

**PALLIATIVE
MEDICINE
& HOSPICE:
CARE IN
21ST
CENTURY
MEDICINE**

Session #1

**Work in the Great New
Frontiers: PAs in Hospice,
Telehealth/Telemedicine
and Home Medicine**



Disclosure

Nothing To Disclose

Non-Declaration Statement: I have no relevant relationships with ineligible companies to disclose within the past 24 months.

Anything we talk about, we just happen to like!



Objectives

Hospice and PM Across the Continuum

- 1. Identify models for delivery of palliative and hospice care.**
- 2. Define and Discuss Best Practice in Interdisciplinary Team (IDT) Practice and Telehealth, and related ways to optimize PA Practice.**
- 3. Delineate the differences among the terms home health, home care, and home medicine.**
- 4. Discuss transitions between care settings.**

Agenda

- ▣ Introduction of panelists

Kris Pyles-Sweet DMSc, PA-C,
*Moderator

Christine Gardella, PA-C

Rose Direny-Jean, MS, PA-C, DsPH
(student)

- ▣ Panelist presentations

- ▣ Questions and Answers*



Palliative Medicine & Hospice Care in 21st Century Medicine

Rose Direny-Jean DMSc, PA-C

Clinical Assistant Professor Stony Brook University

Critical Care PA, Mercy Medical Center



Palliative Medicine and Hospice Care

PALLIATIVE CARE^{2,3}

Team
Approach

Not have to be
on hospice

Improves
quality of life

Range of
services

Pain Control,
but Limited

Various
professions

Available for
many illnesses

Hospice⁴

Team
Approach

Covers
terminal
illness

Focuses on
quality of life
in last days

No other
options
available

Patient choice

Death is
inevitable

Case Study

Marie (90 y.o African Caribbean Female)

Admitted for Acute Respiratory acidosis/ Acute CHF exacerbation

Family Declined Intubation Due to poor Prognosis and unknown neck mass

They opted for a Non-invasive Measure

She recovered within 24 hours

She was discharged home with family with home hospice

Hospice was discontinued 6 months later as she continued to progress clinically



Palliative care

The answer for many patients and
their families



Key Advice

“Identify yourself and your role on the team:

“Hello my name is Rose I am one of the clinicians on the Palliative Care team.”

“I understand that this may be a difficult situation for most”
“I am here to assist you if you would like”

Further discuss their loved one condition and how the institution is caring for them

Discuss the area that are only relevant to them

Further Guidance

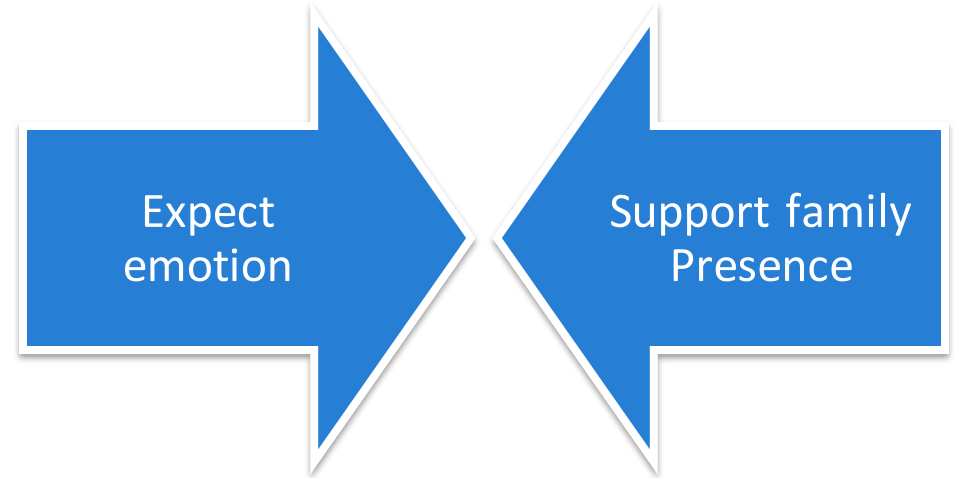
“Thank you”

“I love you”

“Goodbye”

Forgiveness

Give loved ones
permission to
die



If Family cannot be physically present



Video, phone calls



Record voice



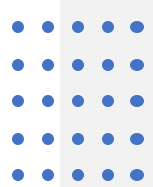
Send video
messages for their
family



Write messages or
letters for their
family



Share favorite
stories or memories



Pastoral care support:

Most cultures have traditions and rituals for illness and end of life.

Chaplain can facilitate.

Call pastoral care

AFTER A DEATH/ THE CALL

01

Ask if they are
in a place
where they can
talk

02

Use the word
“dead” or
“died” to notify

03

Allow space for
silence and
emotion

04

Express
sadness,
validate their
feelings

05

Answer
questions

It is estimated
that only 14%
of those who
need
palliative care
receive it¹



Palliative Medicine and Hospice care

PALLIATIVE CARE^{2,3}:

Interdisciplinary Team Approach

Not have to be on hospice

Improves quality of life and longevity

Range of services

Various professions and specialties

Available for all patients with serious illness



Palliative Medicine and Hospice Care

Hospice⁴:

Team Approach

Covers terminal illness

Focuses on quality of life in last days

No other options available

Death is inevitable



Case Study

Carlos (Hispanic male 69 yrs old)

- Discharged from rehab
- Homebound, s/p CVA
- Left side weakness and paralysis, difficulty swallowing...
- HTN, HLD, GERD
- Family history of HTN, CVA
- Family expected full recovery
- Discontinued house calls, home health, PT/ST/OT
- Suffered another stroke
- Restarted house calls and brought in palliative care from beginning



Palliative care
is the answer
for many
patients and
their family



A Model for the Delivery of Palliative Medicine and Hospice Care: House Calls Medicine

Otherwise referred to
as...

- House Calls Medicine
- “House Calls”
- Direct Primary Care
- Home Concierge Care
- Home Care Medicine
- Home Based Primary Care



A Model: HOUSE CALLS MEDICINE



What is House Calls Medicine?



What is House Calls Medicine?

Direct Primary Care and palliative medicine treating the frail and the seriously ill in the private home and assisted living facility

Professional Organizations and Affiliations:

- AAHCM: American Academy of Home Care Medicine
- AGS: American Geriatrics Society
- PAHPM: PAs in Hospice and Palliative Medicine
- HCCI: Home Centered Care Institute

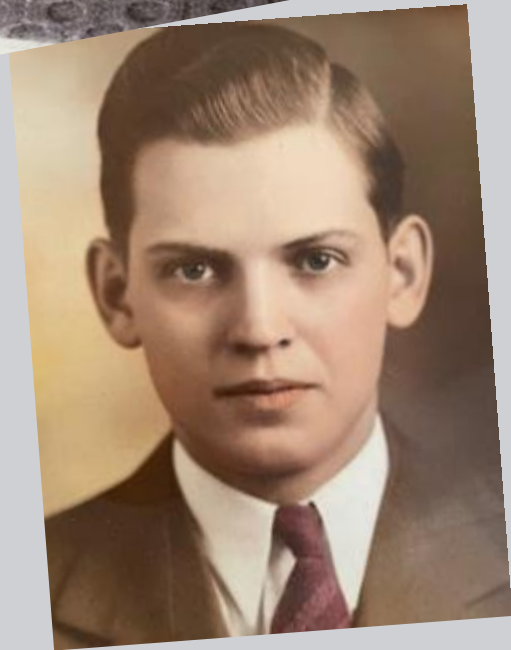


Case Study

GT: 102 yo male

- Est Care: 11/12/2020
- 2 hospitalizations during 12 months prior to 1st visit
- Lives in his private small split level rancher of 50 years. Present chronic conditions including Afib, Vascular Insufficiency with LE edema, Bed-bound with muscle weakness, Mild dementia. MOLST: DNR/DNI. George has 24 hour care with private duty **home care** aides. Son lives nearby and visits often to manage care.





A Model for Palliative Care A Case Study: GT

17+ home
visits since
Dec 2020
to present

Diagnosing
and
successfully
treating:

- TIAs
- PNAs
- UTIs
- CHF exacerbations,
- Seizures
- Hypothyroid Dx
- LE weeping edema with ulcerations,
- Stage 2 pressure hip ulcers
- Dental Abscesses with multiple extractions.




A Model Palliative Care Team

Case Study: **GT**

*Zero
Hospitalizations*






A Model Palliative Care Team Case Study: GT

- Best Practices:
- Team-Based Palliative Approaches in the Home

- PA conducts home medical visits q 30 days
- or more frequently when necessary





A Model for Palliative Care Case Study: GT

- Using Available Diagnostic Tools:
- Home phlebotomy
 - Mobile home imaging
 - Thorough history taking, assessments and planning at each visit
 - Coordinated care and communication among all team members.
- Telehealth/Telemedicine



A Model for Palliative Medicine and End-Of-Life Care Case Study: GT

Best Practices

Team-Based Palliative Approaches Prevents Hospitalizations

- PA Coordinates Care with:
 - Part A Home Health Agency (HHA) services:
PT/OT
 - Part B home PT/OT
 - HHA skilled nursing when warranted
 - Ongoing RPM BP monitoring
 - Refer to home visiting part B providers
 - Chronic care management w/ frequent check-ins
and close communications.



I'M LOST!
I'VE GONE TO LOOK
FOR MYSELF.
IF I SHOULD RETURN
BEFORE I GET BACK,
PLEASE ASK ME TO
WAIT.



A Model for Palliative Care Case Study: GT

- Challenges to optimizing PA practice on Interdisciplinary teams:

HOSPICE



Resources

1. World Health Organization. Palliative Care. World Health Organization. Published 2020. <https://www.who.int/news-room/factsheets/detail/palliative-care>
 2. What is Palliative Care? | National Institute of Nursing Research. Nih.gov. Published 2020. <https://www.ninr.nih.gov/newsandinformation/what-is-palliative-care>.
 3. World Health Organization. Palliative Care. World Health Organization. Published 2020. <https://www.who.int/news-room/factsheets/detail/palliative-care>.
 4. American Cancer Society. What Is Hospice Care? Cancer.org. Published 2019. <https://www.cancer.org/treatment/end-of-life-care/hospice-care/what-is-hospice-care.html>
- [PAHPM.org/education](https://www.pahpm.org/education)

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3. World Health Organization. Palliative Care. World Health Organization. Published 2020.
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4. American Cancer Society. What Is Hospice Care? Cancer.org. Published 2019.
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