Session #2

PAs are Perfect for Palliative Care:

How to demonstrate what you already know!

Panelists

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Moderator

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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

- Describe the scope of programs and resources that have been developed for clinician training in the management of serious illness patient populations.
- Discuss how training programs can enhance clinical practice and address social determinants of health.
- Using a case-based presentation, delineate ways in which clinical PAs have pivoted in the last two years to encompass palliative medicine for all serious illness patient populations.

Upcoming panelist discussion

- Education and training opportunities available to PAs
- Enhancement of primary palliative skill sets
- PA leadership in the field

Training Background of PAs:

PAs are required to have palliative skills and “end-of-life” care training as part of their program in order to meet national accreditation requirements.

- ARC-PA 5th Edition
- PA Educational standards
- palliative
- end-of-life care

- B2.08 Instruction in palliative and end-of-life care
- B2.11 Instruction in death, dying and loss
- B2.17 Instruction in laws and regulations in professional practice

ARC-PA Standards, 5th Edition (March 2022)

PAs employ a comprehensive approach to the management of primary care patients. The same approach applies to serious illness patients who would benefit from palliative interventions.

- Care across lifespan and settings
- Holistic, person-centered care
- Culturally inclusive
- Respecting patient autonomy
- Communicative and collaborative
- Mindful of health disparities
- Interprofessional team approach
- Complies with ethical and legal aspects of care

ARC-PA Accreditation Standards, 5th Edition

NCHPC-NCP Guidelines, 4th Edition

Challenges in Education and Training for Serious Illness, Palliative Medicine and Hospice care Providers

- Medical school teaching variations
- PA program variations
- RN training variations
- Education in our medical facilities: preceptors and clinicians

Powe, Michael 2018. AAPs in Hospice and Palliative Care [ppt]

Training Programs Enhance Clinical Practice

Palliative Care Goals: providing patients relief from pain and other symptoms of a serious illness, no matter the diagnosis or stage of disease.
Palliative care teams aim to improve the quality of life for both patients and their families.

Programs Available:

- Certificate program
- Master's degree program
- PhD program

Advantage of PAs addressing Serious Illness Care

PAs are trained as generalists and as such are able to appreciate the whole patient and therefore are well positioned to be the steward of information for patients and families concerning the importance of planning for QOL, GOC and end of life

Flexible training provides scenario based, collaborative cases in which PAs can practice prognostication, discussion/delivery, support (emotional/spiritual) and plans for transition to end of life

Which PAs Can Support Patients with Serious Illness?

- Discussions of GOC should be as important to primary care as mandated preventative measures and can be quantified as such
- This **focus on QOL** can start with providers in any specialty- particularly primary care, geriatrics, FM, IM and even subspecialties like surgery, oncology, cardiology and pulmonology

Training programs that include PAs from various practice environments provide invaluable opportunities for collaboration and enhance PAs relationships with patients and their families which ultimately leads to more collaborative care and patient engagement throughout the course of an illness

Opportunities Enhanced by Training for PAs

Training specific to palliative care provides PAs with opportunities for leadership within a growing field of medicine that experienced enhanced recognition during our global pandemic.

‘I was the first PA to join my inpatient Palliative Medicine team of 2 MDS and 2 APNs

This training enhanced my CV’

- PAs are poised to lead Palliative care teams
- Provides a means for more leadership roles in healthcare among primary palliative care and specialty services/teams
- Enhanced need for PAs to collaborate on a national level

PAs Know How To:

Be aware of the whole patient and what they bring to the experience

Ways to move forward:

Expand to home and/or community centers

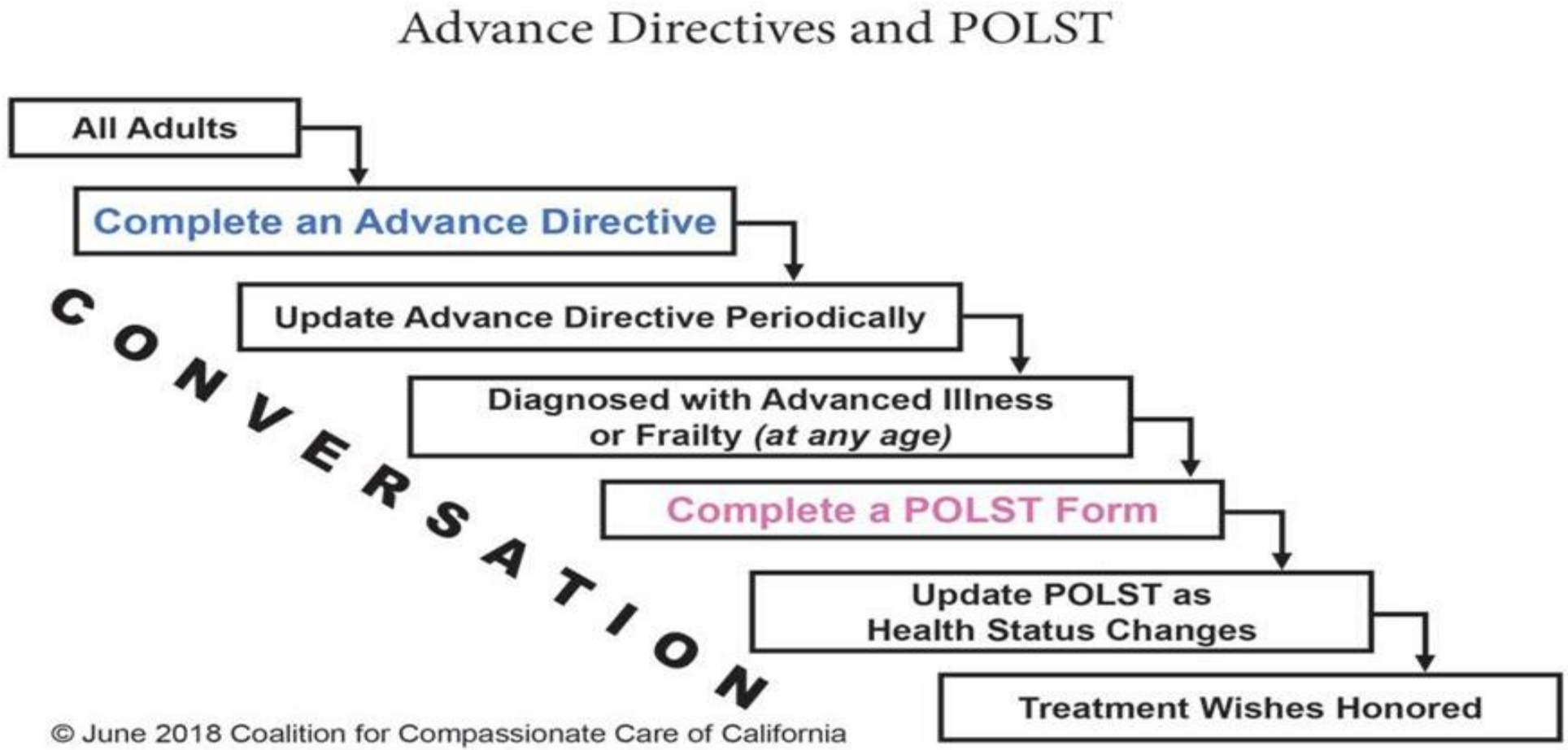
Part of the interdisciplinary team

Addressing SDOH

Expand to home and/or community centers with PAs as part of an interdisciplinary team

- home based Palliative care and telehealth services: can include ACP
- use community resources to support patient's non-medical needs
  - spiritual, emotional
- work to address/overcome disparities in palliative care including patient/caregiver experience, QOL and eventual hospice access
- skills to find resources, coordinate care and enhance communication among the patient, health care provider

Home based Serious Illness care can & should include ACP using Telehealth/Telemedicine communication



How do we become part of the solution?

- Use community resources to support patient's non-medical needs
  - Spiritual, emotional
- Work to address/overcome disparities in serious illness care including patient/caregiver experience, QOL and eventual hospice access
- Skills to find resources, coordinate care and enhance communication among patient and health care provider
  - Social workers, care managers, alternative visits

Online PHD, MS, and Graduate certificates in palliative care*

4 - 8 week graduate courses complete the graduate certificate requirement

Principles and Practice of Hospice and Palliative Care

Clinical Aspects of Hospice and Palliative Care

Leadership and Administration in Hospice and Palliative Care

Psychosocial/Spiritual Aspects of Hospice and Palliative Car

Advanced Non-Pain Symptom Management

Advanced Disease State Management

Clinical Management of Specific Patient Populations

Advanced Pain Management and Opioid Dosing

* Four certificates available for all interprofessional providers who want to add PC skills to their current scope of practice

MS in palliative care track options

- Option of earning graduate certificates while earning master's degree
- Four elective pathways with 2 graduate certificates
- Two required courses for the MS in palliative care

➔ Research and /Outcomes Assessment in Hospice and Palliative Care
➔ Advanced Team-Based Palliative Care

PhD program launched in Fall 2021

36 graduate hours online

Courses are 8 weeks in length

What now?

➔ Training modules for all members of a palliative care team available free online

➔ CME and palliative care training available through http://www.pahpm.org

- ◆ Podcasts, CME training in PC, interviews with experts in the field of HPM, and videos links to training as a member.

More Resources:

➔ All training will prepare PAs for CAQs in Hospice and Palliative Care

Available in 2023 through NCCPA

How can you start practicing your PC skills with or without designated palliative care teams?

Emergency medicine practice

Code status, advance directives and goals of care discussions
Consider a PC consult if available in your practice
What to do when PC teams are not available

Hospital medicine practice

Re address goals of care discussions prior to discharging and confirm code status

- Consider a PC consult again if not done in ED

Pulmonary medicine/Critical care

- Partner with your local hospital and offer assistance with helping them improving readmission data by starting transition care visits upon discharge from hospitals

- Partner with your local hospice and begin a small home based program that is patient-centered and addresses psychosocial determinants of health and cultural and spiritual values in your patient population. This will improve QOL and readmission data with patients in your practice that have advanced and serious diagnoses in both rural and urban settings.

Social Determinants of Health

Rural settings vs urban settings

Telemedicine and virtual health programs improves access to care for all social settings. This not only improves patient access to healthcare in their homes but it improves readmission data CMS often requires for ACO(accountable care organizations) and all hospitals that see Medicare patients.

- How does this help rural patients with limited access?

  ⇨ Virtual Health, Home Monitoring devices specifically designed for your practice

- Form partnerships with hospice companies and local hospitals in rural and urban communities to start transitional care programs in your practice. Must see the patient within 7 days of discharge and reach out for appointment within 48 hours of discharge.

- Guide your stakeholders to the online training offered that meets the standard for patients with serious illness that have needed for advanced symptoms management while meeting all the variety of social determinants in health are included in the NCHPC guidelines

National Coalition for Hospice and Palliative Care Clinical Practice Guidelines Domains of Care

1. Structure and Processes of Care
2. **Physical Aspects of Care**
3. **Psychological and Psychiatric Aspects of Care**
4. **Social Aspects of Care**
5. **Spiritual, Religious and Existential Aspects of Care**
6. **Cultural Aspects of Care**
7. **Care of the Patient Nearing End of Life**
8. Ethical and Legal Aspects of Care

Reference: https://www.nationalcoalitionhpc.org/wp-content/uploads/2018/10/NCHPC-NCPGuidelines_4thED_web_FINAL.pdf

Case Presentation #1

75 yo M living in rural community with PMH of advanced dementia and chronic indwelling foley due to BPH who has been in HH for 3-4 years since the death of his wife. He drives to his PCP visits locally but is unable to drive to specialty practices in the urban setting. He has had 10-12 ER visits in 12 months due to his foley becoming obstructed due to infection that sometimes where related to trauma, infection or falling at home.

Meds: finasteride 5, hydrocodone 5mg prn, tamsulosin 0.4mg

Domain 2	**Physical aspect**	⇨	**manage physical symptoms-> pain +/- Rx**
Domain 3	**Psych/psychiatric aspect**	⇨	**Dementia w/ Delirium→related to UTIs etc**
Domain 4	**Social Aspects**	⇨	**lives alone, no caregivers and limited family**
Domain 5	**Spiritual, Religious and Existential**	⇨	**explore his spiritual needs or faith**
Domain 6	**Cultural Aspect of Care**	⇨	**language→ cognitive and health literacy**
Domain 7	**Care of the Patient at End of Life**	⇨	**home health and hospice collaborative efforts**

Case Presentation #2

64 yo F with PMH O2 dep COPD in COVID ICU awake on ventilatory support PMH of CML on dasatinib with no AD or code status established. No PC team available or family presence due to COVID-19 pandemic. She is alert and nods to questions asked and is able to follow commands. She is tearful at times and has coughs which alarms the ventilator often.

Meds: MS and lorazepam prn for anxiety and dyspnea
Hydralazine and Metoprolol for prn SBP elevations
CXR: increased bilateral ground glass opacities with increased interstitial edema c/w ARDS

Domain 3,5,6 and 7 addressed without PC team available for consult

Discussed spirituality, religious needs, current social aspects and psychological aspects in the setting of isolation from family support

- Code status, Confirmed AD, offered spiritual prayer and facetiming with family to help the symptom burden of suffering the patient endured.

Pt died alone due to cardiopulmonary arrest, acute lung injury 2/2 ARDS and SARS/COVID-19

Reference: https://pubmed.ncbi.nlm.nih.gov/32371026/

Different & Intersecting Lenses

GERIATRIC MEDICINE

- Function
- Quality of Life
- Chronic conditions
  - Multiple, co-existing
  - Acute interactions
- Complex care
- Multidisciplinary team-based
- Patient + Caregiver/Family

PALLIATIVE CARE

- Serious Illness/life-threatening
- Integrated teamwork
- Management of pain and physical symptoms
- Holistic care/Quality of life
- Timely and responsive care
- Patient and family preparedness

Alzheimers Disease & Related Disorders: Model for Palliative Care in Older Adults

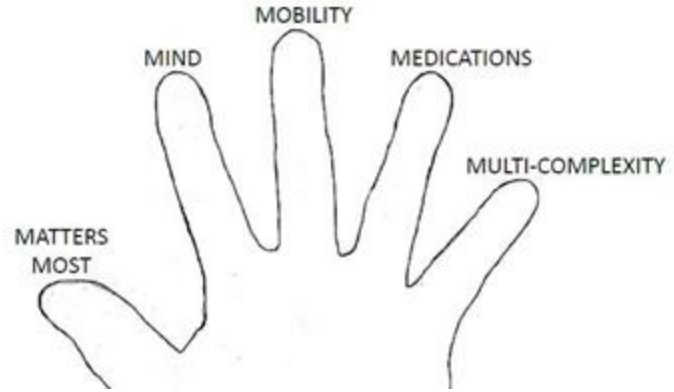
Dyad/family focused
Chronic, progressive condition
No known cure
Minimally effective pharmacotherapeutics
Symptomatic management
Longitudinal illness (8-18 yrs)
Terminal illness

Case: HS, 86 yo male

- Moved to AL facility 15 mos ago, from senior retirement community where he had lived with wife for 5 yrs, 1yr after wife died from prolonged illness. Has advanced directive, DNR, and adult daughter is POA. He uses a cane for stability, manages his medications with pill set up provided by one of his daughters, engaged in social activities several times a week outside AL (dinner with friends, poker game), independent in his self care (basic ADLs).
- Active Medical Problems: DM2, HTN, Hyperlipidemia, Obesity (BMI 25.9),[Metabolic Syndrome], Hypothyroid, A-fib, GERD, Diabetic Gastroparesis, Vascular Cognitive Impairment (VCI), Heart Failure
- Past Medical Hx: Spinal stenosis w/ laminectomy, L hip fx x/ ORIF (post-op confusion and fall), cholecystectomy
- Medications: Metformin, Glypizide, Lisinopril, Lotensin, Eliquix, Synthroid, Metoclopramide, Atorvastatin

Advanced Care Planning; Cornerstone of Palliative Care and Geriatric Medicine

- An ongoing discussion, not a one-time event
- Routine care
  - Medicare Wellness Exam
  - Annual Exam
- Geriatric 5Ms – What MATTERS
- Dementia Diagnosis
  - Opportunity to engage pt in their care planning & future care needs
  - Plan for time when unable to express wishes
  - Communication of values & wishes to others



HS – Case Continued

- Fall in bathroom, early am (early February 2020)
  - Assisted back to bed, refused EMTs/hospital, confused x hrs
  - Family contacted by facility, daughter contacts medical provider
  - Appt with internal med 5 days later, low bp, wt loss, meds adjusted +
- Public Health Restrictions (March 15, 2020)
  - Attempts to leave building twice, angry, raises cane threatening staff
  - Family contacted by facility, daughter contact medical provider +
- Found down in bathroom early am
  - Confused, garbled speech, transported to ED (COVID neg), observation, return to baseline over several hours
  - Telehealth meeting with family and staff +
- 20# wt loss x 8 mos, irritability, late night/early morning episodes confusion
  - Telehealth meeting with family and staff
  - Pt relocated to live with daughter +

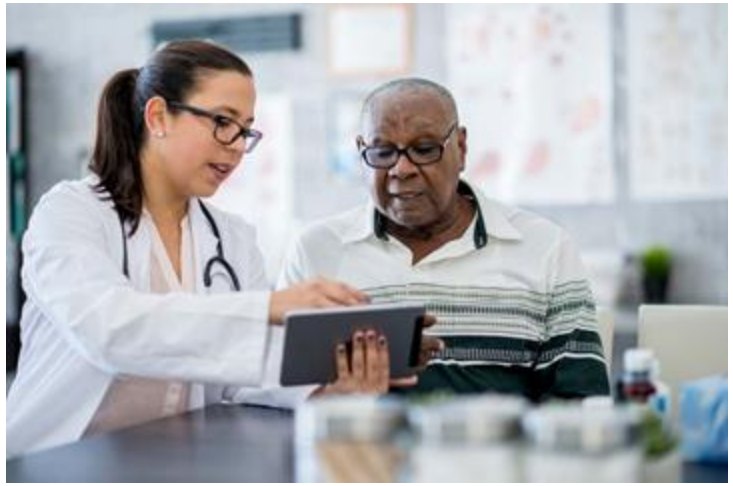
+ Serious Illness Interverion Opportunity

COVID Pandemic: Challenges Encountered

- Social isolation
  - Exacerbation of cognitive decline
  - Behavioral changes
- Non in-person medical appointments
- Staffing reductions & changes
- Transportation to ED for care needs
- Accessibility of family decision makers
- Restricted access to outside services (including Palliative Care)

COVID Pandemic:
Opportunities & Lessons for Palliative Care

- Serious illness & ‘high risk’ patient groups
- Increase attention to resident in Assisted Living and other facilities
  - Flexibility in meeting residents needs
- Utilization and integration of telehealth
  - Patient assessment
  - Engagement of family members
  - Inclusion of facility staff



Interprofessional Care & Practice

- Cornerstone of palliative care *and* geriatric medicine
- Collaborative practice facilitated by
  - EHR
  - Telehealth
- IPE curriculum adaptations during COVID
  - Remote/video-enabled student teams
  - Opportunity for topical discussions
    - Personal choice and values
    - Advanced care planning