Agenda Item 1: Welcome and introductions
The Palliative Care Interdisciplinary Advisory Council (PCIA) meeting was called to order at 10:03 a.m. by Mr. Jimmy Blanton, HHSC serving as presiding officer on behalf of Council Chair Dr. Larry Driver and Council Vice-Chair Barbara Jones. Mr. Blanton welcomed everyone to the meeting and expressed his gratitude and appreciation to the members who have participated on the council since its inception. Mr. Blanton introduced Ms. Heather Paterson who was attending her first meeting and congratulated her on her appointment. New and existing members introduced themselves. Mr. Blanton stated that agenda items would be switched to accommodate presenters and agenda item 3 a & b would be tabled to allow more time to review and discuss the council’s legislative recommendations.

Mr. Jimmy Blanton, Health and Human Services Commission (HHSC), made announcements and introduced Ms. Emily Igunbor and Mr. John Chacón, HHSC staff also supporting the Council. Mr. Chacón noted that a quorum was present at the start of the meeting.

Table 1 notes Council member attendance.

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<tr>
<th>MEMBER NAME</th>
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<th>NO</th>
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<td>Allmon, Jennifer Carr</td>
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<td>Carmona, Jo Ann</td>
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<td>Jones, Nathan Jr. RPh</td>
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<td>Christensen, Bruce DHSc</td>
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<td>Madisetti-Vemireddy, Bhavani</td>
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<td>Driver, Larry MD</td>
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<td>Moss, Amy DO (am only)</td>
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<td>Fenter, Jerry</td>
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<td>Fine, Robert MD</td>
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<td>Gross, Gary MD</td>
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<td>Ragain, Roger Mike MD</td>
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<td>Scott, Cam</td>
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Yes: Indicates attended the meeting  
No: Indicates did not attend the meeting  
P: Indicates phone conference call

Agenda Item 5: Discussion on lessons from “Being Mortal”.
Dr. Gary Gross lead discussion regarding "Being Mortal and referred to Handout entitled “Atul Gawande Excerpt”. Highlights of the discussion and committee member discussion included:

- Dr. Gross stated that providing congruent care has had a positive impact on patient care. Advance Directives increased to 85% for example.
• Dr. Craig Hurwitz stated that he advised that people go see the play "Wit" which describes a person going through end of life treatment for ovarian cancer. There is also a discussion after the play. It is at the Scottish Rite Theater.
• Dr. Fine stated that he wanted to point out the author’s work affords many public education opportunities. He stated that one can watch the author’s one hour video and see other Atul Gawande items on PBS. The author is not an end of life doctor but a head and neck surgeon.
• Ms. Heather Paterson stated that children do not have the autonomy in the decision making process. Many children who can speak for themselves chose not to and acquiesce to treatments that they do not want. Families do not think that their child will have an illness where it will cause them to die. She stated that she tells parents to think of what you would want for yourself.
• Ms. Erin Perez stated that she also deals with this with adolescents and young adults. They too have a lot of struggle. They have a child life specialist because young adults may not be operating at their chronological age. It's a slow pace that they move through.
• Dr. Gross stated that the book makes it clear there is another way to do this.

**Agenda Item 2: Review and approval of meeting minutes from June 14, 2018**

Mr. Jimmy Blanton asked for any changes or edits and called for review and approval of the minutes of the June 14, 2018 meeting.

**Motion:** With no corrections, Dr. Robert Fine moved to approve the minutes of the June 14, 2018 meeting. Dr. Hattie Henderson seconded the motion. By voice vote, with ten yea’s, no nays, one abstention, the motion passed.

**Agenda Item 6: 2018 legislative recommendations and report Part I**

Mr. Jimmy Blanton provided a brief update on staff work to compile from members their 2018 legislative report recommendation proposals and described the format for the recommendations. Mr. Blanton referenced PowerPoint entitled PCIAC -August 17, 2018 Full Council Meeting #11”. Ms. Erin Perez and Dr. Josh Reed provided the 2018 legislative recommendations from Workgroups 1 and 3 and referenced handout entitled “2018 PCIAC Draft Report Recommendations. The following are highlights from the Council:

• **Regarding Workgroup 3, recommendation #6**, Dr. Reed stated that the thought from the work group was to tap into the national discussion in a way that was sensitive to the misuse and also that opioids are useful in many situations. Pain management is an important part of palliative care. Opioids are only one tool available to impact suffering. The goal was to not over react and broaden the definition of suffering and pain to better address the crisis and the roots of the crisis.

Comments and discussion by council members on the recommendation #6 included:

• There is a grant that can assist with education from the American Society of Addiction Medicine (ASAM).
• Education will be the major cornerstone.
• Dr. Fine talked about dealing with a patient who had very high opioid needs. There were problems with insurance coverage for methadone and a psycho-stimulant. The idea of balance must include non-discrimination of patients with chronic advanced illness.
• We can modify the recommendation or make another recommendation.
• The recommendation should state the council opposes step therapy.
• There is an opportunity to include the proper use of opioids in the education of the public.
• We should support education and address the issues of public awareness related to life limiting illness.
• If you put up too many barriers, people start taking their lives.
• The balance was designed to make clear that opioids are only one tool.
• There were some minor technical corrections to the narrative.
• It was agreed that work group three would do the wordsmithing discussed above.

**Regarding Workgroup 1, recommendation #1**, Ms. Perez stated that the development of this recommendation has been collaborative with many parties nationally and statewide.

**Comments and discussion by council members on recommendation #1 included:**

- Recommendation 1a should reference the article on economic impact that had been circulated
- "licensed or certified" should be added
- Under recommendation 1b perhaps state “across all settings of health care.”
- Technical corrections were made.
- The issue of a certified agency appears unclear.
- A key part of the motivation for this is to build a structure that is supportive of funding by Medicaid.
- We should be careful on specific language. There is no evidence based definition of the care team.
- There is a role for outpatient palliative care and so I want to keep the nurse practitioner engaged. We have to clarify that a nurse practitioner is different from a nurse.
- We should tweak the language some more to eliminate the “shall” and “should” language.
- Some of what is in the recommendation includes “24/7 meaningful coverage.” This is a joint commission standard and if you want your facility to be certified it must be 24/7. We have to be careful what is in the statutory language.
- There is a concern where we statutorily state what the standard of care is. We can state a best practice is “X” but most cannot meet the prescriptive standard in this recommendation. We should be cautious in being too prescriptive in the statute.
- We looked at the hospice statute for language for palliative care. Texas does not meet the bare standard of palliative care.
- The national standard for palliative care is done by an interdisciplinary team and not one person.
- We have rich data that show all the value in palliative care, but you have to pay for it.
- When Baylor Scott and White looked at cost benefit they studied five hospitals in their system. All the studies showed significant cost savings (no cost avoidance). The teams varied but there were teams providing the services. The greatest cost savings was where there were more comprehensive teams. Can the state watch...
matched patients and look at hospitals that have true 4 component teams and then compare to the partial team hospitals or single person hospitals (Nurse Practitioner). This data would support the four component team concept.

- Mr. Blanton stated that there is a lot of claims data that can be looked at but this is a fairly complex analysis. This could be a potential recommendation that involves an academic center. The legislature historically has asked HHSC to conduct a number of studies.
- Showing savings would be a good thing.
- We can say that the four component team is the goal and that not everybody is ready or able to do that.
- The definition provided for the legislation is acceptable to everyone but there is a second part where we can talk about the fact that the four component team is the national standard and that we are not there yet. So the definition recommendation can go into the legislation and then an explanation underneath about the four component goal.
- Also we should include Dr. Fine’s statement about removing “shall” should also be addressed. Recommendation 1c should be rolled into the explanation and not part of the recommendation.
- The Recommendation for definition should only include letter “a” then have an explanation about the 4 component teams.
- We may want to look at other entities to certify providers and not just the Joint Commission on Accreditation of Healthcare Organizations. (JACHO).
- The Council agreed that this should be the approach using a limited definition without prescribing a standard of care. All members should review this and then vote at another meeting. Mr. Blanton stated that they would be bringing this back to the group for a vote and that it appeared that the council no longer had a quorum anyway. He summarized that 1a would be the definition and that 1b and 1c would not be recommended for statute at this time. Then they would also recommend that a study be conducted. This recommendation would be changed and then it will be brought back for a final vote at the next full meeting of the PCIAC.

Public Comment.

- **Maxine Tomlinson, Texas and New Mexico Hospice** stated that the recommendation was for the definition be placed in the Health and Safety Code and she wants to be sure the definition applies to providers in a meaningful way because it is in a different section from the Hospice definition.
- **Ellen Martin Texas Nurses Association, End of Life Taskforce** stated that they appreciate the distinction between Hospice Palliative care and Supportive Palliative Care. They support advance care planning. The pain and symptom management 24/7. They asked for a table to be added in the report and that maybe telehealth should be considered.
- **Troy Alexander, TMA** asked if they would have an opportunity to review and comment before a final vote. Mr. Blanton answered in the affirmative. He stated that he shares the concern about where it is placed in statute and that maybe it should be stand alone.
**Agenda Item 3: Palliative Care Program updates**

Mr. Jimmy Blanton stated that agenda items 3a and 3b would be tabled to focus on the legislative recommendations. Regarding agenda item 3c - Bylaws status, Mr. Jimmy Blanton stated that HHSC legal approved the change recommended by the Council related to the scope of the council addressing the differences in supportive palliative care and hospice care. Mr. John Chacón asked members physically present to sign and date the “Statement by Members” page from the approved bylaws.

**Agenda Item 4: H.R. 1676 Palliative Care and Hospice Education and Training Act**

Mr. Jimmy Blanton provided a brief update on HR 1676, The Public Health Services Act. He stated that under the Act, The Agency for Healthcare Research and Quality must provide for a national education and awareness campaign to inform patients, families, and health professionals about the benefits of palliative care. Mr. Blanton referenced handout entitled “H.R. 1676 Summary”.

**Agenda Item 6 & 7: 2018 legislative recommendations and report Part II and Next steps and goals for the 2018 legislative report**

Mr. Jimmy Blanton provided a brief overview of next steps and goals for the 2018 legislative report. Mr. Blanton referenced PowerPoint entitled PCIAC - August 17, 2018 Full Council Meeting #11”. Dr. Robert Fine, and Dr. Hattie Henderson provided the 2018 legislative recommendations from Workgroups 2 and 3 and referenced handout entitled “2018 PCIAC Draft Report Recommendations. The following are highlights from the Council

- **Regarding Workgroup 2, recommendations #4 and #5**, Dr. Fine stated that what is being recommended is the encouragement of Texas Medicaid to use financial incentives to develop interdisciplinary palliative care. The issue is how one incentivizes that. The private sector using value based payment mechanisms are more likely to embrace palliative care programs. Those not using quality based payment approaches do not want to pay for chaplains and other professionals because they are not covered in the payment mechanism they have. This will save the state money in the long run. Many hospitals do not understand interdisciplinary palliative care. There is data from Sean Morrison to support this proposal and if the study is approved, recommended previously, then we could use Texas specific data.

  **Comments and discussion by council members on recommendations #4 and #5 included:**

  - Reorganize the numbers and bullets in the recommendation.
  - Advance planning is not presently a benefit under Medicaid (but is available for duals). It is a Medicare benefit (Goal concordant care).
  - The typical advance care planning conversation can take less than 30 minutes.
  - Getting qualified for Medicaid long term care is time consuming and patients that need palliative care are not getting the timely discussion they need. The need often occurs before a person is Medicaid eligible.
  - No matter what insurance coverage you have you should have access to palliative care.
  - Some people would be better served with home hospice, but they do not have a safe home to go to. The better choice may be inpatient hospice but people are ending up in skilled nursing facilities instead.
• Some facilities think they are doing palliative care and so they believe there is no need for hospice. This is because there is not a standard.
• A study has indicated that advance care planning did not result in earlier deaths. A small study could be crafted for Texas also using three nursing homes trained in advance care planning and three that are not.
• Even if the conversation occurs and is documented when the person changes facilities the documentation is lost. Perhaps there could be a Quick Response (QR) code implemented.
• Since there is not a vote happening at today’s meeting, it was stated that there is time to include the above changes suggested.
• Mr. Blanton stated that they could make more data available related to palliative care.
• **Regarding Workgroup 3, recommendation #2,** Dr. Henderson stated that the goal is to encourage all professional interactions to address palliative care when appropriate. We want everyone’s paperwork should be up-to-date when they are nearing the end of life.

Comments and discussion by council members on recommendation #2 included:

• Resources should be placed on the website related to “five wishes” and “My wishes”.
• Mr. Blanton stated the recommendation can address a structured process and staff would identify resources.
• A question was asked about the five wishes and where the Texas Medical Association (TMA) stands. It is not included in statute in Texas but it is not illegal. As of the end of June TMA had not accepted the “Five Wishes”.
• The power of attorney part of “Five Wishes” is the only part that is not allowable in Texas because Texas has its own power of attorney statute. If there was a court battle over the medical power of attorney in “Five Wishes” the state power of attorney would prevail.
• We should have some language for structured documentation.

• **Regarding Workgroup 3, recommendation #3,** Dr. Henderson stated that the work group sent out inquiries to hospitals and medical schools. The results demonstrated that physicians going into palliative care are a very small percentage of the Texas medical school graduates.

Comments and discussion by council members on recommendation #3 included:

• Add a segway related to the new federal legislation and the national standard
• The majority of the programs were hospital based palliative care clinics
• The nurse practitioners went through acute care training but not hospice. They do not specifically train in hospice. Who controls that and can we recommend training for Nurse Practitioners (NPs)?
• The Texas Nurses Association might be able to address the issue of NP and Advance Practice Nursing.
• We could make a recommendation that is like the federal legislation and is a lot more inclusive on educating everybody
• Texas Nurses Association (TNA) stated that the Texas Board of Nursing (TBN) has the family tracks for nurse practitioner, you can find your own training opportunities for clinical hours but that is the extent of that.
• Perhaps we can make a recommendation to the TNA on the training/education issue.
• For nurse practitioners palliative care will always be a sub-specialty.
• There are not fellowships available for this except through the Veterans Administration (VA).
• The nursing board would probably not separate hospice from palliative care.
• Hospice and palliative care can be addressed as an added Continuing Education Unit (CEU).
• We went from 46 Advanced Palliative Nurses (APNs) certified in Hospice and palliative care to 73.
• Baylor Scott and White has trained 36 NPs for palliative care.
• Suggestions made above will be included in the redraft of the recommendation.

Public Comment.

• **Maxine Tomlinson, Texas and New Mexico Hospice** stated that they asked the board of nurses to include hospice and palliative care in their training and they stated that they would not do so.

**Agenda Item 8: Palliative Care Interdisciplinary Advisory Council planning**

Mr. Jimmy Blanton stated that agenda items 8b and 8c would be tabled for the next full PCIAC meeting. Mr. Blanton lead the discussion on the palliative care continuing education event and referenced the PowerPoint entitled "Palliative Care Interdisciplinary Advisory Council - August 17, 2018 Full Board Meeting #11". Mr. Blanton stated that there would be a continuing education event and that planning is continuing through the planning committee. Multiple disciplines will get credit and they hope to advance to where the materials can be on the HHSC website. The Learning objectives and topics include:

• 2018 legislative report overview
• Advance care planning
• Opioids, including non-opioid and non-pharmacologic methods

The Goals include:

• Credit for multiple disciplines
• Include at least one ethics credit
• Live event available in person and through webinar

Proposed Timeline:

August:

• CE packet due (60 Days Prior to event)
• Promotional efforts
• Registration form/link to webpage
• Save the date announcement

September:

• Promotional efforts
• Registration

Early November:

• CE event
• Post event: Evaluation and certification
**Agenda Item 9: Action items for staff or member follow-up**

The action items for the staff were touched during agenda item #6, 2018 legislative recommendations and report.

**Agenda Item 10: Public comment**

No additional public comment was offered.

**Agenda Item 11: Adjourn**

Mr. Jimmy Blanton adjourned the meeting at 2:00 p.m.

Below is the link to the archived video of the August 17, 2018 Palliative Care Interdisciplinary Advisory Council (PCIAC) meeting.

[https://texashhc.swagit.com/play/08172018-829](https://texashhc.swagit.com/play/08172018-829)