HHSC: Palliative Care Interdisciplinary Advisory Council, February 25, 2020

The Palliative Care Interdisciplinary Advisory Council consults with and advises on matters related to the establishment, maintenance, operation and outcome evaluation of the statewide palliative care consumer and professional information and education program.

House Bill (HB) 1874, 84th Legislature, Regular Session, 2015 established the Palliative Care Interdisciplinary Advisory Council to assess the availability of patient-centered and family-focused palliative care in Texas. HB 1874 charges the council to consult with and advise the Texas Health and Human Services Commission (HHSC) on matters related to the establishment, maintenance, operation, and outcome evaluation of the statewide palliative care consumer and professional information and education program.
In addition, the council must submit a biennial report assessing

- the availability of palliative care in Texas,
- barriers to greater access to palliative care and
- policies, practices, and protocols in Texas concerning patients' rights related to palliative care.

The Council will publish its first report by Oct. 1, 2016. The Palliative Care Interdisciplinary Advisory Council is codified under Chapter 118, Texas Health and Safety Code.

Members can be found here.

***Due to auditory difficulties with the webcast, the level of detail available through this report may be compromised*.**

1. Welcome and introductions. The meeting was convened by the Chair, Larry Driver, MD, on February 25th, 2020.

2. Approve minutes from February 27, 2019, and November 5, 2019, meetings. The minutes were approved as written.

3. Update on PCIAC New Member Appointment Process. Outgoing Members are:

- Bruce Christensen
- Larry Driver
- Erin Perez
- Hattie Henderson
- Craig Hurwitz
- Barbara Jones
- Nat Jones

Outgoing members are eligible for another term. The selection process and timeline are as follows:

1. Applications should open around the end of February
2. There is a one-month application deadline

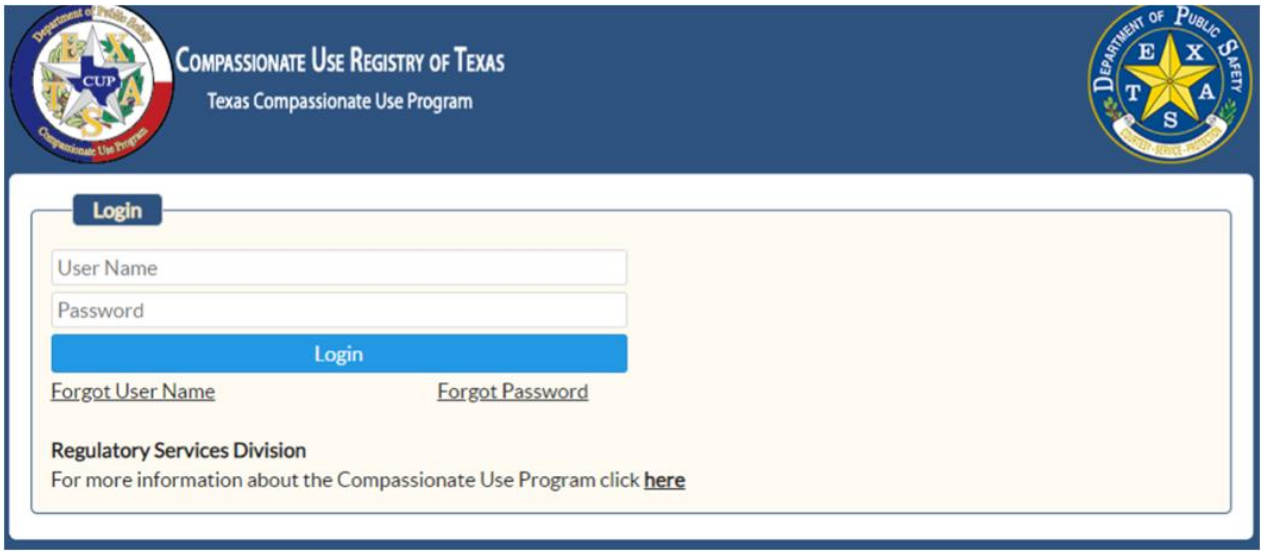
3. There will hopefully be new members by the next CE Event on November 5, 2020

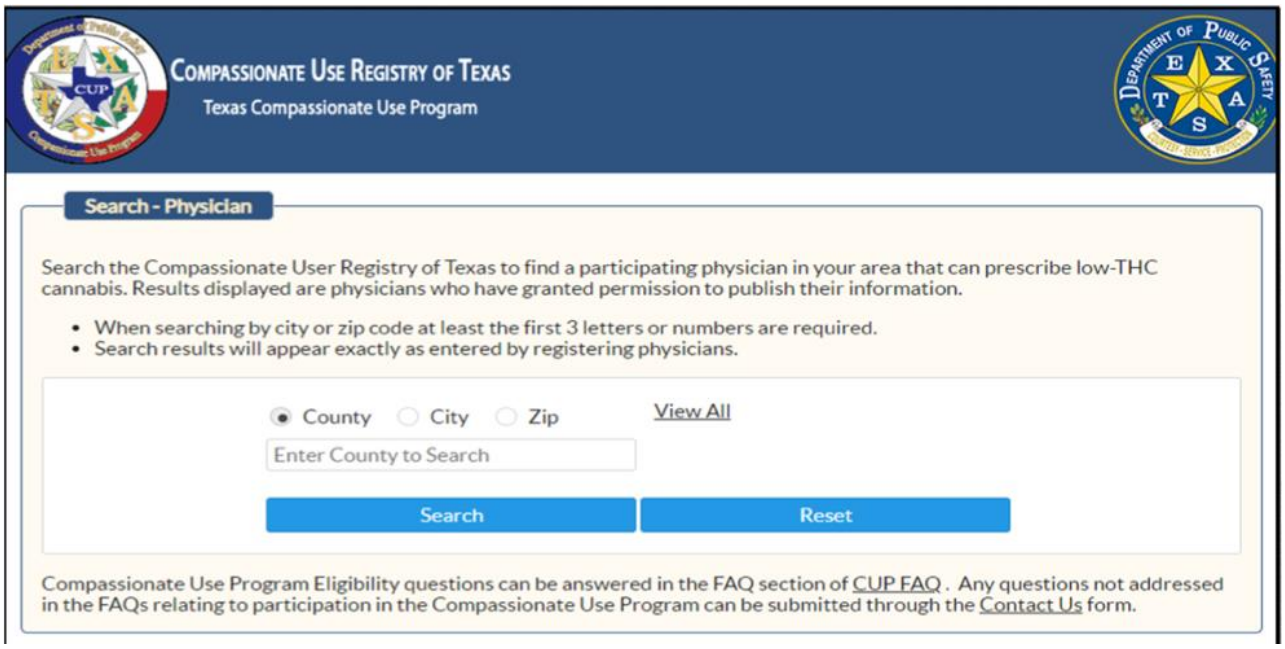
4. Presentation: Compassionate Use Program. Jason Hester, Assistant Chief Texas Department of Public Safety Regulatory Services Division
Jason.Hester@dps.texas.gov

Department of Public Safety TEXAS CUP Compassionate Use Program	**HB 3703 did the following:** • Amended the Occupations Code. • Deleted the term and definition of "intractable" epilepsy. • Added "Incurable neurodegenerative disease" and "Terminal cancer" to the list of conditions for which low-THC cannabis can be prescribed. • Required prescriptions for low-THC to be written in the compassionate use registry. • Eliminated "not less than 10 percent by weight of cannabidiol." • Left THC at not more than 0.5%.

The bill further

- Added language that only a physician "qualified with respect to a patient's particular medical condition…to treat the applicable medical condition."
- Added that a physician is qualified to prescribe low-THC cannabis with respect to a patient's particular medical condition if the physician is board certified in a medical specialty relevant to the treatment of the patient's particular medical condition by a specialty board approved by the American Board of Medical Specialties or the Bureau of Osteopathic Specialists…"
- Removed certain references to epilepsy and certain special qualifications that were in the original bill.
- DPS is not allowed to publish the name of a physician registered unless granted by the physician (opt-in provision).





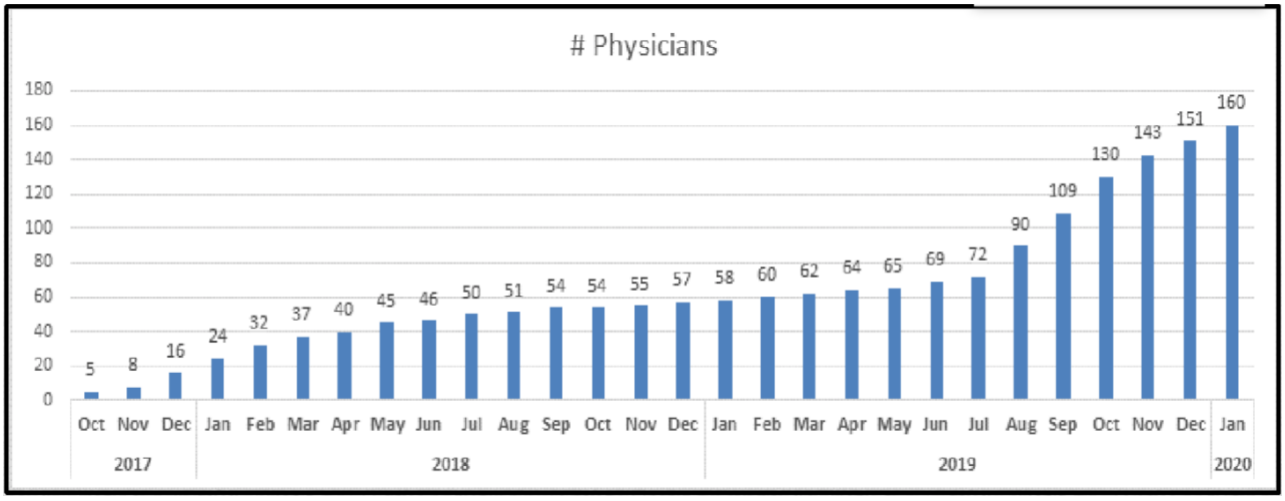
Prescription Changes: The physician certifies to the department that the patient is diagnosed with:

- epilepsy;
- a seizure disorder;
- multiple sclerosis;
- spasticity;
- amyotrophic lateral sclerosis;
- autism;

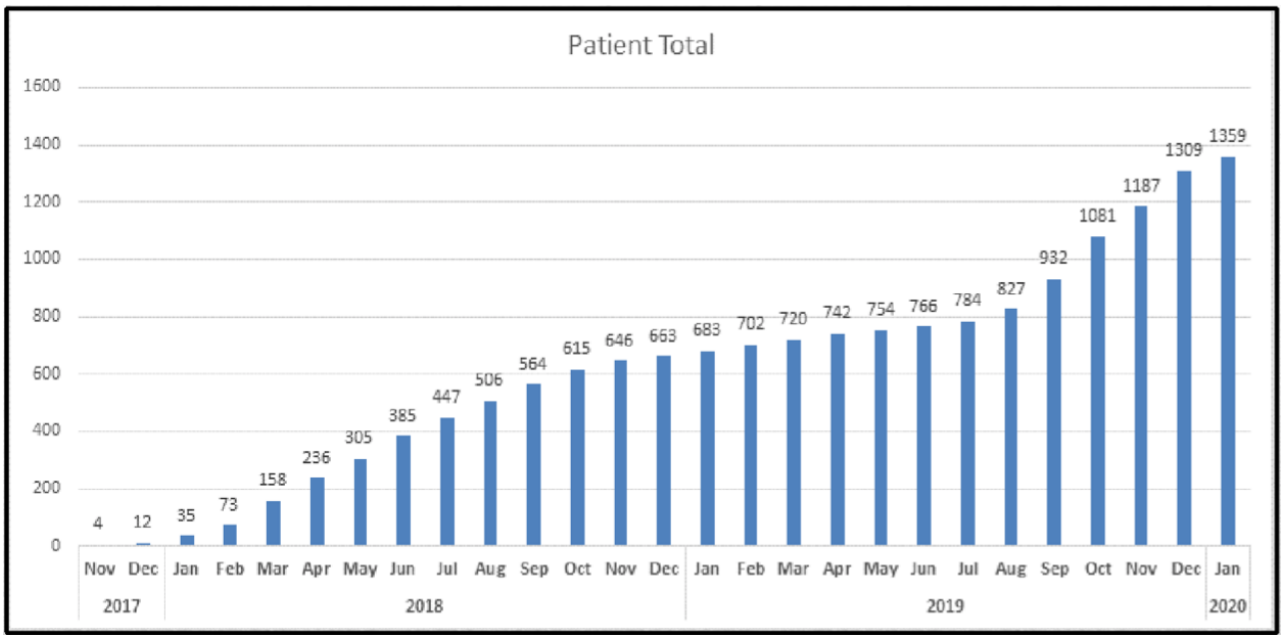
- terminal cancer; or
- an incurable neurodegenerative disease.

The bill removed the requirement for a second physician to concur with the determination; required HHSC to adopt rules designating diseases as incurable neurodegenerative disease.

Number of Registered Physicians



Number of Patients



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There were ~890,000 potential patients eligible, and just over 1,300 patients are active in the program. There are three licensed dispensaries in Texas.

The Chair asked what has been done as far as outreach and public education. The speaker stated that there was no funding for outreach, but that there are FAQs on the DPS website. The Chair stated that he hopes to see funding for outreach made available.

Dr. Fine asked about registered subspecialists. The speaker stated that some physicians have multiple certifications. They do not have that data immediately available.

Dr. Fine asked how many doctors opted to be listed publicly. The speaker stated that the majority did so. Dr. Fine talked about THC and its effects. He asked about cross-referencing between THC prescribing and those who are prescribing CBD. The speaker stated that he is not aware of THC prescribing. He stated they do not track that.

The Speaker stated that prescriptions are all prescribed electronically.

The Chair asked if this would show up on the PMP? The speaker replied, no.

The Texas PMP collects and monitors outpatient prescription data for controlled substances dispensed by a pharmacy in Texas. It is a patient care tool that can be used to inform prescribing practice and to address prescription drug misuse, diversion, and overdose.

The next speaker was Morris Denton, CEO of Compassionate Cultivation.

Compassionate Cultivation, One Seed Texas, is a home-grown medical cannabis company serving patients throughout America's second-most populous state. As the only Texas-licensed cannabis business from the Lone Star State, Compassionate Cultivation is dedicated to representing the integrity of this great state and helping patients and families in need – and the physicians recommending our cannabis-based medicine.

- Dedicated to helping Texas patients find relief with cannabis-based medicine.
- Committed to providing patients with reliable, high-quality products at transparent, affordable prices.
- Cultivate the highest-quality medical cannabis by implementing rigorous quality control measures and ensuring consistency, purity and freedom from contaminants.
- Strive to deliver the purest, cleanest cannabis oils utilizing hydrocarbon-free, non-toxic C02 extraction methods.
- Pledge to support patients and families in need, and the physicians recommending cannabis-based medicine.
- Seek to represent the integrity of the great state of Texas and exceed all regulatory requirements.

The speaker described them as:

- One of three licensees in Texas

- First to market with 80% of the market share
- A science-focused company with ratio-based formulations based on clinical trials
- Governed by a nine-person advisory board
- Tremendous engagement with patients and their families, constantly working to improve the patient experience
- Ongoing focus groups with patients and prescribers
- Trusted and respected relationship with key members of the Texas Legislature and senior political leaders
- A leader in the cannabis industry

He described the issues they faced establishing their business. He further mentioned the testimonials they have received from families expressing the importance of their company and their products.

He stated that they have more than 1,200 registered patients. The following is the breakout by indication.

- Epilepsy - 6.5%
- Autism - 9.0%
- MS - 4.0%
- Spasticity - 3.0%
- Incurable Neurodegenerative - 4.0%
- Terminal Cancer - 1.0%
- ALS - 1.0%
- Undetermined - 1.3%

They stated that the doctors were not able to register until fall. They stated they have physicians across different specialties and some D.O.s are registering.

Dr. Fine stated that the reason there are so few oncologists is because, by the time they get involved, the patient is pretty far along and in hospice services.

The speaker stated that they have tried to provide consumer information and outreach.

There is an increased interest in the use of cannabinoids in the treatment of symptoms in cancer and palliative care patients. Chronic pain can be a serious, negative consequence of surviving cancer and 70%–90% of patients with advanced cancer experience significant pain.

In 2016, The American Society of Clinical Oncology published guidelines to help cancer survivors manage chronic pain. These recommendations included the use of cannabis and cannabinoid-based medicines. Researchers at Harvard Medical School reported that cannabis can provide relief for chronic pain.

In recent years, there has been a new wave of more disciplined medical research regarding the use of medical cannabis as a possible treatment method for symptoms often associated with terminal cancer, including pain, loss of appetite, anxiety, insomnia, and nausea.

Symptoms treated with cannabis-based medicines:

- Nausea and vomiting – HIV/AIDS and Cancer
- Chronic pain – showed roughly 40% improvement of pain compared to control across 7 RCTs using plant derived cannabis-based medicine [Sativex 2.7% THC & 2.5% CBD]
- "There is substantial evidence that cannabis is an effective treatment for chronic pain in adults" – National Academy of Sciences
- AIDS Wasting Syndrome (Anorexia)-RCTs – Evidence of weight gain from cannabinoids (~10mg THC/dose)
- Spasticity – Patient reported improvements using 1:1 CBD:THC
- Insomnia/Sleep Disorders – evidence that 1:1 CBD:THC is an effective for treatment
- Nausea and vomiting – 28 RCTs reviewed showing cannabinoids (THC or CBD & THC) were effective at reducing nausea and vomiting caused by chemotherapeutics. ("There is conclusive evidence that oral cannabinoids are effective antiemetics in the treatment of chemotherapy induced nausea and vomiting" - National Academy of Sciences)
- Chronic pain – showed roughly 40% improvement of pain compared to control across 7 RCTs using plant derived cannabis-based medicine [Sativex 2.7% THC & 2.5% CBD] – cancer is one of conditions included in these studies
- Neuropathic pain included in studies
- Anorexia – Promising, but more quality studies needed.

	Epilepsy	MS	ALS	Autism	Cancer	Neuro-Degenerative
Pain			Balanced		Balanced	Balanced
Depression				High CBD		
Appetite Loss			Balanced		Balanced	
Spasticity		Balanced	Balanced			
Seizures	High CBD			High CBD		
Vomiting					Balanced	Balanced
Anxiety	High CBD	High CBD			High CBD	High CBD
Restlessness				High CBD		
Disruptive Behavior				High CBD		
Insomnia					Balanced	Balanced
Nausea					Balanced	Balanced
Tics				Balanced		
Neuropathic Pain		Balanced				

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	Active Ingredient	Ingredients per mL	Average Daily Dose	Average Bottle Duration	Price per 30-mL bottle
20:1 CBD:THC (30 mL)	CBD	100 mg CBD/mL 5 mg THC/mL	100 mg CBD 1 mL tincture	30 days	$342
3:1 CBD:THC (30 mL)	THC	15 mg CBD/mL 5 mg THC/mL	10 mg THC 2 mL tincture	15 days	$90
1:1 CBD:THC (30 mL)	THC	5 mg CBD/mL 5 mg THC/mL	15 mg THC 3 mL tincture	10 days	$75

Possible Side Effects	**Possible interactions**
Somnolence Nausea Dry mouth Dizziness Euphoria Fatigue	Patients taking concomitant medications should start at the lower dose and titrate more slowly. Medications metabolized by liver enzymes or highly protein-bound in the blood should be considered and titrated slowly. Some may require measurement of serum drug levels after starting CBD to allow further adjustment.

Dr. Fine stated that these agents can be effective in chronic pain, but in advanced cancer pain, cannabinoids were no more effective than placebo.

The next speaker was Dr. Nat Jones, Clinical Compounding Pharmacist.
As a disclaimer, Dr. Jones stated that he is an employee of Professional Compounding Centers of America (PCCA).

- PCCA is an international company based in Houston, Texas.
- Supply the highest quality pharmaceutical grade chemicals [Active Pharmaceutical Ingredient (API), excipients] and bases in the world to member pharmacies in the US, Canada, and Australia.
- Provide more than 9,300 compounding formulas with step-by-step instructions to subscribing members.
- Provide industry-leading research & development, training, CE, and support in all aspects of compounding.

Eagle Analytical Laboratory – offers full analytical chemistry services to all pharmacies in the country.

Pharmacy Compounding is when a pharmacist makes a customized medication for a patient or physician that is not commercially manufactured to fit their need or suitability for patients who:

- Have allergies to common mass-produced medicine fillers (casein, gluten, dyes, etc.)
- Aren't taking medication as prescribed due to unpleasant side effects or lack of improvement
- Need custom medicine strengths and dosage forms (like a liquid if not manufactured, creams or suppositories)

They are not new drugs, only different dosage forms!

Compounding differs from manufacturing in the following ways: Drug manufacturing is a large-scale production process with no ability to customize treatment to those patients with unique problems. Because of the mass production nature of manufacturing, specific patient needs such as allergies or dosage form choice, cannot be taken in to account. The approach of prescribing manufactured drugs is primarily that of fitting the patient to the drug products available vs. prescribing a compound gives us the ability to fit the drug therapy to a specific patient.

Compounding pharmacies are regulated like standard pharmacies. They use state-licensed pharmacists that compound under section 503A of the Federal Food, Drug, and Cosmetic Act (FD&C Act) who may only compound drug products using bulk drug substances that:

- Comply with an applicable United States Pharmacopeia (USP) or National Formulary (NF) monograph if one exists, and the USP chapter on pharmacy compounding;
- Are components of FDA-approved drug products if an applicable USP or NF monograph does not exist; or
- Appear on FDA's list of bulk drug substances that can be used in compounding (the 503A bulks list) if such a monograph does not exist and the substance is not a component of an FDA-approved drug product.

In addition, bulk drug substances must be accompanied by a valid certificate of analysis and must have been manufactured by an establishment registered with FDA under section 510 of the FD&C Act.

According to Federal law and FDA Guidance documents, compounding pharmacies are also not supposed to compound "essential copies" of a manufactured drug…unless it is on the FDA Shortage list.

Full Spectrum CBD products contain the entire spectrum of phytonutrients — synergistic cannabinoids, terpenes, essential oils, and other medicinal compounds — derived from the cannabis plant. The Drug Enforcement Agency's (DEA) clarification on marijuana extracts is

clear in that any product containing **any amount** of tetrahydrocannabinol (THC) is considered a Schedule 1 controlled substance. CBD oil does not currently meet the federal requirements for use in compounding under sections 503A or 503B of the Federal Food, Drug, and Cosmetic Act.

The total number of natural compounds identified in C. sativa L. in 1980 was 423 (Turner et al., 1980) and in 1995 was 483 (Ross and ElSohly, 1995). This review reports 6 new compounds; four new cannabinoids and two new flavonoids. There are 70 known Cannabinoids with four of those being new.

CBD actually stands for "cannabidiol" which is one of the cannabinoids found in hemp.

Cannabidiol (>98% Powder). Cannabidiol, is an Rx-Only API/DRUG
And is the active ingredient contained within the FDA approved drug product Epidiolex®, which is indicated for the treatment of seizures. The FDA considers cannabidiol (CBD) to be a drug but lacks the psychoactive properties that are commonly associated with delta-9-tetrahydrocannabinol (THC). Other important attributes include:

- It is a white to pale yellow powder, with little to no taste
- Insoluble in water and soluble in organic solvents and oils
- Because it is a high purity synthetic API, it is free of pesticides and unwanted plant materials
- It is a single chemical entity, highly purified, with a defined cannabidiol content verified by assay and with specifications/controls for impurities

What it is not:

- NOT hemp oil
- NOT Medical Marijuana, nor is it extracted from marijuana
- NOT a full spectrum mixture of cannabinoids
- NOT an OTC drug
- NOT a Dietary Supplement

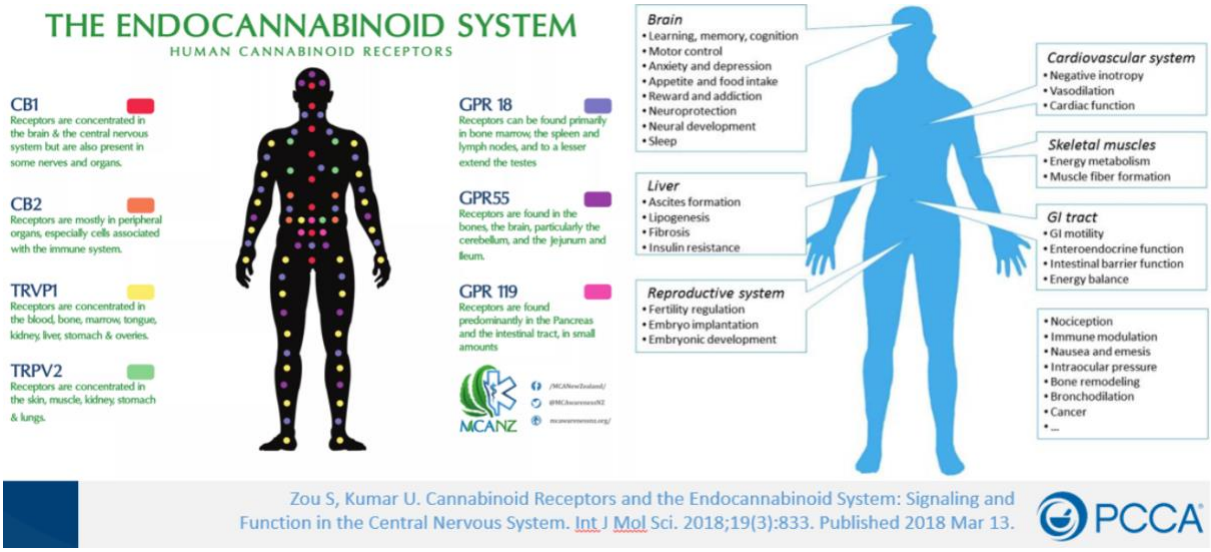
Cannabidiol (>98% Powder) IS an Active Pharmaceutical Ingredient (API), for prescription compounding only. The FDA has stated that it is best if this drug is used under medical supervision, which occurs in prescription compounding.

What does cannabidiol do and how is it used?
The Endocannabinoid System:

- A biological system composed of endocannabinoids, which are fat-based retrograde signaling substances produced in the nervous system that bind to cannabinoid receptors.
- Cannabinoid receptors are found throughout the central and peripheral nervous system.

- Endocannabinoid signaling is a key regulator of neurotransmission throughout the brain.
- Compelling evidence shows that its upset leads to development of epileptic seizures, thus indicating that endocannabinoids play an intrinsic protective role in suppressing pathologic neuronal excitability.
- Responsible for homeostasis (Balance).
- Sleep, inflammation, pain, mood, immune function, hormone regulation.
- Found in almost all animals.
- The most abundant receptor system in humans.

In the 1990's two cannabinoid receptors, CB1 and CB2, were discovered along with strong pharmacological evidence for additional cannabinoid receptors. CB1 receptors are among the most abundant types in the brain, and their levels are comparable to those of ionotropic glutamate receptors. CB2 receptors are primarily found on immune cells, particularly cells of macrophage lineage.



All humans have an underlying endocannabinoid tone that is a reflection of levels of the endocannabinoids, anandamide (arachidonylethanolamide), and 2-arachidonoylglycerol, their production, metabolism, and the relative abundance and state of cannabinoid receptors. The greatest evidence for CED is present for migraine, fibromyalgia, and irritable bowel syndrome (IBS).

Several studies suggest that CBD is non-toxic in non-transformed cells and does not induce changes on food intake, does not induce catalepsy, does not affect physiological parameters (heart rate, blood pressure and body temperature), does not affect gastrointestinal transit

and does not alter psychomotor or psychological functions. Also, chronic use and high doses up to 1,500 mg/day of CBD are reportedly well tolerated in humans.

The speaker presented some technical information not included in this report.

PCCA has developed 25+ formulations using cannabidiol as an API, which are available to our subscribing member pharmacies. Additionally, analytical work to assess the physicochemical stability of some of these formulations is underway. They currently have approximately 350 members in Texas.

Oral and Sublingual Cannabidiol Formulations:

- Cannabidiol 5mg, 25mg, 50mg, 100mg in NataTroche
- Cannabidiol 20mg/ml Oral Solution
- Cannabidiol 20mg, 50mg Oral Capsules
- Cannabidiol 100mg/ Synapsin 100mg/ml Oral Suspension
- Cannabidiol 100mg/ Naltrexone HCl 10mg/ml Oral Solution

Rectal Cannabidiol Formulations

- Cannabidiol 10mg, 20mg, 50mg, 100mg Suppository
- Cannabidiol 100mg Retention Enema (MucoLox)

Additional Cannabidiol Formulations

- Cannabidiol 0.5% Topical Cream
- Cannabidiol 0.5%/Naltrexone HCl 0.5% Topical Cream
- Cannabidiol 0.5% Nasal Spray

Question and Answer Session:

- **Q:** Do I need to register to get the cannabidiol product? The speakers replied no, you do not have to register since there is no THC involved. In the dispensary, products are very different, and registration is required.
- **Q:** How much would a patient pay for the product through the dispensary? The speaker stated that it is $275-300 per month. The Chair stated that someone had told him he could get the product on the street for significantly less. The speaker stated that through a dispensary, there would be physician involvement. You do not need a prescription for CBD oil. The state regulates the dispensaries and their products. Their product is also pharmaceutical grade. People are often interested in getting more THC than the state would allow through a dispensary.
- **Dr. Fine** was critical of limiting the product to terminal cancer patients, when it is less effective. We should be treating patients early and controlling their symptoms early—at the right time, then we should get them into hospice. Medicaid will not cover CBD products. Medicare covers limited amounts of Cannabinol.

5. Medicaid Community-Based Palliative Care Benefit. Mr. Blanton stated that there were several states selected to participate in a seminar on palliative care. The work in California was interesting enough to follow up on. There were issues in California that were similar to Texas. However, Texas is not an expansion state and California is. Tory Smith was the contact person in California.
California - Palliative Care Benefit.

Phase 1: Planning Phase

- Legislator champions palliative care benefit
- MCOs utilize grant funding from community stakeholders to conduct pilot projects (private philanthropy)
- California's Department of Health Care Services conducts retrospective claims analysis to determine benefit eligibility and prospective return on investment
- Four eligible conditions: COPD, Cancer, Liver Disease, Heart Disease. They also looked at savings from ER visit reductions.
- This was implemented without state funds
- Task force of palliative care experts created to determine services covered for patients.

Services offered include:

- Advanced Care Planning
- Palliative Care Assessment and Consultation
- Plan of Care
- Pain and Symptom Management
- Mental Health and Medical Social Services
- Care Coordination
- Palliative Care Team
- Chaplain Services (spiritual care)
- 24/7 Telephonic Palliative Care Support (recommended)
- Access to Curative Care/Disease Modifying Care

They looked at existing billing codes. In this way, they did not need a state plan amendment or a waiver. They did have to work with CMS to get bundled service codes.

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Billing Codes:

Palliative Care Service	Billing Codes
Advance Care Planning (Inpatient/Outpatient [I/O] and Hospital [H])	Evaluation and Management (E&M) codes 99497 (reimbursable twice a year before Treatment Authorization Request [TAR] override) & 99498 (reimbursable once a year before TAR override)
Palliative Care Assessment and Consultation (H)	E&M codes for counseling
Pain and Symptom Management (I/O)	E&M codes 99341 – 99350 for MD/NP, or Home Health for RN/LPN
Pain and Symptom Management (H)	Home Health Physical Therapy
Mental Health Services, Discharge Planning (I/O)	Individual and group psychotherapy, hospital or Nursing Facility Level B discharge planning
Mental Health Services and Caregiver Assessment/Support (H)	Medical social services within home health
Plan of Care (I/O)	E&M Codes
Plan of Care (H)	Home Health or E&M codes 99341 – 99350
Care Coordination (I/O)	E&M Codes
Care Coordination (H)	Home Health or E&M codes 99341 – 99350
Palliative Care Team (I/O)	E&M Codes 99366 and 99368
Palliative Care Team (H)	Home Health or E&M does 99341 - 99350

Phase 2: Implementation Phase

- MCOs finish planning portion of pilot project & receive implementation grants. Philanthropy was involved in phase two also.
- Aim was to demonstrate value added & feasibility
- Unfunded Medicaid Mandate was passed
- No State Plan Amendment or Waiver was needed
- MCOs took mandate positively and required coverage of the four conditions listed above. MCOs went above the four conditions.
- Additional training opportunities for providers and health plans were offered

Lessons Learned:

- Do not implement the benefit without setting quality measures (value-based payment approach was used and quality measures were developed later)
- Lack of direction for reporting requirements & plan payment
- Increase benefit eligibility for serious illnesses
- Wished they had included diabetes and kidney disease (but some MCOs included these voluntarily)
- Link to defined value-based payment model from the start
- Original model used PMPM payment with no link to value
- Later in implementation, methods become linked to value-based payment
- State should work with stakeholders to define the payment model during planning phase

This body has been interested in addressing/expanding palliative care through Medicaid.

The Chair addressed the demographics issues of both states.

Dr. Fine asked about data and when they will have something to report. Mr. Blanton stated that they may have data available now. The uptake for the benefit was less than they expected. Dr. Fine stated that we are not able to mine data right now related to Cancer patients, and the services they received including palliative care. Mr. Blanton stated that within the program, we have claims information and with SB 916, there is the possibility to look at the services and do some research through EQRO.

The Chair stated that the data may be available in some unrefined form.

6. Staff Update: Palliative Care Pilot Study Progress. Mr. Blanton and Staff made the presentation. The SB 916 study is designed to assess potential improvements of SPC on:

- Health quality, health outcomes, and cost savings from the availability of SPC services in Medicaid
- Must include an evaluation and comparison of other states that provide Medicaid reimbursement for SPC
- PCIAC must provide recommendations on study
- HHSC may solicit and accept gifts, grants, and donations to fund the study
- Study not required if money not received for this purpose
- Study findings due by September 1, 2022

SB 916 Bill Analysis. Palliative care provides support and care planning services to patients and families of patients with serious illnesses and seeks to relieve their suffering and improve their quality of life. Palliative care also offers advantages to health care organizations since it lowers incidents of preventable readmissions.

In 2015, the legislature passed Rep. Zerwas' H.B. 1874 creating the Palliative Care Interdisciplinary Advisory Council (PCIAC) to advise the state of Texas on issues relating to

palliative care. S.B. 916 seeks to implement one of the advisory council's recommendations about a clearer definition in statute for "supportive palliative care." A forthcoming committee substitute will strike a vague definition of "palliative care" in current statute and will create and clarify statutory language for "supportive palliative care" that is slightly different from the original bill in order to encompass all patients, not just those with terminal illnesses.

The committee substitute will require the Health and Human Services Commission (HHSC) to conduct a study, with consultation from the current PCIAC, to seek improvements in current supportive palliative care programs in Texas, including those who are recipients under the Medicaid program. HHSC can partner with and solicit funds from public or private sources, as needed, to fund the study. The PCIAC must report HHSC's findings in their biennial report not later than October 1, 2020. Finally, the committee substitute will entirely strike the original version of Sec. 142A.0002 and 142A.0003 which would have set rules and minimum standards and created a pilot program for certain parts of the state. These changes were made based upon suggestions from stakeholders and allies, including PCIAC.

Baylor Scott and White, University Health System-Supportive Palliative Care System, and Texas Medical Association are in support of the committee substitute for S.B. 916. (Original Author's/Sponsor's Statement of Intent)

S.B. 916 amends current law relating to supportive palliative care.

The study is in two parts:

Part 1:

- Community-Based Innovation in SPC
- Inpatient study & community-based study
- Replicate claims-based study used in California
- Potential for innovative practices such as telehealth

Part 2:

- Medicaid Palliative Care Benefit Comparison
- Comparison study of other states SPC benefit

Other Considerations:

- Statutory standards for Supportive Palliative Care Services
- Rules (There may be a need for rules)
- Licensing (There is lack of clarity on how to deliver services in a community setting).

Expected Outcomes:

- Evidence to improve patient quality of care & health outcomes. Looking at the Triple AIM
- Cost savings/offsets of Medicaid palliative care benefit
- New policies to apply the benefit to Texas Medicaid
- Development of alternative payment models to support palliative care services

Funding for the Pilot Study is provided through Rider 158: Palliative Care Program.

> **158. Palliative Care Program.** Out of funds appropriated above in Strategy L.1.1, HHS System Supports, the Executive Commissioner shall allocate $135,309 in fiscal year 2020 and $135,309 in fiscal year 2021 in General Revenue to support the Palliative Care Interdisciplinary Advisory Council established in Health and Safety Code Chapter 118 and a statewide palliative care consumer and healthcare professional information and education program. The Health and Human Services Commission shall consult with the Advisory Council on the implementation of the information and education program.
>
> Any unexpended balances as of August 31, 2020, are appropriated for the fiscal year beginning September 1, 2020, for the same purpose.

The Rider provides overview and direction
Fiscal Impact:

- General Revenue— $270,618
- All Funds— $270,618 (Carryover was allowed)

The Executive Commissioner shall allocate $135,309 in fiscal year 2020 and $135,309 in fiscal year 2021 in General Revenue to support the Palliative Care Program established in Health and Safety Code Chapter 118. Any unexpended balances as of August 31, 2020, are appropriated for the fiscal year beginning September 1, 2020, for the same purpose. Some funding is already allocated for program operations, but dollars remain to support analytics

There are service records for Medicaid patients.

Dr. Fine asked about quality and patient-perceived quality. They survey patients for how things changed and how they felt. Mr. Blanton stated that the aforementioned qualitative study was looking at what other states were doing. Using the Triple Aim, it would be difficult given the current data. DSRIP exists, but it is not very systematic (data availability). Dr. Fine stated that maybe the state could cooperate with large institutions (MD Anderson, Baylor, Texas Tech) collecting patient-centered quality data. Mr. Blanton stated that it would be a voluntary effort and would have to be Medicaid clients so protections would be enforced. We would need a study design that makes sense.

The Chair suggested perhaps using a three-month snapshot, prospectively using agreed-upon data points. He stated that the involvement of statisticians in defining the data needed would be helpful.

Mr. Blanton stated that they could look at claims data and readmissions. He stated that we have a good look at claims, benefits that should be added to the study and include telemedicine. We have to look at the patient-centered outcomes. That will take longer because we have to establish relationships with the different systems.

Dr. Patterson stated that the information has to be set up to be queryable. You would be looking at two points in time entrance and exit, and if you felt better. We would be looking for pain, but what else? The Chair stated that they would look at sleep, anxiety, and depression.

Dr. Fine stated that MD Anderson is the pro at this. Baylor Scott & White is still in the process of electronic medical record transferring. We ask about advanced directives but with pain, it is dependent on the palliative care professional; it is a subjective symptom. It is good, but not nearly as robust as MD Anderson.

Mr. Blanton stated that they had a good discussion on the study, and staff can work on the plan. The hard part will be looking at quality and we will need partnerships with others at the table.

Pilot Milestones:

Milestone	Target Completion Date
Support Council Workgroup charged with drafting the 2020 Legislative Report	Through 8/10/2020
Hold Palliative Care Interdisciplinary Advisory Council Meeting to obtain final approval for the 2020 Legislative Report and receive an update on the SB 916 Study	9/01/2020
Program submits information memo to Executive Commissioner on 2020 Legislative Report	9/15/2020
Chair submits biennial Legislative Report to HHSC and legislative offices (Report Due)	9/31/2020
Host 2020 continuing education event	11/05/2020
2020 Legislative Report presented to the Executive Council	1/31/2021
Complete evaluation of Palliative Care Council progress	5/31/2021
Monitor progress on SB 916 Report	8/31/2022

HHSC provides interim update to the Advisory Committee on study decisions and progress for inclusion in the Committee's 2020 Legislative Report	8/31/2020
HHSC completes study and draft write-up and routes for internal review	4/30/2022
Advisory Committee monitors study progress, including by receiving reports during Quarterly and Workgroup meetings	9/1/2022
HHSC submits study to the Advisory Committee	7/1/2022

7. 2020 Legislative Report. *The discussion could not be included in the report due to malfunctioning audio in Brown-Heatly*.

Timeline & Goals

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Recommendation Topics

Possible topics include:

- Enhancing Family Caregiver Support. Dr. Hurwitz stated that care must be family-centered to include the caregivers.
- Utilizing Telemedicine for Supportive Palliative Care (an emerging issue)
- Adoption of a Medicaid community-based palliative care benefit

- Fine-tuning Texas policy surrounding Low-THC cannabis eligibility requirements for cancer patients

There have been some meetings already.

Topic breakout session:
1. Enhancing Family Caregiver Support. Lead: Dr. Craig Hurwitz
2. Telemedicine for SPC Meet with the pilot study workgroup today*. Leads: Dr. Gross and Erin Perez
3. Medicaid community-based palliative care benefit. Leads: Dr. Henderson and Dr. Paterson
4. Low THC cannabis eligibility for cancer patients. Lead: Dr. Fine; Members: Nat Jones
5. SB 916 Pilot Study Workgroups. Lead: Dr. Erin Perez; Members: Mr. Fenter, Dr. Ragain, Dr. Moss, Dr. Reed

Topic breakout reports. Inaudible.

Next steps and goals. Inaudible.

8. Action items and topics for staff or member follow-up. Inaudible.

9. Public comment.

Kristin McGarity, patient representative, addressed the issue of patients falling through the cracks between palliative care and pain care. There are people who have failed at different pain therapies. There are many pain specialists but no one to serve the more challenging cases. People are trapped in their homes with autoimmune disease. They were wondering if palliative care professionals could address this group who have fallen through the cracks.

10. Adjourn. There being no further business, the meeting was adjourned.

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