Indiana Palliative Care and Quality of Life Advisory Council Meeting Minutes

Indiana Palliative Care and Quality of Life Advisory Council			
Date	October 29, 2018		
Time	1:00-2:30 pm		
Location	Indiana State Department of Health, Yoho Board Room, 2 North Meridian Street, Indianapolis, IN 46204		
Recorder	Grace Miller		
Attendees	Susan Hickman, Natasha Young, J. Derek Imars, Amy Haskamp, Keylee Wright, Grey Pelc, Colleen Brown, Rafael Rosario		
Other	Call in – Mika Hill, Tom Ledyard, Lynn Robbin, Stacey Sharp, Matt Blair,		
Topics	**Discussion**	**Action or Follow-up**	**Responsible Person**
Welcome and Introductions	Susan Hickman, PhD, Council Chair, provided welcoming remarks and attendees gave introductions.		
Approve Meeting Minutes	Meeting minutes from the Sept 26th, 2018 meeting were redistributed to council members and they plan to review and approve at the next meeting.	Send both Sept. & Oct. minutes out before next mtg.	Natasha Young
Updates on Palliative Care in Indiana	The following updates were provided during this meeting: - Now available is an Advanced Care Planning Training for nurses in nursing homes – they get 5 of value-based purchasing points if a nurse takes the training over 9 months. - Michigan City opened an outpatient clinic and is getting a new hospital with space granted in the outpatient area for an adult clinic. - Riley Children's Hospital has a second palliative care physician and plans for getting another. - The Palliative Care and Hospice Education and Training Act (PCHETA) update: we still need to work on Sen. Young. Grace to send out script & info. - It is expected the CDC will announce another round of funding for cancer survivorship and ISHD is waiting to apply and can incorporate some PC support. There are active discussions about updating the living will & health care rep		

	statutes. Likely some legislation introduced next session. Clean up problems from old laws. Power of attorney for health care is very confusion. Looking encouraging. Has been 26 years since they were first visited.		
Workgroup Summaries & Recommendations for Council	Susan Hickman began discussion of the Access to Palliative Care Workgroup. Co-chair, Chris Brinneman was not able to attend and Stacey Sharp participated via phone. The workgroup summary report draft was handed out. First idea discussed was defining the practice of palliative care – some states already have, or are working on, definitions in statute. Our definition sunsets with the sunset of the Council itself, something to work on would be separating so it doesn't sunset. Looked at definitions from around the country. Decided that it should include a team, talked about reimbursement, opioid limits – PC patients would need exceptions on length of time. Team definition: want to make sure we're inclusive of folks who have teams that may be growing. Should include a doctor, nurse, who else – if anyone? CAPNI – working towards not having to have a physician, rural areas might not have a physician. Could we deliver a definition that includes a percent trained in PC, but not specific on who that is? Interdisciplinary team. Led by PC certified clinician. This way the SW doesn't have to be dedicated to the team, but you have access to them and they provide support. Recommended making a definition that lived in the Indiana Code, this would need legislative action. How do we get into the legislative process to get that solidified? Can ISDH help with that? What would the definition be? We need to come up with specific language – we want something that meets the intent. Conceivable that it could be tied into the Advance Directive work that is coming up. The definition section will likely need updated anyway. Second topic discussed regarding best practices for health programs & informing patients of the availability of PC was tabled in workgroup.	Provide the counsel sample statute language for an Indiana Palliative Care definition. Check with Advance Care planning group to see if the definition can be included in their bill.	Chris Brinneman and Stacey Sharp Susan Hickman

	Workgroup was unsure if this is best course of action. Already have NQS guidelines. Better to simply promote those practices. However, we can include some information in report. Because of the workforce issues, it might not be best to mandate informing patients on access since they likely won't have any in their area. It would have to be something fairly general that all these different kinds of systems and staff could use. Including something about a lack of workforce in the report as a barrier seems reasonable and important for the folks who will read the report. People need to know we are in need. Could also be important to raise with ISMA? Next topic on encouraging patients on HIP to use to PC was also tabled by the workgroup. Because there isn't a definition, it would be difficult. But there are already processes that move patients around if needed, but not common for PC (lack of workforce one issue). It was recognized the great help from the HIP experts, Darris Harrison and Steve Bordenkecher. For the topic regarding in-patient non-terminal care it was suggested the group could recommend a pilot program. It was unclear for the workgroup where the licensure would be housed? And there is not enough information yet to move forward. CA is in a different place as far as resources & in-patient facilities. Medicaid folks were more than willing to work on it, but more work needs to be done. Best way to get conversation started is to submit a suggestion to the policy email inbox (HIP). They are required to respond. Next, Derek Imars gave the workgroup summary update for the Pain medication Access & Management Workgroup. The first topic discussed was adjusting the 7 day limit on opioid scripts for PC patients. In SB 226 – there are exemptions including physician exemptions, cancer and PC. Board of Pharmacy was working on this to provide guidance and build out and close the loop. But people are still having problems with some pharmacies and for sure the insurance. It was recommended to include reference to this in the		

	report. PC patient are not defined and they need to be in order to make sure the right patients are getting the help. We don't want it to be abused so that PC gets un-included. Things to consider- if etiology or provider driven? Provider is probably easier. Board certified, approved, to be certified…that puts the focus on the provider. Could it be DEA waiver based? Like Saboxone? Where will it say if the prescriber is certified/approved? It was suggested to look into what they're doing for hospice and Derek agreed. The second topic discussed was the issue of mandating CME training on PC. While specialized training exists, there's no mandatory training. Mandating the training would be difficult, but exposure to the idea would be beneficial. Could tie into being a PC prescriber. Want to make sure this would be something of value. For the states where they have PC CME requirements, has it made a difference? But there are models that could be embraced. Other states have models but not for sure of the benefits and the interests. Third topic discussed was providing efficient & streamlined ways of opioid destruction. Workgroup looked at DEA legislation (2010) and HR 6 (fed level) – signed and allows nurses to take drugs back and destroy on site which is a huge win. Derek suggested if we could get state funding for the destruction devices that would be a great recommendation. Or even other hospice or private organizations could help distribute. A question was proposed about what else could the state do around destruction? More take-back days? County requirements? What could we suggest – the problem is certainly not solved. Firehouses, police stations – they could have these so how can the state help facilitate, be more proactive. Come up with a recommendation as far as a paper trail that these really got taken care of? Is there already something? Where would this live?	Repository? Look at what is being done for Hospice.	Derek Imars

	Lastly, topic four regarding drafting a model policy for a standard of care that includes accountability measures. Hospitals are measured on quality & standard of care. Sites do not have to register. Need to have some defined policies. CMS has a hand on this – each site has to have approved policy, but what does that look like.		
Summary and Planning for Report	Report is due at the end of the year and we plan to have a draft for review before December. Year three report or final report? It was suggested by Dr. Hickman to do a year three report then a final/follow-up report when the council sunsets in June 2019. Our goal is to firm up the report and identify action items. As well as, fitting in pediatrics. Next meetings of the Council we'll work on those action items. Do we want to recommend the group be continued? Likely needs legislation and would have to happen this session. There are other options though to possible continue group without legislation. Need to address pros and cons of this.		
Upcoming Meeting	December 12, 2018 11:00 - 12:30 pm		