

- SUBJECT:** Establishing palliative care advisory council, education program
- COMMITTEE:** Public Health — committee substitute recommended
- VOTE:** 11 ayes — Crossover, Naishtat, Blanco, Coleman, Collier, S. Davis, Guerra, R. Miller, Sheffield, Zedler, Zerwas
- 0 nays
- WITNESSES:** For — Christi Ming and Lillian Villarreal, American Cancer Society Cancer Action Network; John Voliva, PCCA; Craig Hurwitz, Seton Hospital System; Lauren Dobbs, Texas Academy of Physician Assistants (TAPA); Erin Perez, Texas Nurse Practitioners; Larry Driver; Barbara Jones; (*Registered, but did not testify*: Amanda Fredriksen, AARP; Kaitlyn Murphy, American Heart Association; Jim Arnold, American Lung Association; Vicki Perkins, CHRISTUS Health; Kathy Hutto, Coalition for Nurses in Advanced Practice; Chris Masey, Coalition of Texans with Disabilities; David Lofye, LIVESTRONG Foundation; Freddy Warner, Memorial Hermann Health System; Marina Hench, Texas Association for Home Care and Hospice; Rebekah Schroeder, Texas Children’s Hospital; Irene Gilliland, Texas Clinical Nurse Specialist Association; Joel Ballew, Texas Health Resources; Jennifer Banda, Texas Hospital Association; Troy Alexander and Dan Finch, Texas Medical Association; Marsha Jones, Texas Oncology; Krista Crockett, Texas Pain Society; Rene Garza, Texas Pharmacy Association; Michael Wright, Texas Pharmacy Business Council)
- Against — (*Registered, but did not testify*: John Seago, Texas Right to Life)
- DIGEST:** CSHB 1874 would create a Palliative Care Interdisciplinary Advisory Council to assess the availability of patient-centered and family focused palliative care. The bill also would require the Health and Human Services Commission, in coordination with the advisory council, to establish a statewide palliative care information and education program.

Members. The advisory council would be composed of members appointed by the Health and Human Services executive commissioner and would serve at the pleasure of the executive commissioner. The advisory council would include:

- at least five physicians, including two who were board certified in hospice and palliative care and one who was board certified in pain management;
- at least two advanced practice registered nurse members who were board certified in hospice and palliative care;
- five health care professional members, including nurses, social workers, pharmacists, and spiritual care professionals, with experience providing palliative care to all ages and in a variety of settings and who had expertise in interdisciplinary palliative care;
- at least three members who had experience as advocates for patients and the patients' family caregivers and who were independent of a hospital or other health care facility, including at least one member who was a representative of an established patient advocacy organization; and
- ex officio representatives of the commission or another state agency as the executive commissioner determined appropriate.

Advisory council members would serve four-year terms. If a vacancy opened up, a person would be appointed to fill the vacancy for the unexpired term. Members would elect a chair and vice chair, as well as establish their duties. The executive commissioner would establish a time and place for meetings that would occur at least twice a year. Members could not receive compensation for their service on the council, but could be reimbursed for travel expenses.

Information and education program. The commission, in consultation with the advisory council, would establish a statewide palliative care consumer and professional information and education program to ensure that comprehensive and accurate information and education about palliative care was available to the public, health care providers, and health care facilities.

The commission would make available on its website information and resources regarding palliative care, including:

- links to external resources regarding palliative care;
- continuing education opportunities for health care providers;
- information about palliative care delivery in the home, primary, secondary, and tertiary environments; and
- consumer educational materials regarding palliative care, including hospice care.

The council would consult with and advise the commission on the establishment, maintenance, operation, and outcome evaluation of the palliative care information and education program.

On or before October 1 of each even-numbered year, the council would submit a biennial report to the standing committees of the Senate and the House of Representatives with primary jurisdiction over health matters. The report would include the council's assessment of the availability of palliative care in Texas for patients in the early stages of a serious disease and the council's analysis of barriers to greater access to palliative care.

Notwithstanding any other law, the advisory council and the information and education program established by the bill would not create a cause of action or create a standard of care, obligation, or duty providing a basis for a cause of action.

The advisory council would be subject to the Texas Sunset Act and, unless continued, would be abolished September 1, 2019.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2015.

**SUPPORTERS
SAY:**

CSHB 1874 would establish an advisory council to evaluate Texans' access to palliative care, which can be effective in relieving the stress, symptoms, and pain associated with chronic illnesses. The council and the

palliative care information and education program it would help establish could ensure information about this important form of health care was available to the public and health care facilities. This could break down the barriers to palliative care access for Texans and improve outcomes and quality of life for patients and their families.

The bill could help bring the benefits of palliative care to Texans living with life-threatening disease, which would promote the delivery of quality care and potentially result cost savings. A 2010 study of patients with lung cancer published in the *New England Journal of Medicine* found that patients assigned to early palliative care had a better quality of life, fewer symptoms of depression, and a longer median survival rate than patients receiving standard care. Furthermore, early introduction of palliative care can lead to less aggressive end-of-life care, which helps reduce health care costs but in no way denies a patient who wants access to curative treatment. The timely introduction of palliative care may serve to mitigate unnecessary and burdensome financial, personal, and societal costs.

The bill would ensure that three members of the advisory council had experience as advocates for patients and patients' families and were independent of any hospital or health care facility. One of these three would have to represent an established patient advocacy organization.

Furthermore, the goal of HB 1874 is to increase awareness. It would have no direct implication for Texas patients other than to bring other care options to patients and their families and would not discourage them from seeking life-saving treatment.

**OPPONENTS
SAY:**

CSHB 1874 may not adequately protect the rights of patients. As written, the bill would require the council to have only one patient advocate representing an established patient advocacy organization. This would not give sufficient attention to the rights of patients and informed consent.

The bill should take into account other patient needs, such as the involvement of primary care physicians in palliative care decisions. The delivery of palliative care may involve increasing pain medications or

result in the removal of a ventilator, which would end the patient's life. It is crucial that the patient and the patient's family have access to the doctor most familiar with their situation to help in navigating these difficult decisions. A primary care physician typically is the provider most familiar with the needs and concerns of the patient and the patient's family.