massachusetts. The definition of palliative care in the State of Massachusetts is outlined in Mass Reg, Part I, Title XVI, Chapter 111, Section 227. This section emphasizes the distribution of information regarding the availability of palliative care and end-of-life options. It serves to define and establish the framework for palliative care within the state.

	It also emphasized the importance of promoting palliative care utilization, encouraging early referrals to palliative care during treatment, and collecting local health care utilization data to measure the impact of palliative care in Hawaii more accurately. HI (R)SB804 Establishes a culturally competent palliative care pilot program that provides palliative care public education and conducts bidding for two home- or community-based pilot programs. In addition to legislative efforts, Hawaii has a statewide movement called Kōkua Mau, which serves as the central hub for individuals and organizations involved in hospice care, palliative care, end-of-life care, and advance care planning. Kōkua Mau leverages the innovative work of its partners, including major medical centers, hospices, insurers, health profession schools, and government agencies, to bring about community change in the field of end-of-life care. The organization has received national recognition for its leadership and innovation in this area. Collectively, these initiatives and collaborations aim to enhance the availability and quality of palliative care services in Hawaii, ensuring that individuals receive culturally competent care and support throughout their illness journey.	of psychological, spiritual, and bereavement services. Proper pain and symptom management, along with education and support for caregivers, are also highlighted. COMAR 10.07.01.31 "Palliative care" defined as specialized medical care for individuals with serious illnesses or conditions that: (a) Is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness or condition, whatever the diagnosis; (b) Has the goal of improving quality of life for the patient, the patient's family, and other caregivers; (c) Is provided at any age and at any stage in a serious illness or condition; and (d) May be provided along with curative treatment. (27) "Palliative care program" means an interdisciplinary team that provides palliative care service. Additionally, the regulations address referrals to hospice services when appropriate, compliance with advance directives and authorized decision makers, access to ethics committees, and participation in quality improvement activities. The Department overseeing these programs has the authority to access data to ensure compliance with state and federal regulations. House Bill 378 (2022) directed MHCC to convene a workgroup to study palliative care services and make recommendations to improve palliative care services. The MD Code, Health-General Article §§13-1601 through 13-1604 in 2002 created the State Advisory Council on Quality Care at the End of Life. Effective October 1,	105 Mass. Reg. 140.1201 is focused on provision of information on palliative care and end-of-life options. The Massachusetts Expert Panel on End-of-Life Care, established in 2009, was tasked with studying the healthcare delivery for patients with serious chronic conditions in the state. Their objective was to identify best practices and recommend any necessary legislative, regulatory, or policy changes. In their October 2010 report, the Expert Panel made two key recommendations. Firstly, they proposed that all healthcare organizations should offer access to palliative care and hospice services, taking inspiration from the New York State Palliative Care Information Act. Secondly, they recommended that all health plans, specifically including the three MassHealth plans (MassHealth Basic, Limited, and Essential), should provide coverage for hospice services, addressing the current exclusion of hospice coverage in those plans.

		2022, and ending September 30, 2024, HB 378 directed the Maryland Health Care Commission to convene a palliative care services workgroup and submit two reports in 2023 to the governor and general assembly on its findings, including recommendations around improving palliative care services in Maryland.	
EDUCATION	In Hawaii, Kōkua Mau is a prominent organization that provides information and resources on accessing palliative care. The state has 9 centers offering palliative care, along with 2 outpatient care facilities and 1 community-based palliative care service. Kōkua Mau's website serves as a comprehensive platform with links to publications, resources, POLST information, webinars, and palliative care curriculum for providers. Hospitals and centers providing palliative care in Hawaii have PDF overviews detailing the services they offer and care plans. However, referrals for outpatient palliative care mainly come from medical oncologists, radiation oncologists, and surgeons, indicating a need for increased education on palliative care among primary care providers. Efforts such as locally based End-of-Life Nursing Education Consortium (ELNEC) courses for physicians and nurses can be encouraged to address this gap. One recurring recommendation is to raise awareness and education about palliative care among both the community and healthcare providers. Sharing success stories and promoting the positive impacts of palliative care can help increase awareness. It is also suggested to improve education and resources to help everyone understand the scope and benefits of palliative care programs. Additionally, marketing efforts targeted at community	Maryland Cancer Collaborative provides information for the public on palliative care resources. A Maryland Comprehensive Cancer Control Plan that has chapter on palliative care. The Hospice & Palliative Care Network of Maryland has an education and outreach program to health care professionals with information on palliative care and information for the public about palliative care.	Hospice & Palliative Care Federation of Massachusetts (HPCFM). HPCFM's mission is to advance and promote excellence in end of life care by advocating for its members, patients, families, and the end-of-life care giving community; providing education and enhancing awareness. They develop education tools and documents for palliative care. Massachusetts Medical Society provides a web site on health care proxy, advance directives, discussion guides, and links to other resources. ALM GL ch.111,234 Palliative care consumer and professional information and education program - Requires Department of Public Health's website to include information about continuing education opportunities for providers; palliative care delivery in the home and other environments; and consumer educational materials and referral information for palliative care, including hospice.

	physicians to inform them about supportive care options are recommended.		
FUNDING	In Hawaii, there have been notable efforts to secure funding for palliative care initiatives. The state is actively pursuing a Medicaid benefit for community-based palliative care through an 1115 CMS waiver. This grassroots effort, supported by organizations like Kokua Mau and Hui Pohala, in collaboration with the Hawaii Department of Health Services Med-QUEST Division and the Stupski Foundation, aims to expand community-based palliative care services to individuals with serious illnesses enrolled in Medicaid across all islands and in urban and rural areas. Legislation such as HB 722 has established a bidding process for culturally competent palliative care pilot programs. It also requires the Department of Health to provide palliative care education, promote palliative care, facilitate referrals, and collect healthcare utilization data. Hawaii is also working on implementing improved benefits for individuals with serious illnesses, including the development of a community-based palliative care benefit through the state's QUEST Integration Medicaid 1115 waiver. Stakeholder listening sessions and the creation of an actuarial model with a consultant have been supported by philanthropic funding. Suggestions for outpatient palliative care include expanding coverage for Supportive and Concurrent Care and strengthening payer-provider relationships. Similarly, community-based palliative care organizations have proposed increasing Supportive Care services and widening the range of end-stage diagnosis codes covered. Removing time limits on Supportive Care benefits and advocating for expanded access through other health plans available throughout Hawaii are also among the recommendations put forth by respondents.	Government-funded insurance programs like Medicaid and Medicare, as well as private insurance, provide coverage for palliative care services to a limited degree. Although Medicare and Medicaid do not specifically use the term "palliative" care to describe the services they cover, the Center to Advance Palliative Care confirms that the services covered are essentially the same. Medicare and Medicare Advantage plans cover certain services under specific conditions, such as a terminal illness diagnosis or for advanced care planning. Medicare covers palliative care both with and without end-of-life hospice care. In Maryland, Medicaid has implemented a person-centered planning approach to administer Long-Term Services and Supports (LTSS). This approach aims to improve health outcomes, enhance independence, and promote a better quality of life for participants. Consequently, Medicaid is gradually shifting its focus from institutional-based care towards home and community-based services, aligning with the goal of enabling individuals to receive care in their preferred setting.	Palliative care is provided on an ad-hoc basis for Medicaid beneficiaries who were either ineligible for, did not have access to, or did not elect hospice. MassHealth Medicaid program currently does not offer a palliative care benefit for their members with a terminal illness who are not eligible for hospice. MA and all the study states, except FL, have implemented Section 2302 of the federal Affordable Care Act, Concurrent Care for Children, which allows coverage of curative treatment for Medicaid members younger than 21 years of age who elect the hospice benefit. (PL 111-148 Patient Protection and Affordable Care Act, Title II, Sub. D, §2302, “Concurrent Care for Children” (124 STAT. 293) 3/23/10). A new value-based sub-capitation model for primary care providers participating in the MassHealth Accountable Care Organization (ACO) program launched in April 2023. MassHealth, in its commitment to enhancing primary care, will allocate over $115 million to support this program. Providers participating in the program are required to meet access and team-based, integrated care standards. The initiative also offers increased flexibility in care delivery to ensure that patients' diverse needs are met effectively.
WORKFORCE DEVELOPMENT	In Hawaii, there are several workforce development needs identified in the field of	Maryland maintains the Maryland Loan Assistance Repayment Program (MLARP).	Massachusetts Loan Repayment Program for Health Professionals. Massachusetts is

	palliative care. Inpatient palliative care programs emphasize the importance of establishing more outpatient palliative care clinics to enhance continuity of care and shift focus on early intervention. They also advocate for increased support and staffing to enable early involvement in the care of patients with severe illnesses. Outpatient palliative care programs highlight the need for greater diversity in interdisciplinary care and additional team members to meet the growing demands. There is a proposition for enhanced interdisciplinary training in primary palliative care skills to ensure healthcare professionals are equipped to provide comprehensive palliative care. Moreover, there is a recognized need for the expansion of pediatric hospice and community-based palliative care services, both on the island of Oahu and neighboring islands. This reflects the growing recognition of the importance of providing specialized care for children with serious illnesses and their families. Overall, these workforce development needs in Hawaii's palliative care sector aim to improve access, quality, and interdisciplinary support for patients with serious illnesses, with a focus on expanding outpatient care, enhancing primary palliative care skills, and addressing the unique needs of pediatric patients.	The MLARP provides educational loan repayment funds to physicians, physician assistants, and medical residents who must serve a 2 year obligation in a HPSA or MUA or state designed health professional shortage area.	experiencing high labor shortages in health care and is conducting a new annual MA Health Care Workforce Survey to collect information on the capacity and diversity of the workforce across key healthcare sectors.
QUALITY/ DATA COLLECTION	In Hawaii, efforts have been made to assess the quality and data collection in palliative care. The Palliative Pupus event, hosted by Kōkua Mau, provides a platform for clinicians to network and discuss cases, challenges, and opportunities, promoting improved interdisciplinary care for palliative care patients. To evaluate the sufficiency of palliative care programs in Hawaii, a comparison was made between the number of patients served and the estimated need for palliative care based on the	The State Advisory Council on Quality Care at the End of Life published policy recommendations to increase electronic advance directive registrants in December 2020. Recommendations include mandating carrier participation, embedding advance care planning into health system workflows, making completion and access to advance directives easier, and public awareness and engagement campaigns.	Hospice & Palliative Care Federation of Massachusetts (HPCFM) oversee a hospice quality reporting scorecard. Massachusetts Pediatric Palliative Care Program is funded by the state Department of Public Health program, separate from MassHealth.

	number of deaths in 2017. The survey results indicated that approximately 21.9% of those who needed palliative care received it in the inpatient setting, while roughly 4.7% received it in the outpatient setting, and 6.1% received it in the community-based setting. There is a recognized gap in community-based palliative care, with programs expressing the need for increased capacity to serve more patients. Barriers to providing more palliative care include lack of insurance coverage, fragmented payment or reimbursement systems, and a knowledge deficit among community and healthcare providers regarding palliative care versus hospice. These findings highlight the importance of addressing gaps in palliative care services and increasing awareness and education about palliative care in Hawaii. By improving access, funding, and interdisciplinary collaboration, efforts can be made to enhance the sufficiency and quality of palliative care in the state.		

STATE ISSUE	NEBRASKA	NEVADA	OREGON
LEGISLATION	LB 323 established the Palliative Care Council in 2017. The council "shall consult with and advise the Department of Health and Human Services on matters relating to palliative care initiatives." Palliative care is currently defined under the Hospice Licensure Act and Nebraska is working to update it.	Nevada's Palliative Care and Quality of Life Information and Education Program, established by legislation in 2017, mandates the creation of a website by the Department of Health and Human Services. The updated website, in compliance with the law and revised in 2022, provides valuable resources such as information on palliative care, best practices, educational materials, and referrals. Additionally, it includes details about the Advisory Council on Palliative Care and Quality of Life (est. 2017) and a Frequently Asked Questions section, further enhancing access to comprehensive	HB2981 Requires the Oregon Health Authority to establish and administer a program that will provide in-home palliative care, through coordinated care organizations by an interdisciplinary team. SB 608 established the Palliative Care and Quality of Life Interdisciplinary Council in the Oregon Health Authority in 2015 to consult with the director on "matters related to the establishment, maintenance, operation and evaluation of palliative care initiatives in this state." Senate Bill 177: Permits licensed hospice program to provide palliative care without obtaining in-home care agency license.

		palliative care information for consumers and professionals. Senate Bill 136, which created the council, required DHHS to encourage hospitals, assisted living facilities, and facilities for skilled nursing with 100 beds or more to educate their physicians, nurses, and clinical staff members regarding palliative care; identify barriers to access to palliative care in Nevada; and to provide information and resources to patients or residents regarding palliative care.	
EDUCATION-PUBLIC	Nebraska Revised Statute 71-4501 et seq. The palliative care consumer and professional information and education program requires the Department of Health and Human Services' website to include information about continuing education opportunities for providers; palliative care delivery in the home and other environments; and consumer educational materials and referral information for palliative care, including hospice. State website includes information about palliative care providers and services in the state and resources for patients/families, resources on pediatric care, and resources for providers. Statute § 71-4501 through 71-4504, established the Palliative Care Consumer and Professional Information and Education Program. To continue expanding palliative care awareness, the Council began working on a strategy to introduce palliative care to the relevant health care licensing boards in Nebraska.	Palliative care resources are available through the Advisory Council on Palliative Care and Quality of Life, which includes information for patients, families, and health professionals. This is a state run website. Nevada Palliative Care works with foundations, institutions, companies, and the community to advance the awareness and education of palliative care. The palliative care and quality of life consumer and professional information and education program requires the Department of Health and Human Services (DHHS) to create a website with information about: -Delivery of palliative care in the home and other environments; Best practices for delivery of palliative care; and educational materials and referral information for palliative and hospice care.	Oregon Hospice & Palliative Care Association provides education and resources for patients, families, and providers. Palliative Care and Quality of Life Interdisciplinary Council also provides public education and supporting resources.
FUNDING	Nebraska Medicaid only reimburses for Advanced Care Planning and Home/Community Interdisciplinary Care Team consult. Reimbursement is limited to Fee-for service billing, there is no Medicaid benefit that supports team-based care for serious illness.	Nevada Palliative Care bills Medicare, Medicaid, and other payors only for consultation services performed by a licensed clinician and ordered by the patient's attending physician.	S.2565: Payers include participating providers: providers eligible to participate under the model may include palliative care teams working as • an independent practice or • associated with a hospice program, • home health agencies, • hospitals,

			• integrated health systems, • and other facilities determined appropriate by the Secretary. • Other Payers: as determined by written agreements.
WORKFORCE DEVELOPMENT	Access to specialty palliative care programs in Nebraska is limited and there are disparities based on geographic region.	The Nevada Health Workforce Research Center aims to improve the collection and analysis of data on health care workforce supply and demand to enhance health workforce planning and development in Nevada. They publish an annual report.	Shortages of health care professionals are predicted due to the health care demands of aging populations and increases in chronic diseases. As Oregon's population grows, the supply of direct patient care FTE must also grow to ensure continued access to health care professionals
QUALITY/ DATA COLLECTION	In 2022, the council released a report detailing the council's progress and proposing recommendations, including updating definitions of palliative care, creating new Medicaid codes for palliative care, expanding palliative options in existing Medicaid plans, convening a palliative care summit, and holding periodic legislative hearings on serious illness.	Advisory Council on Palliative Care and Quality of Life Nevada had the second largest population increase (47.9 percent) of persons aged 65 and older between 1999 and 2009. The website includes information about the Advisory Council on Palliative Care and Quality of Life and an FAQ section that includes information about palliative care, including where it can be provided, how to choose the best options, and the differences between palliative care and hospice.	Palliative Care and Quality of Life Interdisciplinary Council was established within the Oregon Health Authority (OHA) by Senate Bill 608 in the 2015 legislative session. The legislation seeks to improve the lives of children, youths, adults, and the elderly who would benefit from palliative care and to facilitate access through better coordination of care. The OHA Quality Improvement Program aims to work with key partners across the state, coordinated care organizations, quality improvement staff within health systems and community-based organizations to use data to develop targeted interventions for improving health outcomes.

STATE ISSUE	SOUTH CAROLINA	WASHINGTON	WEST VIRGINIA
LEGISLATION	The South Carolina Palliative Care and Quality of Life Study Committee was created by joint resolution H. 4935 in 2018. In South Carolina, the existing legislation regarding Do Not Resuscitate (DNR) and Physician Orders for	Washington State contains multiple laws supporting Advanced Care Planning with a focus on Power of Attorney and WA Advance Directive Documents.	WV [R] SB 748 requires the State Advisory Coalition on Palliative Care to work with the Bureau of Public Health to develop educational materials to raise awareness about palliative care services. WV §16-5C-20 Hospice palliative care

	Scope of Treatment (POST) does not apply to minors. Presently, legal guardians have the authority to make end-of-life decisions for their children within a hospital setting.	Washington is active in National POLST activities. FY 2022-23 Budget Notes that, amongst other requirements, a joint legislative executive committee on planning for aging and disability issues must identify strategies to promote palliative care planning, and advance care directives through the Bree Collaborative palliative care guidelines. FY 2019-20 Legislates that Washington's Office of Insurance Commissioner and the Health Care Authority convene a work group to determine next steps for insurance coverage of specialty palliative care. SB 5187-FY 2023-2025 Budget. Requires a joint legislative executive committee on planning for aging and disability issues to identify strategies to promote palliative care planning, and advance care directives through the Bree Collaborative palliative care guidelines. Designates funds to increase pediatric palliative care rates to the equivalent hospice care rates for Medicare and to design a standardized payment methodology for a palliative care benefit for the state Medicaid program and the employee and retiree benefits programs.	required to be offered. CMS Approval of WV 1915(c) Home and Community-Based Services Waivers Emergency Preparedness and Response. WV [R] SCR 53 encourages specified facilities to provide access to palliative care.
EDUCATION	To enhance the quality of palliative care initiatives in the state, a permanent South Carolina State Advisory Council on Palliative Care and Quality of Life was established. This council serves as a resource providing consultation and guidance to the Governor and General Assembly. It also works to ensure that accurate information and education about palliative care is easily accessible to the public. The South Carolina Department of Health and Environmental Control (DHEC) maintains and funds a statewide Palliative Care website and conducts awareness campaigns. Additionally, an online resource guide on	The Palliative Care Institute has collaborated with various agencies and community organizations to assess the necessary measures required to create a thriving and inclusive community that promotes successful aging for all individuals. The Washington State Hospital Association published The Palliative Care Roadmap to help patients and providers. Northwest Pediatric Palliative Care Coalition (NWPPCC)- NWPPCC's mission is to empower our interprofessional workforce to advocate for every child and family to have access to the support	State Advisory Coalition on Quality of Life produces educational materials and provides resources for patients, families, and providers. Education and Training: The Performance Center has utilized the Public Health Foundation to offer Quality Improvement Symposiums for the Bureau for Public Health and Local Health Departments. The West Virginia Hospital Association is committed to helping our member hospitals improve quality, reduce medical errors and adverse events, and maximize patient safety through the implementation of education programs and quality initiatives.

	Palliative Care education has been developed to support the educational needs of the state. The Hospice & Palliative Care Foundation (HPCF) is a registered 501 (C) (3) not-for-profit foundation working with health care professionals across South Carolina to enhance the quality of life for both hospice and palliative care patients. Requires the Division on Aging website to publish information about palliative care, including: Continuing education opportunities for providers; Information about palliative care delivery in the home and other environments; Best practices for palliative care delivery; and Consumer educational materials and referral information for palliative care, including hospice.	necessary to live as well as possible with serious illness.	
FUNDING	**South Carolina's** Healthy Connections Prime Financial Alignment Initiative (FAI) model demonstration incorporates palliative care by including a palliative care benefit in its contract, which covers comfort care and pain management. Eligibility includes those with a serious, chronic, or life-limiting illness who may not qualify for hospice services.	FY 2023-2025 Budget: Requires a joint legislative executive committee on planning for aging and disability issues to identify strategies to promote palliative care planning, and advance care directives through the Bree Collaborative palliative care guidelines. Designates funds to increase pediatric palliative care rates to the equivalent hospice care rates for Medicare and to design a standardized payment methodology for a palliative care benefit for the state Medicaid program and the employee and retiree benefits programs. The Apple Health program, which is the state's Medicaid program, has implemented an integrated Medicaid managed care for health care and behavioral health services to help provide whole-person care under one health plan. Washington has defined rules for palliative care for individuals 20 and younger in Medicaid and lists palliative care for adults as a covered service within its Apple Health contract. Home health services, including palliative care, through state-licensed agencies are also listed as a	FY 2022-23 Budget: Provides a $1.5M grant in aid to Samaritan hospital for expanded access to palliative care and renews $4M in funding for the palliative care pilot program at Holy Name Hospital. Palliative care is grouped under Hospice services in the WV DHHS resources.

		covered service in the Apple Health contract. As part of the **Washington Rural Palliative Care Initiative**, Washington State developed the Palliative Care Road Map funded through the state legislature. The roadmap includes information for patients and caregivers on palliative care services and support, including culturally sensitive content. Through Washington State legislation, the Washington State Health Care Authority's medical director is authorized to certify patient decision aids for assisting patients in shared decision-making.	
WORKFORCE DEVELOPMENT	The demand for palliative care in South Carolina is increasing, but there is a significant shortage of trained professionals across the state to meet this growing need. In their 2019 Committee report, South Carolina acknowledged the rising demand for palliative care and the shortage of trained professionals to address this need. As a recommendation, they proposed that state health professional licensure and continuing education requirements should include a minimum number of hours dedicated to palliative care instruction, specifically focusing on communication skills and symptom management skills.	The Health Workforce Council brings attention to current and projected workforce shortages in healthcare occupations and proposes strategies to address these issues. In July 2022, the Workforce Board began implementation of a three-year project to strengthen Washington's long-term care workforce. The Bree Collaborative was established by the Washington Legislature in 2011 to bring public health care purchasers for Washington state, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations together to identify specific ways to improve health care quality, outcomes, and affordability in Washington State. The Bree takes on different topics and develops clinical recommendations.	West Virginia has serious healthcare workforce shortages. The Performance Center is working closely with the Bureau for Public Health's Human Resources area on Workforce Development Initiatives. The Bureau for Public Health has recently launched the West Virginia Public Health Workforce Assessment
QUALITY/ DATA COLLECTION	SC Palliative Care and Quality of Life Study Committee Report (2019) details many quality related recommendations including improving education, requiring participating in the annual Palliative Care Registry Surveys and Community Mapping Project through the CAPC, and	Washington State Hospice & Palliative Care Organization Palliative Care Institute at Western Washington University. The Bree Collaborative outlines specific quality metrics for palliative care.	HB 4035.State Advisory Coalition on Quality of Life. The purpose of the coalition created under this article is to improve quality and delivery of patient centered and family focused care in West Virginia. WV QI Model: The Performance Center is currently working with

	identifying Centers of Excellence of palliative care practice to support workforce development.		all Offices within the Bureau for Public Health to identify QI projects that may help to improve processes and efficiencies.

Appendix F - 2023 Palliative Care Provider Directory

PALLIATIVE CARE PROVIDER ORGANIZATION DIRECTORY 2023*

ORGANIZATION NAME	ORGANIZATION TYPE	ADDRESS	MAIN PHONE NUMBER	WEBSITE	PARTICIPATED IN SURVEY	PALLIATIVE CARE PROVIDER
AccentCare**	Hospice Program	5457 Twin Knolls Rd Suite 10, Columbia, MD 21045	(888) 523-6000	https://www.accentcare.com/our-services/hospice-palliative-care/greater-baltimore/	Yes	Yes
BridgingLife, Inc-Hospice Care (Westminster)**	Hospice Program	292 Stoner Ave, Westminster, MD 21157	(410) 871-8000	https://www.lifebridgehealth.org/main/bridging-life-hospice-care	Yes	Yes
Capital Caring Health**	Hospice Program	9885 Greenbelt Rd, Suite 300, Lantham, MD 20706	(301) 909-5770	https://www.capitalcaring.org/	Yes	Yes
Coastal Hospice**	Hospice Program	2604 Old Ocean City Rd, Salisbury, MD 21804	(410) 742-8732	https://www.coastalhospice.org/	Yes	Yes
Compass Regional Hospice**	Hospice Program	255 Comet Dr, Centreville, MD 21617	(443) 262-4100	https://compassregionalhospice.org/	Yes	Yes
Gilchrist**	Hospice Program	1060 East 33rd St., Baltimore, MD 21218	(888) 823-8880	https://gilchristcares.org/	Yes	Yes
Hospice of Chesapeake**	Hospice Program	90 Ritchie Hwy, Pasadena, MD 21122	(410) 987-2003	https://www.hospicechesapeake.org/	Yes	Yes
Hospice of the Chesapeake/Chesapeake Supportive Care**	Hospice Program	90 Ritchie Hwy, Pasadena, MD 21122	(410) 987-2003	https://www.hospicechesapeake.org/hospice-supportive-care/	Yes	Yes
Hospice of Washington County + LifeCare Health**	Hospice Program	1710 Underpass Way suite 300, Hagerstown, MD 21740	(301) 791-6360	https://hospiceofwc.org/care-services/lifecare-advanced-illness-management	Yes	Yes
Medstar St. Mary's Hospital-Hospice**	Hospice Program	44724 Hospice Ln., Callaway, MD 20620	(301) 994-3023	https://www.medstarhealth.org/locations/hospice-of-st-marys	Yes	Yes
Montgomery Hospice Inc.**	Hospice Program	1355 Piccard Dr # 100, Rockville, MD 20850	(301) 921-4400	https://montgomeryhospice.org/	Yes	Yes

Promedica Hospice Baltimore**	Hospice Program	7001 Johnnycake Rd # 204, Windsor Mill, MD 21244	(410) 719-8670	https://www.promedicahospice.org/find-an-agency/promedica-hospice-baltimore/	Yes	Yes
Talbot Hospice**	Hospice Program	586 Cynwood Dr, Easton, MD 21601	(410) 822-6681	https://talbothospice.org/	Yes	Yes
Adventist HealthCare Shady Grove Medical Center	Hospital	9901 Medical Center Drive, Rockville, MD 20850	(204) 826-6000	https://www.adventisthealthcare.com/locations/profile/shady-grove-medical-center/	No	Yes
Adventist Healthcare White Oak Medical Center**	Hospital	11890 Healing Wy, Silver Spring, MD 20904	(240) 637-4000	https://www.adventisthealthcare.com/locations/profile/white-oak-medical-center/	Yes	Yes
Ascension Saint Agnes**	Hospital	900 South Caton Ave, Baltimore, MD, 21229	(667) 234-6000	https://healthcare.ascension.org/locations/maryland/mdbal/baltimore-ascension-saint-agnes-hospital	Yes	Yes
Atlantic General Hospital	Hospital	900 South Caton Avenue, Batlimore, MD 21229	(410) 368-6000	https://www.atlanticgeneral.org	No	Yes
CalvertHealth Medical Center**	Hospital	100 Hospital Rd, Prince Frederick, MD 20678	(410) 535-4000	https://www.calverthealthmedicine.org/	Yes	Yes
Carroll Hospital Center - A LifeBridge Health Center	Hospital	200 Memorial Avenue, Westminster, MD 21157	(410) 876-3000	https://www.lifebridgehealth.org/main/carroll-hospital	No	Yes
ChristianaCare, Union Hospital	Hospital	106 Bow Street, Elkton, MD 21921	(443) 406-1825	https://www.uhcc.com	No	Yes
Frederick Health Hospital**	Hospital	400 W 7th St, Frederick, MD 21701	(240) 566-3300	https://www.frederickhealth.org/	Yes	Yes
Garrett Regional Medical Center**	Hospital	251 N 4th St, Oakland, MD 21550	(301) 533-4000	https://wvumedicine.org/garrett-regional-medical-center/	Yes	Yes
Greater Baltimore Medical Center (GBMC)**	Hospital	6701 N Charles St, Towson, MD 21204	(443) 849-2000	https://www.gbmc.org/	Yes	Yes
Holy Cross Germantown Hospital**	Hospital	19801 Observation Dr, Germantown, Maryland 20876	(301) 557-6000	https://www.holycrosshealth.org/location/holy-cross-germantown-hospital	Yes	Yes

Holy Cross Hospital (Silver Spring)	Hospital	1500 Forest Glen Road, Silver Spring, MD 20910	(301) 754-7000	https://www.holycrosshealth.org/location/holy-cross-hospital-silver-spring-2	No	Yes
Johns Hopkins Bayview Medical Center	Hospital	4940 Eastern Ave, Baltimore, MD 21224	(410) 550-0100	https://www.hopkinsmedicine.org/johns-hopkins-bayview	No	Yes
Johns Hopkins Hospital	Hospital	1800 Orleans St, Baltimore MD	(410) 550-0100	https://www.hopkinsmedicine.org/the-johns-hopkins-hospital	No	Yes
Johns Hopkins Howard County Medical Center	Hospital	5755 Cedar Ln, Columbia, MD 21044	(410) 740-7890	https://www.hopkinsmedicine.org/howard_county_general_hospital/	No	Yes
Johns Hopkins Suburban Hospital	Hospital	8600 Old Georgetown Rd, Bethesda, MD 20814	(301) 896-3100	https://www.hopkinsmedicine.org/suburban-hospital	No	Yes
Levindale Geriatric Center and Hospital **	Hospital	2434 W Belvedere Ave, Baltimore, MD 21215	(410) 601-2400	https://www.lifebridgehealth.org/main/levindale	Yes	Yes
Luminis Health Anne Arundel Medical Center**	Hospital	175 Harry S. Truman Parkway, Annapolis, MD 21401	(443) 481-1000	https://www.luminishealth.org/en	Yes	Yes
Luminis Health Doctors Community Medical Center	Hospital	8118 Good Luck Rd, Lanham, MD 20706	(301) 552-8118	Luminis Health Doctors Community Medical Center | Luminis Health	No	Yes
Medstar Franklin Square Medical Center**	Hospital	9000 Franklin Square Dr, Baltimore, MD 21237	(443) 777-7000	https://www.medstarhealth.org/locations/medstar-franklin-square-medical-center	Yes	Yes
MedStar Good Samaritan Hospital	Hospital	5601 Loch Raven Boulevard, Baltimore, MD 21239	(443) 444-8000	https://www.medstarhealth.org	No	Yes
MedStar Harbor Hospital	Hospital	3001 South Hanover Street, Baltimore, MD 21225	(410) 350-3200	https://www.medstarhealth.org	No	Yes
Medstar Montgomery Medical Center**	Hospital	18101 Prince Philip Dr, Olney, MD 20832	(301) 774-8882	https://www.medstarhealth.org/locations/medstar-montgomery-medical-center	Yes	Yes
MedStar Saint Mary's Hospital	Hospital	25500 Point Lookout Rd, Leonardtown, MD 20650	(301) 475-8981	https://www.medstarhealth.org/locations/medstar-st-marys-hospital	No	Yes

MedStar Southern Maryland Hospital Center	Hospital	7503 Surratts Road, Clinton, MD 20735	(301) 868-8000	https://www.medstarhealth.org	No	Yes
Medstar Union Memorial Hospital **	Hospital	201 E University Pkwy, Baltimore, MD 21218	(410) 554-2000	https://www.medstarhealth.org/locations/medstar-union-memorial-hospital	Yes	Yes
Mercy Medical Center**	Hospital	345 St. Paul Place, Baltimore, MD 21202	(410) 332-9000	https://mdmercy.com/	Yes	Yes
Meritus Health Medical Center-Hagerstown**	Hospital	11116 Medical Campus Road, Hagerstown, MD 21742	(301) 790-8000	https://www.meritushealth.com/	Yes	Yes
Northwest Hospital	Hospital	5401 Old Court Road, Randallstown, MD 21133	(410) 521-2200	https://www.lifebridgehealth.org/main/northwest-hospital	No	Yes
Sinai Hospital**	Hospital	2401 W. Belvedere Ave., Baltimore MD 21215	(410) 601-9000	https://www.lifebridgehealth.org/main/sinai-hospital	Yes	Yes
Suburban Hospital**	Hospital	8600 Old Georgetown Rd Bethesda, MD 20814	(301) 530-5171	https://www.hopkinsmedicine.org/suburban_hospital/	Yes	Yes
TidalHealth Peninsula Regional**	Hospital	100 E Carroll St, Salisbury, MD 21801	(410) 546-6400	https://www.tidalhealth.org/our-locations/tidalhealth-peninsula-regional	Yes	Yes
University of Maryland Baltimore Washington Medical Center**	Hospital	301 Hospital Dr, Glen Burnie, MD 21061	(410) 787-4000	https://www.umms.org/bwmc	Yes	Yes
University of Maryland Capital Region Health**	Hospital	901 Harry S Truman Dr, Largo, MD 20774	(240) 677-1000	https://www.umms.org/capital	Yes	Yes
University of Maryland Charles Regional Medical Center	Hospital	701 East Charles Street, La Plata, MD 20646	(301) 609-4000	https://www.umms.org/charles	No	Yes
University of Maryland Harford Memorial Hospital	Hospital	501 S Union Ave, Havre De Grace, MD 21078	(443) 843-5000	https://www.umms.org/uch/locations/um-harford-memorial-hospital	No	Yes
University of Maryland Medical Center	Hospital	22 S Greene Street, Baltimore, MD 21201	(410) 328-8667	https://www.umms.org/	No	Yes

University of Maryland Medical Center Midtown Campus	Hospital	827 Linden Avenue, Baltimore, MD 21202	(410) 225-8000	https://www.umms.org/midtown	No	Yes
University of Maryland Rehabilitation & Orthopaedic Institute	Hospital	2200 Kernan Drive, Baltimore, MD 21207	(410) 448-2500	https://www.umms.org/rehab	No	Yes
University of Maryland Shore Medical Center at Easton	Hospital	219 South Washington Street, Easton, MD 21601	(410) 822-1000	https://www.umms.org/shore/locations/medical-center-easton	No	Yes
University of Maryland St. Joseph Medical Center**	Hospital	7601 Osler Drive Towson, MD 21204	(410) 337-1000	https://www.umms.org/sjmc	Yes	Yes
University of Maryland Upper Chesapeake Medical Center **	Hospital	500 Upper Chesapeake Dr, Bel Air, MD 21014	(443) 643-1000	https://www.umms.org/uch/locations/um-upper-chesapeake-medical-center	Yes	Yes
UPMC Western Maryland**	Hospital	12500 Willowbrook Rd, Cumberland, MD 21502	(240) 964-7000	https://www.wmhs.com/	Yes	Yes
Althea Woodland Nursing Home or Skilled Rehabilitation Facility**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	1000 Daleview Dr, Silver Spring, MD 20901	(301) 434-2646	https://www.altheawoodland.net/	Yes	Yes
Asbury Solomons Waterfront Retirement Community**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	11100 Asbury Cir, Solomons, MD 20688	(410) 394-3000	https://www.asbury.org/asbury-solomons/	Yes	Yes
Atlee Hill Skilled Nursing and Rehabilitation Facility**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	297 Stoner Ave, Westminster, MD 21157	(443) 289-3790	https://www.lifebridgehealth.org/main/atlee-hill	Yes	Yes
Autumn Lake Healthcare at Alice Manor**	Nursing Home or Skilled Rehabilitation Facility or Skilled	2095 Rockrose Ave, Baltimore, MD 21211	(410) 889-9700	https://autumnlakealicemanor.com/	Yes	Yes

	Rehabilitation Facility					
Autumn Lake Healthcare at Birch Manor**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	7309 2nd Ave, Sykesville, MD 21784	(410) 795-1100	https://autumnlakebirchmanor.com/	Yes	Yes
Autumn Lake Healthcare at Bridgepark**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	4017 Liberty Heights Ave, Baltimore, MD 21207	(410) 542-5306	https://www.autumnlakebridgepark.com	Yes	Yes
Autumn Lake Healthcare at Loch Raven**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	8720 Emge Rd, Baltimore, MD 21234	(410) 668-1961	https://autumnlakelochraven.com/	Yes	Yes
Autumn Lake Healthcare at Long Green**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	115 E Melrose Ave, Baltimore, MD 21212	(410) 435-9073	https://autumnlakelonggreen.com/	Yes	Yes
Autumn Lake Healthcare at Spa Creek**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	35 Milkshake Ln, Annapolis, MD 21403	(410) 269-5100	https://autumnlakespacreek.com/	Yes	Yes
Autumn Lake Healthcare at Waugh Chapel**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	1221 Waugh Chapel Rd, Gambrills, MD 21054	(410) 923-2020	https://autumnlakewaughchapel.com/	Yes	Yes

Broadmead**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	13801 York Rd, Cockeysville, MD 21030	(410) 527-1900	http://www.broadmead.org/	Yes	Yes
Brooke Grove Retirement Village**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	18100 Slade School Rd, Sandy Spring, MD 20860	(301) 924-2811	https://www.bgf.org/	Yes	Yes
Carroll Lutheran Village**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	300 St Luke Cir, Westminster, MD 21158	(410) 848-0090	https://clvillage.org/	Yes	Yes
Chapel Hill Nursing and Rehab Center **	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	4511 Robosson Rd, Randallstown, MD 21133	(410) 922-2443	https://chapelhillnrc.com/	Yes	Yes
Citizens Care Center**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	415 Market St, Havre De Grace, MD 21078	(410) 939-5500	https://www.citizenscarecenter.com/	Yes	Yes
Communicare Commons at Cumberland**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	506 White Ave, Cumberland, MD 21502	(301) 722-5535	https://communicarehealth.com/location/commons-at-cumberland/	Yes	Yes
Communicare Health Services-Fayette Health and Rehabilitation Center**	Nursing Home or Skilled Rehabilitation Facility or Skilled	1217 W Fayette St, Baltimore, MD 21223	(410) 727-3947	https://communicarehealth.com/location/fayette-health-and-rehabilitation-center/	Yes	Yes

	Rehabilitation Facility					
Complete Care Wheaton**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	4011 Randolph Rd, Silver Spring, MD 20902	(301) 933-2500	https://ccwheaton.com/	Yes	Yes
Crescent Cities Nursing & Rehabilitation Center**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	4409 East-West Hwy, Riverdale, MD 20737	(301) 699-2000	https://seniorcarefinder.com/providers/21998/md/riverdale/crescent-cities-nursing--rehabilitation-center	Yes	Yes
Frederick Villa Nursing Home or Skilled Rehabilitation Facility**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	711 Academy Rd, Catonsville, MD 21228	(410) 788-3300	https://www.nursinghomes.com/md/catonsville/frederick-villa-nursing-rehab-center/	Yes	Yes
FutureCare Chesapeake**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	305 College Pkwy, Arnold, MD 21012	(410) 647-0015	https://futurecare.com/senior-care-maryland/chesapeake/4/	Yes	Yes
Futurecare Irvington**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	22 S Athol Ave, Baltimore, MD 21229	(410) 947-3052	https://futurecare.com/locations/irvington/	Yes	Yes
FutureCare Lochearn **	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	4800 Seton Dr, Baltimore, MD 21215	(410) 358-3410	https://futurecare.com/senior-care-maryland/lochearn/8/	Yes	Yes

Homewood at Frederick**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	7407 Willow Rd, Frederick, MD 21702	(301) 644-5600	https://homewoodfrederick.com/	Yes	Yes
Lorien Bel Air**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	1909 Emmorton Rd, Bel Air, MD 21015	(410) 803-1400	https://www.lorienhealth.com/locations/bel-air	Yes	Yes
Lorien Mays Chapel**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	12230 Roundwood Rd, Timonium, MD 21093	(410) 252-0880	https://www.lorienhealth.com/locations/mays-chapel	Yes	Yes
ProMedica Hospice and Palliative Care (Beltsville)**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	12304 Baltimore Ave suite a, Beltsville, MD 20705	(240) 264-1692	https://www.promedicahospice.org/Beltsville	Yes	Yes
Promedica Wheaton**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	11901 Georgia Ave, Wheaton, MD 20902	(301) 942-2500	https://www.promedicaskillednursing.org/locations/promedica-skilled-nursing-and-rehabilitation-wheaton/	Yes	Yes
Regency Care of Silver Springs**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	9101 2nd Ave, Silver Spring, MD 20910	(610) 444-6350	https://regencycaresilverspring.com/	Yes	Yes
Salisbury Rehabilitation and Nursing Center**	Nursing Home or Skilled Rehabilitation Facility or Skilled	200 Civic Ave, Salisbury, MD 21804	(410) 749-1466	https://www.genesishcc.com/salisburyrehabandnursing/	Yes	Yes

	Rehabilitation Facility					
Stadium Place Nursing and Rehab**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	1010 E 33rd St, Baltimore, MD 21218	(410) 554-9890	https://www.medstarfamilychoice.com/maryland-members/facilities/the-nursing-and-rehab-center-at-stadium-place-11152720-1010-e-33rd-st	Yes	Yes
Sterling Care Belair**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	410 E Macphail Rd, Bel Air, MD 21014	(410) 838-7810	https://sterlingcarehealth.com/sterling-care-bel-air/	Yes	Yes
Sterling Care South Mountain**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	141 S Main St, Boonsboro, MD 21713	(301) 432-5457	https://sterlingcarehealth.com/sterling-care-south-mountain/	Yes	Yes
Vita Senior Healthcare **	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	1842 Calvert St NW, Washington, DC 20009	(202)483-5800	https://www.vitaseniorliving.com/	Yes	Yes
Westgate Hills Rehabilitation & Healthcare Center**	Nursing Home or Skilled Rehabilitation Facility or Skilled Rehabilitation Facility	10 N Rock Glen Rd, Baltimore, MD 21229	(410) 646-2100	https://westgatehillshc.com/	Yes	Yes
Medstar Health Home Care	Home Health	5233 King Ave, Ste 200, Baltimore MD 21237	(410) 933-2900	https://www.medstarhealth.org/services/home-care	Yes	Yes

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*** Disclaimer: The information contained within this Provider directory is based on data provided by organizations that have self-reported the existence of a palliative care program that meets the CAPC definition of "palliative care program", as well**

as hospitals known to maintain such a program in compliance with Maryland law. Please note that Maryland law mandates that all hospitals with 50 or more beds must have a palliative care program. While efforts have been made to verify the accuracy of this information, the directory does not guarantee its completeness or correctness. It is recommended to verify the specific details of any palliative care program with the respective provider or institution.

**Organization participated in the 2023 MHCC Maryland Statewide Palliative Care Survey

			LAST UPDATED:	8/17/2023