MARYLAND
Health Care
Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

Palliative Care Services Workgroup Meeting
September 21, 2022
Meeting Summary

ATTENDANCE:

Workgroup Members:
Dr. Deneen Bowlin, Carefirst
Cindy Carter, AARP
Matthew Celentano, League of Life
Erin Davis, Maryland Hospital Association
Amanda DiStefano, Maryland Department of Aging
Peggy Funk, Hospice & Palliative Care Network of Maryland
Dr. Marian Grant, Palliative Care Nurse Practitioner and Consultant
Dr. Christopher Kearney, State Advisory Council on Quality Care at End of Life
Cindy Massuda, CMS
Joanna Ruth, Maryland Medicaid

MHCC Staff:
Ben Steffen
Linda Cole
Tracey DeShields
Stacy Howes
Zoram Kaul
Shadae Paul
Catherine Victorine
Cathy Weiss

Interested Parties/Public:
Scott Brown, MyDirectives.com
Allison Ciborowski, Leading Age
Leah Couture, MedStar Union Memorial Hospital
Dr. Ethan Goldstein, MedStar Good Samaritan Hospital
Aaron Greenfield, Greenfield Law, Leading Age
Cathy Grason, Carefirst
Ted Myerson, Nursing home general interest
Sarah Oiveria, Frederick Health
Tracie Shwoyer-Morgan, Gilchrist Hospice

WELCOME AND INTRODUCTIONS:
Ben Steffen, Executive Director of the Maryland Health Care Commission (MHCC) welcomed all participants to the first meeting of the Palliative Care Services Workgroup. After introductions of staff and workgroup members, Mr. Steffen presented some housekeeping items about conduct of zoom meetings (mute microphones; use Q&A feature) and asked participants to hold questions until after the presentations.

REVIEW OF HB 378:
Linda Cole, Chief of Long-Term Care Policy and Planning at MHCC, reviewed the enabling legislation (HB 378). The legislation requires the MHCC to convene a group of interested stakeholders; those representatives have been introduced as workgroup members who explained their connection to the subject of palliative care in Maryland.

Ms. Cole then reviewed the Scope of Work outlined in the bill and explained that the focus of this first meeting would be on the first three bullets: palliative care resources, capacity of providers to offer care, and gaps in resources. Other items included in the Scope of Work, such as collaboration, financial support, public education, and other strategies would be the focus of future meetings.

The timelines include an Interim Report, due July 2023, and a Final Report, due November 2023. Ms. Cole noted that settings recommended to be studied include hospitals, nursing homes, hospices, home health agencies, and community settings.

MHCC WORK AND OTHER STATE STUDIES:
Ms. Cole explained that previous MHCC work included a 2008 “Study of Health Care Services for Children with Life-Threatening Conditions,” conducted jointly with the State Advisory Council on Quality Care at End of Life. In 2015, MHCC conducted a study entitled “Maryland Hospital Palliative Care Programs: Analysis and Recommendations.” While staff recommends collecting data across multiple settings, the focus of the current study is on community-based palliative care.

Ms. Cole noted that the Center to Advance Palliative Care (CAPC), in conducting a nationwide study of palliative care, awarded an “A” to Maryland, primarily in the provision of hospital-based palliative care.
Ms. Cole offered a staff recommendation for a definition of palliative care to guide the work of this group:

> *“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 the 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 at any stage of a serious illness, and it can be provided along with curative treatment."*
> *Source: Center to Advance Palliative Care*

SURVEYS IN OTHER STATES:
Ms. Cole reviewed palliative care work done in four states: Hawaii, Colorado, South Carolina, and Nebraska. Hawaii is cited as a model that inspired work on the development of HB 378. The research reported was limited, as they surveyed 30 programs and received responses from six.

The Colorado research is far more robust and has been repeated three times. It involves a telephone survey of palliative care resources identified in the state. This survey could be a good starting point for Maryland.

South Carolina did not conduct a survey, but relied on the CAPC report for its state. A major focus was on pediatric palliative care.

Nebraska also relied on CAPC data in lieu of a state survey. The report includes case studies to describe the types of patients that might be appropriate for palliative care.

WORKPLAN:
Ms. Cole briefly reviewed the workplan, which had been included in the workgroup mailing. The first three sections describe background and planning work presented at this meeting. Future meetings are planned as follows:

Meeting 2: Review survey instrument and determine how to measure services and gaps.
Meeting 3: Review survey results and recommend complementary data sources.
Meeting 4: Discuss strategy for collaboration and for expansion of financial support.
Meeting 5: Discuss strategy for ongoing data collection and for public education.
Meeting 6: Discuss preliminary findings and draft Interim Report
Meeting 7: Review recommendations
Meeting 8: Develop consensus on final recommendations and review Final Report.

DISCUSSION AND COMMENTS:
Peggy Funk, Executive Director of the Hospice & Palliative Care Network of Maryland, explained the background and development of HB 378 and thanked the MHCC for bringing together this workgroup.

There was some discussion of the CAPC report card. It is self-reported data and focuses primarily on hospital services. Some commenters indicated that patients do not want to stay in hospitals for care, but palliative care services outside the hospital are in limited supply.

Financing of Care:
Mr. Steffen asked the payors how palliative care is financed. Payment is fragmented and provided under various other services. Many employers, as well as the general public, are not aware of palliative care. Representatives of commercial insurers and Carefirst said that they would do some research and supply additional information to the workgroup.

Definition:
Ms. Cole recommended the CAPC definition of palliative care and asked for feedback.

Members stated that this definition is widely used by CAPC and for public education. It has also been endorsed by the National Hospice and Palliative Care Association (NHPCO). Other commenters stated that examples of services are needed. Some commented that it is unclear what the specially trained teams include in an era of workforce shortages.

Ms. Funk clarified the differences between hospice and palliative care. As she stated, all hospice is palliative care, but not all palliative care is hospice. Both involve a multidisciplinary team approach and include spiritual care.

Dr. Grant, Palliative Care Nurse Practitioner and Consultant, indicated that the issue can also be defined in terms of "serious illness" in the general population. She offered to supply staff with data on this.

Settings:
Ms. Cole recommended the following settings for the survey: hospitals, nursing homes, hospices, home health agencies, other community providers. Commenters said that settings are influenced by workforce and payment issues. It was pointed out that settings can also include types of specialty clinics (e.g., oncology, dialysis) that provide palliative care.

State Surveys and Data:
Questions were raised as to why Colorado was recommended, though some members supported this suggestion. It was recommended that staff explore other state programs including the following:

California recently included palliative care in its MediCal (state Medicaid program). Hawaii updated its research within the past year. Massachusetts and Florida are also doing work in this area. Members offered to provide the staff with additional information from other states.

Other:
Mr. Steffen raised questions about Iris Health, Halifax, and other for-profit organizations that might offer palliative care. He also asked how Accountable Care Organizations (ACOs) address this issue.

He also stated that the use of a contractor to help with a statewide survey (or other workgroup tasks) would involve the bid board process, which is limited to contracts up to a maximum of $50,000.

Next Steps:
Following public comments, Mr. Steffen said that Survey Monkey will be used to set up the next few meetings to address issues as identified in the workplan.