



Health and Human Services

Palliative Care Interdisciplinary Advisory Council

April 16, 2026

This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.





[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.

Physician Representatives

- Larry Driver, MD, Houston
- Robert Fine, MD, MACP, FAAHPM, HEC-C, Dallas
- Alison Wiesenthal, Vice-Chair, MD, FACP, FAAHPM, San Antonio
- Neela Patel, MD, Shavano Park
- Nancy Weber, DO, MBA, FACOEP, FACEP, El Paso
- Kelly Klein, Chair, MD, FAAFP, FAAHPM, HMDC
- Mohammed Iqbal, MD, Richardson

Advanced Practice Registered Nurse Representatives

- Heather Paterson, MS, RN, Dallas
- Erin Perez, DNP, APRN, ANP-C, AGNP-C, ACHPN, Live Oak

Physician Assistant Representative

- Daniel Tamez, DSc, MPH, MS-PA, Edinburg

Nurse Representative

- Carol Cates, RN, Tyler

Social Worker Representative

- Crystal Walter, MPA, MSW, LCSW, Bellaire

Pharmacist Representative

- Genoveva "Hennie" Garza, MS, Plano

Spiritual Care Professional Representative

- Jerry Fenter, Beaumont

Advocate for Patients and Families Representatives

- Jennifer Carr Allmon, MA, Austin
- Kristin Rombach, RN, BSN, OCN, Austin
- Nancy Jackson, Gainesville
- Maxcine "Max" Tomlinson, Austin

Ex-Officio Members

- Dianne Overshown, MPA, Texas Health and Human Services Commission, Austin

Resources:

- [Supportive Palliative Care.](#)
- [Pediatric Supportive Palliative Care.](#)
- [Email the PCIAC.](#)
- [Read PCIAC reports.](#)

1. Welcome, introductions, and roll call. The meeting was convened by Kelly Klein, Chair.

2. Consideration of January 29, 2026, draft meeting minutes.



3. Consideration of PCIAC Draft Bylaws. The bylaws were approved with the required 2/3rds vote

4. Presentation: Dying to Eat: A Tube Feeding Time Out Amid Life-Limiting Illness.

Summary. Dr. Jennifer Hanners-Gutierrez (Texas Tech, Otolaryngology; medical speech-language pathologist with PhD focus on dysphagia/palliative medicine) presented on selecting feeding routes amid life-limiting illness (“dying to eat”).

Key background points:

- Food is tied to dignity, autonomy, memory, and psychosocial well-being; tube feeding can be isolating for patients and families.
- Aspiration risk is often over-medicalized; tube feeding is not risk-free and should not be the default.
- Ethical principles emphasized: autonomy (with unbiased disclosure), beneficence/non-maleficence (including long-term implications), and justice (equitable access to supports like careful hand feeding).

Dr. Hanners gave a background story about a patient she had served. Illustrative patient stories:

Dr. Hanner’s research was shared (prospective observational pilot, n=65 terminally ill patients with dysphagia receiving oral vs tube feeding; adjusted for age and mortality risk):

- Tube feeding was associated with higher likelihood of pneumonia (OR ~19.28) and depression (OR ~17.25); mortality trended upward but was not statistically significant.
- Composite adverse outcome (pneumonia/depression/death) was much higher in tube-fed patients (reported as ~55x).
- Propensity score matching (15 vs 15) reinforced higher pneumonia and depression in tube-fed group.
- Practical risk-mitigation strategies were discussed:
- Diet/texture modification using IDDSI levels.
- Structured oral care to reduce pulmonary infection risk (including discussion of agents such as chlorhexidine/hydrogen peroxide with proper use).



- Positioning, assisted/interactive feeding techniques, and careful hand feeding (noted for dementia).

Communication and documentation are important. The speaker suggested using SPIKES protocol for difficult discussions. She recommended “informed autonomous consent” documentation (intent, understanding, voluntariness) rather than unenforceable “waivers.”

Dr. Hanner proposed a policy concept for Texas: a “tube feeding time-out” requirement before initiating feeding tube placement in life-limiting illness with dysphagia, with standardized documentation and annual interdisciplinary training. She suggested legislation to accomplish this and provided a model informed consent form regarding feeding.

She clarified that the study design was observational (not randomized); feeding route followed patient choice; propensity matching used algorithmic matching.

Dr. Fine praised the work and offered to carry ideas to the Texas Medical Association council; also emphasized need for larger sample sizes and discussed potential multi-institution collaboration.

Dr. Hanners-Gutierrez noted limited dedicated research time and interest in expanding sample size; pursuing larger retrospective work via Cerner National was mentioned.

Discussion included preferred terminology (e.g., “assisted/artificial/alternative nutrition” vs “feeding tube”) and potential linkage with GI fellows and other statewide partners.

Presentation

Dysphagia...the barrier to comfort through food and drink

1. patients with health care complications can experience difficulty swallowing (Thiyagalingam et al., 2021)
2. can lead to aspiration (foreign material, such as oropharyngeal pathogens carried by food or drink, bypasses the vocal folds and enters the lungs)
3. can lead to withdrawal of oral nutrition and a recommendation for tube feeding
4. can lead to overmedicalization and dismissal of patient’s expressed desires to eat by mouth (Wilkinson et al., 2021)

The Risk of Aspiration

Biomedical Ethics

- Autonomy: Respecting the patient's right to choose
- Beneficence: To do good
- Nonmaleficence: Avoiding harm
- Justice: Ensuring fair and equitable treatment

Establish goals-- take time, be patient, take Establish goals perspective, expect emotions Nothing should be the result of mandating a feeding route based on the bias of the health care provider

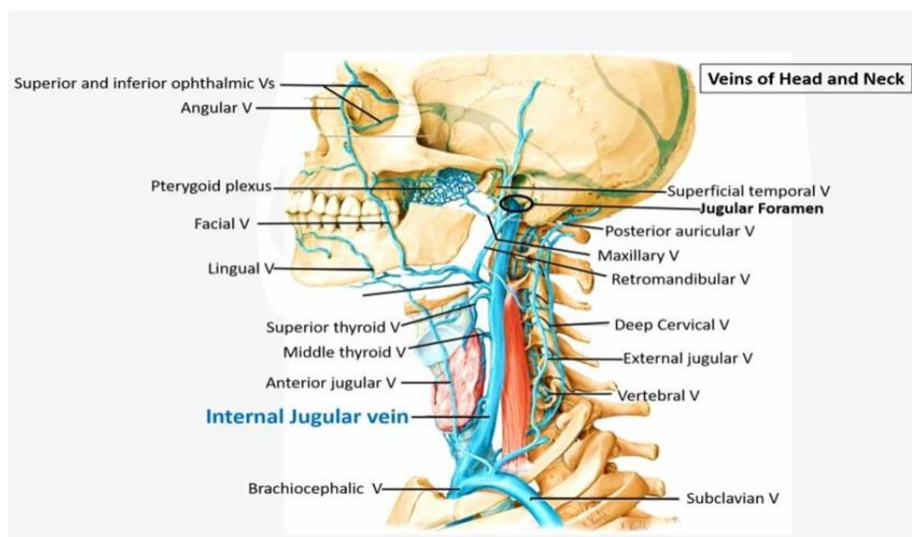
Addressing Family and Cultural Concerns (Colclough, 2017; Lee et al., 2018; Schwartz et al., 2021)

- The role of cultural beliefs in feeding decisions
- Family-centered ethical considerations
- Strategies for culturally competent communication

Artificial Nutrition and Hydration

Tube feeding: Nasogastric tubes, Dobhoff tube, gastrostomy tubes, jejunostomy

Parenteral nutrition (Berlana, 2022; Compher et al., 2022)



Right Subclavian Vein



Tube Feeding Risks

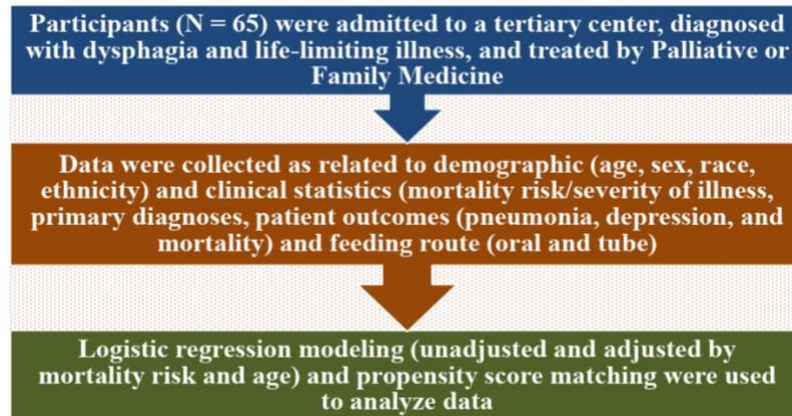
- Medical risks: Aspiration Let's review: pneumonia, infection, reflux, discomfort
- Nonmedical risks: Loss of social eating, potential for restraint/sedation (Zaza et al., 2024; Zuckerman et al., 2024)
- Benefits: Nutrition/nourishment, family peace of mind

Which method of feeding/hydration (i.e., oral versus tube) is the best option when a patient has been diagnosed with a terminal condition due to a disease process or injury, chooses nutritional provision, and has dysphagia with risk of aspiration? This research question was explored through her study.

Purpose of the Research-- To prospectively determine and compare outcomes of enteral nutrition and oral nutrition in terminally ill patients with dysphagia and risk of aspiration, statistically adjusting for:

- mortality risk
- age

Methods and Participants



Inclusion Criteria

- all adult ages (18 years of age or older)
- presence of dysphagia
- presence of life-limiting illness/diagnosis
- admitted to UMC and treated by Palliative Medicine and/or Family Medicine
- patient or authorized representative chooses nutrition by informed autonomous consent
- mortality risk and severity of illness scores accessible via IT Analytics related to diagnoses round in the electronic medical record

Exclusion Criteria Participants who were actively dying (imminent death) or did not desire nor accept nutritional support were excluded from this research study.

Methods and Participants Variables



Mortality Risk – necessary to explore to determine confounding effects potential on associations between feeding methodology and patient outcomes.

- Byproducts of the inpatient prospective payment system
- All Patient Refined Diagnosis Related Groups (APR-DRG)
 - Four subclasses of mortality risk
 - Scored independent of one another
 - Numbered sequentially from 1 to 4, corresponding with minor risk/illness and extreme risk/illness

Summary of Results--Overall, results revealed stronger associations with tube feeding and adverse outcomes. Based on study findings, there is greater likelihood that pneumonia and depression will occur amid tube feeding versus oral feeding in patients with dysphagia who are critically or terminally ill. Mortality also trended upward in participants who were tube-fed versus oral-fed.

Baseline Demographic Variables

Characteristic	Overall, N = 65	Oral, N = 41	Tube, N = 24	P-value ¹
Age				0.032
N	65	41	24	
Mean (SD)	70.66 (14.18)	74.02 (10.90)	64.92 (17.27)	
Median (IQR)	72.00 (20.00)	75.00 (17.00)	65.00 (26.50)	
(Min., Max.)	(18.00,94.00)	(49.00,94.00)	(18.00,89.00)	
Sex				0.140
Male	40 (62%)	28 (68%)	12 (50%)	
Female	25 (38%)	13 (32%)	12 (50%)	
Race				0.800
Asian	2 (3.1%)	1 (2.4%)	1 (4.2%)	
African American	5 (7.7%)	4 (9.8%)	1 (4.2%)	
White	58 (89%)	36 (88%)	22 (92%)	
Ethnicity				0.800
Hispanic/Latino	23 (35%)	15 (37%)	8 (33%)	
Not Hispanic/Latino	42 (65%)	26 (63%)	16 (67%)	
1: P-value is based on Fisher's exact test; Pearson's Chi-squared test for categorical variables; and Wilcoxon rank sum test for continuous variables.				

Baseline Clinical Variables

Characteristic	Overall, N = 65	Oral, N = 41	Tube, N = 24	P-value ¹
Diagnosis				0.400
Neurological	24 (37%)	17 (41%)	7 (29%)	
Respiratory	19 (29%)	9 (22%)	10 (42%)	
Trauma	5 (7.7%)	4 (9.8%)	1 (4.2%)	
Immunosuppressive	3 (4.6%)	1 (2.4%)	2 (8.3%)	
Cancer	11 (17%)	8 (20%)	3 (12%)	
Renal Disease	3 (4.6%)	2 (4.9%)	1 (4.2%)	
Unknown	0	0	0	
Mortality Risk				<0.001
Moderate	9 / 62 (15%)	9 / 38 (24%)	0 (0%)	
Major	22 / 62 (35%)	18 / 38 (47%)	4 (17%)	
Extreme	31 / 62 (50%)	11 / 38 (29%)	20 (83%)	
Unknown	3	3	0	
Illness Severity				<0.001
Moderate	3 / 62 (4.8%)	3 / 38 (7.9%)	0 (0%)	
Major	19 / 62 (31%)	18 / 38 (47%)	1 (4.2%)	
Extreme	40 / 62 (65%)	17 / 38 (45%)	23 (96%)	
Unknown	3	3	0	
n / N (%)				
1: P-value is based on Fisher's exact test; Pearson's Chi-squared test for categorical variables				

The incidence of pneumonia was significantly higher in the tube feeding group compared to the oral feeding group (79% vs 12%, $p < 0.001$). Logistic regression analysis showed that tube feeding was associated with significantly increased odds of pneumonia (adjusted OR = 19.28, 95% CI: 4.5-109.6, $p < 0.01$), even after controlling for age and mortality risk.

The prevalence of depression was significantly higher among those receiving tube feeding (50% vs 9.8%, $p < 0.001$) compared to oral feeding. Adjusted logistic regression indicated a strong association between tube feeding and depression (adjusted OR = 17.25, 95% CI: 3.13-158.78, $p < 0.01$).

Mortality was observed in 18 participants (28%), with a higher death rate in the tube feeding group (46%) compared to the oral feeding group (17%) ($p = 0.012$). Although the unadjusted odds ratio suggested an increased risk of mortality with tube feeding (OR = 4.11, 95% CI: 1.34-13.47, $p = 0.015$), the adjusted model did not reach statistical significance (adjusted OR = 2.78, 95% CI: 0.71-11.7, $p = 0.147$).

A PROPENSITY-MATCHED dataset of 30 participants (15 oral, 15 tube) was analyzed (see Table 8). Results from propensity-matched data reinforced previous findings, showing significantly higher rates of pneumonia (73% vs 13%, $p < 0.001$) and depression (47% vs 6.7%, $p = 0.035$) in the tube feeding group. Mortality remained higher but was not statistically significant in the matched cohort (40% vs 27%, $p = 0.4$). The persistence of significant differences even after controlling for potential confounders further supports the robustness of the observed associations.

Bivariate Associations

Characteristic	Overall, N = 30	Oral, N = 15	Tube, N = 15	P-value
Pneumonia				<0.001
No	17 (57%)	13 (87%)	4 (27%)	
Yes	13 (43%)	2 (13%)	11 (73%)	
Depression				0.035
No	22 (73%)	14 (93%)	8 (53%)	
Yes	8 (27%)	1 (6.7%)	7 (47%)	
Mortality				0.400
No	20 (67%)	11 (73%)	9 (60%)	
Yes	10 (33%)	4 (27%)	6 (40%)	
PDM				0.014
No	9 (30%)	8 (53%)	1 (6.7%)	
Yes	21 (70%)	7 (47%)	14 (93%)	

The significant association between tube feeding and adverse outcomes reinforces the need for an improved approach to nutritional decision-making in palliative care.

Evidence supports prioritization of patient autonomy and quality of life when discussing feeding options with patients who have dysphagia and are pleading to eat by mouth. The results of this groundbreaking pilot study reveal that oral feeding or careful hand oral feeding may be a viable and less harmful alternative to tube feeding for patients with dysphagia and life-limiting illness.

Barrier 1 - Fear of Patient Decline

1. Concern: Aspiration risk in patients with full code status
2. Real-World Example: The complexity in recommending foods like a hamburger
3. Provider Dilemma: Balancing comfort foods with least risk intake strategies

Strategy 1: Dietary Modifications - Adjusting texture and portion sizes

Strategy 2: Using International Dysphagia Diet Standardisation Initiative (IDDSI) levels to guide safe consumption

Example: Modifying a patient's requested food to fit least-risk guidelines (or at least offering taste for comfort)

Risk Reduction Strategies

- Strategy 3: Structured oral care to reduce aspiration risks
- Strategy 4: Patient positioning during and after meals
- Strategy 5: Assisted and interactive feeding techniques

Barrier 2 - Fear of Retaliation

- Provider Concerns: Legal risks if a patient decompensates
- Questionable Practice: Requirement of a waiver if the patient chooses to eat by mouth
- Evidence: Waivers not advised, legal and ethical implications (Horner et al., 2016)

Documentation and Informed Consent

Solution: Emphasis on documentation of patient choice and risks

Education: Thorough, evidence-based explanation of risks

Ethical Standards: Ensuring patient decisions are informed and autonomous

Informed Autonomous Consent (Leslie & Casper, 2015) Risks of aspiration have been disclosed, and the patient has verbalized understanding of potential consequences. The patient intends to choose least risk oral feeding and volunteers this choice by informed autonomous consent.

- Effective communication is critical when discussing nutritional decisions.
- Health care providers must convey risks, benefits, and options while respecting patient preferences. (O'Keeffe et al., 2023; Millum & Bromwich, 2021)

The SPIKES Protocol (**S**et up the discussion, **L**earn the patient's **P**erception, **B**e **I**nvited, **S**hare **K**nowledge, **R**espond to **E**motions with **E**mpathy, **S**ummarize)



How do we leave a permanent legacy? ...LEADING THE CHARGE RELATED TO EVIDENCE-BASED AND PATIENT-CENTERED NUTRITIONAL DECISION-MAKING

Legislative Proposal: Mandating a “Tube Feeding Time Out” in Texas Palliative Care Settings

Executive Summary This proposal recommends that the Texas Palliative Care Interdisciplinary Advisory Council endorse legislation requiring a standardized “Tube Feeding Time Out” protocol before initiating feeding tube placement in patients with life-limiting illness and dysphagia.

The measure is grounded in a broad evidence base showing that tube feeding does not reliably improve survival, reduce pneumonia, or enhance quality of life in advanced disease. In fact, studies across patient populations—including advanced dementia, end-stage stroke, and end-stage Chronic Obstructive Pulmonary Disease (COPD)—have documented associations between tube feeding and increased rates of pneumonia, higher mortality, and worsened depression.

A recent prospective pilot study (Gutierrez et al., 2025) adds to this literature by showing that tube feeding was linked with significantly greater risks of pneumonia and depression, and a markedly higher likelihood of experiencing at least one adverse outcome. While not the only source of evidence, this study highlights the urgency of aligning care with ethical and palliative care standards.

Background and Problem Statement Despite decades of evidence and professional guidelines (e.g., American Academy of Hospice and Palliative Medicine [AAHPM], American Speech-Language Hearing Association [ASHA]), tube feeding is often recommended to patients with advanced illness under the assumption that it is safer than oral feeding. Research consistently demonstrates the opposite: oral or careful hand feeding is equally safe, more humane, and better aligned with patient goals.

Studies in dementia, stroke, and COPD have shown poor tolerance, no improvement in survival, and increased risk of pneumonia and depression. Ethical principles of autonomy, beneficence, non-maleficence, and justice require disclosure and consent in all such cases.



Objectives and Goals

1. Require a Tube Feeding Time Out to ensure decisions are deliberate and informed.
2. Protect autonomous choice by mandating clear disclosure of risks, benefits, and alternatives.
3. Establish annual interdisciplinary training for physicians, speech-language pathologists (SLPs), and dietitians on evidence-based feeding practices in palliative care.
4. Reduce non-beneficial and harmful procedures while promoting quality of life.

Key Provisions Eligibility: Patients with life-limiting illness (Severity of Illness [SOI] or Mortality Risk Score 3–4) and dysphagia for whom enteral feeding is being considered.

Time Out Protocol: Conducted before tube placement by the primary medical team. Must include explicit review of risks, benefits, and alternatives (including careful hand feeding), confirmation of voluntary consent, and standardized documentation signed by physician and patient/surrogate.

Documentation: Standardized form included in the electronic medical record; subject to quality review.

Annual Education: Institutions must provide evidence-based training for providers involved in feeding decisions.

Implementation Plan Year 1: Develop standardized forms and training curricula. Year 1–2: Roll out provider education statewide. Year 2: Enforce Time Out documentation across facilities. Ongoing: Annual audits and reporting

Impact

Patient Autonomy: Protects rights and dignity in end-of-life care.

Clinical Outcomes: Reduces pneumonia, depression, and other adverse outcomes.

Health Systems: Minimizes costs associated with complications and litigation.

Ethical Practice: Aligns Texas law with principles of informed consent and palliative care standards.



Stakeholder Engagement

Texas Medical Association
Texas Hospice and Palliative Care Organization
Texas Speech-Language-Hearing Association (TSHA)
Texas Academy of Nutrition and Dietetics
Elder law, patient rights, and disable

This legislation recognizes that tube feeding in advanced illness is not a neutral or risk-free intervention. Decades of research—including dementia, stroke, COPD, and recent prospective multi-diagnostic evidence—demonstrate consistent harm without clear benefit. By mandating a Tube Feeding Time Out, Texas can lead the nation in ensuring that feeding decisions at the end of life are ethical, evidence-based, and patient-centered. Below is a model consent form.

Tube Feeding Time Out: Informed Consent Documentation
Patient Name: _____
MRN: _____
Date/Time of Time Out: _____

Primary Diagnosis / Life-Limiting Illness: _____
Severity of Illness (SOI): 3 (Major) 4 (Extreme)
Mortality Risk: 3 (Major) 4 (Extreme)

Purpose of the Time Out
Before initiating a feeding tube in a patient with life-limiting illness and dysphagia, the interdisciplinary team must pause to confirm that the decision is:

- Intentional (not a default or coerced choice)
- Volunteered (patient/surrogate decision-maker is freely choosing)
- Well-understood (risks, benefits, and alternatives have been clearly explained and acknowledged)
- Aligned with goals of care (treatment plan reflects patient values, preferences, and overall care objectives)

Discussion Checklist (to be completed by the treating physician)

1. Feeding Routes Discussed:

- Oral feeding / least risk oral feeding / careful hand (oral) feeding (with aspiration risk explained)
- Tube feeding (nasogastric, Dobhoff, PEG, gastrostomy tube, gastrostomy-jejunostomy tube, jejunostomy tube)

2. Risks and Benefits Explained:

- Oral feeding:
 - Aspiration pneumonia risk
 - May support dignity, comfort, and social interaction
- Tube feeding:

May increase risk of pneumonia, depression, infection, and complications
 Does not reliably extend survival
 May improve nourishment temporarily amid low oral intake or when swallowing is impaired

3. Alternatives Discussed:

Comfort feeding only (limited oral intake for taste/pleasure)
 No feeding / allow natural disease course

4. Patient/Surrogate Understanding Confirmed:

Patient (or Medical Power of Attorney [MPOA]) verbalized understanding of risks/benefits
 All questions answered satisfactorily
 Choice was voluntary and free from coercion

Decision

Patient/surrogate chooses Oral / Least Risk Oral / Careful Hand Feeding with understanding of aspiration risk
 Patient/surrogate chooses Tube Feeding (nasogastric, Dobhoff, PEG, gastrostomy, G-J tube, jejunostomy) with understanding of risks and alternatives

Signatures

Treating Physician: _____ Date/Time: _____
 Patient or Surrogate (MPOA): _____ Date/Time: _____
 Witness (Optional): _____ Date/Time: _____

For Institutional Review (if audited):

Documentation filed in EMR
 Meets criteria for intentional, volunteered, well-understood, and goal-aligned consent

Conclusion

Prioritizing patient values and uplifting health care providers struggling to contribute to physiological and psychological health (Nunn et al., 2025)

Encouraging a paradigm shift towards individualized, patient-centered care

Resisting default use of tube feeding as evidence supports oral nutrition amid life-limiting illness

Discussion

Were the 65 patients randomized? It was selective convenience sampling study. It is difficult to randomize.

You really need a larger sample size. Are there plans to get a larger sample? The speaker stated she is limited in expanding the study where she works. She is trying to do this through a retrospective study.

We should never use the phrase feeding tube. Perhaps use nutrition assistance, or other terms. Food is emotional.

5. [PCIAC Committee Updates](#)

2026 Legislative Report draft recommendations (report required by Texas Health and Safety Code, Section 118.010, and Title 1, Texas Administrative Code, Part 15, Section 351.827(d))

Supportive palliative care (SPC) standards under HCSSA home health licensing (presented by Maxine Tomlinson; work with Crystal Walter and Dr. Iqbal):

- Recommended broad rulemaking framework to define SPC services, care coordination/referrals, minimum staffing qualifications, transition parameters to hospice, plan-of-care requirements, IDT meeting expectations, and ongoing education.
- Recommended at least 12 hours/year of hospice/SPC continuing education for home health agency staff/contractors (topics included symptom management, nutrition, medication management, spiritual care, communication, and advance care planning).
- Recommended reviewing and amending rules across other settings/programs where SPC is delivered (e.g., nursing homes, assisted living, ICF/IID, Medicaid/CHIP) to support coordination with outside SPC resources.



Supportive Palliative Care Standards for Home Health Agencies Under the HCSSA License

Recommendation 1

1. HHSC should create a Subchapter or separate sections within 26 TAC Chapter 558 LICENSING STANDARDS FOR HOME AND COMMUNITY SUPPORT SERVICES AGENCIES with rules specific to SPC for home health agencies.

2. Specific rules for home health agencies providing SPC under the HCSSA license would be developed to include, at a minimum:
 - a. The provisions of services under the full array of SPC
 - b. Coordination of care to ensure services and referrals are available to the client and family.
 - c. Minimum recommendation for staffing qualifications
 - d. Twelve hours of Education and training of staff specific to SPC
 - e. Guidance on the management of the IDT
 - f. Number of and specific disciplines required for SPC to meet the needs of the client and family
 - g. Parameters for the referral to hospice, when deemed necessary
 - h. Plan of care requirements
 - i. Initial and continuing education
 - j. Frequency of case conferences and IDT meetings

Recommendation 2 Building upon the recommendation included in the PCIAC 2024 “SPC Standards for Home Health Agencies”: legislative report on

1. HHSC will set minimum qualifications for home health employees and/or contracted staff with experience in supportive palliative care.

2. HHSC will draft rules that require all Texas home health agencies who employ and/or contract providers on the SPC interdisciplinary team to complete at least twelve hours in hospice and supportive palliative care continuing education topics per year.
 - a) These topics include pain and symptom management, nutritional support, medication management in addition to non-pain symptom management, plan



of care, end of life care, spiritual care, complex communication for serious and life limiting illness advance care planning, and how to communicate this information to the patient and family.

3. Texas Home health agencies should also develop guidance on evidence-based standards of care and quality metrics for SPC based on the NQF practice guidelines and implement all eight domains.

Recommendation 3 HHSC will review other program areas to determine what rules need to be amended to reflect the use of outside resources and coordination of care for SPC. Programs include but are not limited to nursing facilities, assisted living, intermediate care facility for persons with intellectual disabilities and Medicaid and CHIP programs.

Paid Family and Medical Leave Act (FMLA) for Family Caregivers of Patients with a Serious or Terminal Illness Recommendation

Paid Family and Medical Leave Act proposal update (Henny Garza and Jerry Fenter):

- Recommended Texas prioritizes research and development of a family/medical leave insurance benefit for qualifying individuals caring for family with serious/life-limiting/terminal illness (target start Sept. 1, 2027).
- Proposed benefit: 80% of average weekly wages for up to 12 weeks in a 12-month period (intermittent or continuous); employers are mandated to participate; employees may opt in/out.
- Updated caregiver prevalence was cited: an increase from 3.1M (2021) to 5.3M (2025), ~23% of Texas adults as unpaid caregivers.

Recommendation

1. The Texas Legislature should prioritize the research and development of a family and medical leave insurance benefit to be offered as payable to any covered and qualifying individual who is caring for a family member with a serious and life-limiting and/or terminal illness or has a serious and life-limiting and/or terminal illness that makes the individual unable to perform the functions of their employment, beginning Sept. 1, 2027.

2. Whether taken intermittently or continuously, the weekly benefit shall be 80 percent of the covered individual's average weekly wages for up to twelve weeks within a twelve-



month period. Employers are mandated to participate but employees may choose to opt in or out to the family and medical leave insurance benefit.

Develop and Implement a Secure, Interoperable, Statewide Digital Advance Directives Repository

A statewide interoperable digital advance directives repository (presented by Dr. Klein with input from Kristen Rombach, Dr. Fine, and Dr. Wiesenthal):

- Recommended developing a secure, interoperable statewide repository accessible across care settings (hospitals, EMS, LTC, outpatient, hospice) to reduce fragmentation and improve goal-concordant care.
- EMS use case highlighted: ability to retrieve valid out-of-hospital DNR/advance directive en route to calls to honor wishes within legal parameters.

Recommendation

1. The Texas Legislature should develop and implement a secure, interoperable, statewide digital advance directives repository to ensure that a patient's documented healthcare preferences are available at the point of care across all settings. Advance care planning is most effective when patient values, surrogate designations, and treatment preferences are documented in a standardized format and retrievable in real time by hospitals, emergency medical services, long-term care facilities, outpatient practices, and hospice programs. Currently, fragmentation across electronic systems limits access during care transitions and emergencies, increasing the risk of care that does not align with patient wishes.

2. A centralized repository, designed with strong privacy protections, interoperability standards, EMS accessibility, and patient-facing access, would promote patient autonomy, improve goal-concordant care, reduce unwanted interventions, and enhance equity across rural and underserved communities. The Committee therefore recommends inclusion of this initiative as a strategic priority in statewide palliative care infrastructure planning and legislative consideration.



Request for HHSC to Pursue a Supportive Palliative Care Texas Medicaid Benefit

Medicaid benefit and billing recommendations (Dr. Klein) reiterated prior recommendations for HHSC to pursue a Texas Medicaid supportive palliative care benefit via SPA/waiver authority. The group recommended allowing reimbursement for advance care planning CPT codes 99497 and 99498 within Texas Medicaid.

Recommendations

1. HHSC should submit a State Plan Amendment (or other waiver authority) to the Centers for Medicare and Medicaid Services (CMS) to allow for Supportive Palliative Care services to become a Texas Medicaid Benefit.
2. HHSC should allow for reimbursement for Advance Care Planning (ACP) procedure codes 99497 and 99498 within Texas Medicaid. This will ensure Medicaid providers are compensated for vital and ongoing ACP discussions in various settings.

Discussion (There was limited discussion)

Other states have implemented FMLA legislation for family care givers.

Continuing Education Event 2026 Topic Recommendations

The 2026 continuing education event topic discussion was presented by Dr. Nancy Weber: Proposed topics list appears below and includes: SPC for individuals with intellectual/developmental disabilities; spirituality in serious illness; SPC for acquired cognitive impairments; communication with families via a family/caregiver panel; caregiver support/self-care; identifying candidates for SPC referral; and primary palliative care skills for non-specialists.

There was strong interest expressed in keeping the top three topics while also incorporating a family panel; suggestions included combining formats or potentially holding two events per year.

Additional suggestions included expanding dissemination through other professional organizations and considering staff burnout alongside caregiver support. A council member offered to help find a spirituality presenter; Crystal Walter offered to present on caregiver-related topics; suggestion to involve GI fellows and leverage prior presenters (e.g., Dr. Terry Weinman for panel experience).



Tentative Dates:

- Wednesday, November 4, 2026, 12-3pm
- Thursday, November 5, 2026, 12-3pm

Topics for consideration:

- SPC for Individuals with Intellectual and Developmental Disabilities (IDD)
- Spirituality and Care of the Seriously Ill
- SPC for individuals with Acquired Cognitive Impairment
- Communication with Families – possibly a Family Panel composed of caregivers/family sharing personal experiences with SPC
- Caregiver Support and Self-Care (include staff)
- Identifying Candidates for Specialty Palliative Care Referral
- Primary Palliative Care Skills for Non-Palliative Care Specialists

Discussion/Questions/Comments

SPC is so new it would be interesting to hear the family perspective.

There is a wide variety of types of attendees, spanning the entire multidisciplinary team.

We have not covered spirituality in any of our previous events

Maybe we should do this more than once a year and expand to twice a year to accommodate all the topics.

Burnout in staff and caregivers is a real problem (point 5)

Have we discussed working with professional organizations to present to those groups?

12 hours of CE are required. We provide only 6 hours. If we could meet the requirements for 12 hours CME that would be helpful.

We could incorporate the burnout issue in some of the other topics.

There was consensus for items one through four also involving a panel. The Committee will discuss the items and bring back a recommendation at the next meeting .

6. Discussion: 2026 priorities and timeline

PCIAC 2026 Legislative Report Timeline

PCIAC 2026 Legislative Report Timeline	
Milestones	Due Date
PCIAC Committees provide preliminary recommendations to full Council	4/16/2026
Preliminary Draft Report submitted by PCIAC members to council liaison	7/2/2026
Draft report prepared for review by council liaison and sent to HHSC SMEs	7/7/2026
HHSC SMEs complete content review and feedback (5 days). Draft Report routed to committee.	7/14/2026
Draft Report finalized by PCIAC committee members and submitted to council liaison	7/28/2026
Draft Report reviewed by QDAR Director/ VBI Manager and returned to liaison	8/3/2026
Draft Report reviewed and finalized by committee members for distribution before full council meeting.	8/10/2026
Draft report approved by PCIAC members at full council meeting	8/13/2026
Draft sent to DAC for review (5-7 days)	8/14/2026
Draft sent to DEC for review (5days)	8/18/2026
Draft sent to SMD for review (20 business days)	8/24/2026
Draft sent to EC (10 business days)	9/17/2026
Report published and posted to website	10/1/2026

Upcoming Full Council Meetings:

- August 13, 2026
- October 9, 2026

Other Key Deadlines/Events:

- October 1, 2026 – Legislative Report Due
- Annual Palliative Care CE Event (November 4 or 5, depending on availability of speakers)

7. Public comment No public Comment was offered

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

- Follow up with committees for report content
- By-laws statement for signature will be sent out



- Encouraged to follow-up with speakers for the education event; Organizations to be contacted regarding the CE event and the potential for making presentations to them

Future Meetings.

- August 13, 2026
- October 9, 2026

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

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