

# SPAP Shout Out

A monthly update for SPAP members with a purpose to educate and encourage the engagement of PAs who work with pediatric patients



## My Experience as a PA Student in Pediatric Hospice and Palliative Medicine

*Morgan Dailey, PA-S*

*Morgan is a dual MSPH/PA student at Campbell University (Buies Creek, NC), where she serves as the class president. She will graduate from the PA program in July 2020. Morgan has a strong interest in pediatric quality improvement assessment. In addition to a clinical practice in pediatrics, her dream would be able to help determine ways to make a pediatric patient's inpatient experience less intimidating and more comfortable. Over the last two years, Morgan has been actively engaged in policy and advocacy efforts for the PA profession at the state and national levels. Outside of her studies, Morgan enjoys photography and spending time with family.*



This was nothing like I thought it would be. I am going to be honest here. I expected to walk into a room, see a child lying in a bed, unable to communicate, with a family gathered around with tearful eyes. Though this may be true for some home visits, this is not at all what my experience has been in pediatric hospice and palliative care so far. What I had failed to understand was that children are strong, even in their weakest moments.

Over the last month I have spent some time with a pediatric hospice and palliative medicine (HPM) group. I had become interested in pediatric HPM during my didactic year – perhaps curiosity would be a more accurate description. We had a couple of lectures that introduced us to HPM in my didactic curriculum. Throughout the lectures I could feel my heart racing, my eyes widening, and my soul leaping at the thought of how HPM and pediatrics could intersect. To my dismay, the lectures did not discuss what HPM looks like for children and adolescents. My curiosity had not been quenched, so I decided to dive deeper.

Eventually I connected with a pediatric HPM physician, who was willing to take me on as a student. I was OVERJOYED! In fact, I can remember leaping for joy and dancing when I found out that he would allow me to learn from him. I know this may not be an area of medicine that most people have a rush of joy when they hear it mentioned. Actually, each time I shared with a family member or a friend that I was going to spend time in pediatric hospice and palliative medicine, I either received a confused look or an expression that you would expect if had said something terrifying. Nevertheless, I counted the days down until I would meet the HPM group. I was eager to learn how to have difficult conversations with patients and families, before I had to encounter them alone as a practitioner. I was ready to pour my heart out into children and families who need it a little extra. I was, quite frankly, a little scared myself.

HPM is a rather new field of medicine. Its roots originated in London, England in the 1960s by a woman named Cicely Saunders. However, it was not until the 2000's when HPM was recognized in the US as a medical specialty. Comparing hospice and palliative medicine, both provide medical care to support quality of life and comfort of terminally-ill patients. In palliative care, life-sustaining treatments can still be pursued (though in children, there are some exceptions that may allow life-saving measures in hospice). A patient can be admitted to hospice, when they have been deemed by a provider that they have 6 months or less to live. However, a patient can be in hospice for more than 6 months. In essence, they may have been in hospice for a few months, but they still are expected to have a prognosis of less than 6 months from that point forward. When a patient is admitted to hospice, they are "certified" into hospice. Then a recertification occurs after the first 3 months they have been in hospice; this recertification essentially means "yes, the prognosis is still less than 6 months." Once a patient has been in hospice for another 3 months (total 6 months), they must be recertified again. Following the 6-month initial period after admission, recertifications must occur every 2 months thereafter. There are 4 levels of care within HPM: routine home care (most patients), respite care (caregiver relief), continuous care (short-term crisis care given to a patient at home), and general inpatient care (short-term higher level of care to control symptoms). The patients I encountered were routine home care patients that had been admitted to either hospice or palliative medicine. Being able to be cared for at home brings peace, and I was humbled to see the effects of that on patients and their families.

The physician I was with described HPM as "an extra layer of support for patients and families going through difficult medical situations." Once I saw HPM in action, I could not agree more. HPM continues to coordinate with a patient's other care providers, enhancing the team dynamic that is integral in HPM. Just imagine – for our most critical patients, what if we could just have another set of eyes to see if a patient is comfortable, another set of ears to hear our patients' goals, another hand to hold when times are difficult. My short time in the medical field, so far, has shown me that everyone, no matter their specialty or their role, is busy – understandably so. We are in the midst of a health care professional shortage crisis, electronic health record documentation can be consuming, and there always seems to be another patient waiting. HPM is an extra care team that is ready to devote their attention to your patient. The earlier that HPM can get involved, the better!

Speaking of teamwork, HPM is a team by design. When I would go on home visits with the physician, we were accompanied by a nurse, a social worker, a chaplain, and sometimes an interpreter. The team regularly meets to have interdisciplinary group (IDG) meetings to discuss every single patient, allowing each team member to voice their concerns, their victories, and their plans. On home visits I have had the opportunity to see each team member's contribution, and the dynamic is nothing short of beautiful. To me, this felt revolutionary – maybe even mythical. I would catch myself, in the moment, smiling as I would think to myself, “this actually exists?” Interprofessional care that constantly prioritizes what a patient and their family actually wants.

As I said before, I expected a very stark, solemn experience – something that would be foreign to my pediatrics experience thus far. To my surprise, a lot of my time with HPM was spent playing with children and their siblings, something that was very familiar to me. Yes, we saw children who were very sick and declining. Yes, we saw children and mothers who were told by others the harsh words of “there is no cure.” Yes, we heard stories that would tug on your heart. But what I cannot express in words is the celebration we had when we found out a patient is eligible for a promising clinical trial, the ability to see a child able to smile because they are no longer in so much pain, and the peace that families and kids were finally able to find. At the end of the day, I was reminded that kids are kids! When we would talk to a parent, kids were still vying for our attention. When we would sing to them, smiles would emerge. Kids were sad when we had to say “see you later.”

PAs have been in HPM, but there have been several limitations. However, huge strides were made for PAs in January 2019 (thank you for your advocacy efforts, AAPA!). PAs are now able to provide care, manage patients, and have services reimbursed by Medicare. In other words, PAs are now able to be considered as an “attending,” which is the appropriate terminology in HPM to designate a provider as a care giver. This change was monumental, because until this year, NPs and physicians were eligible to be reimbursed by Medicare for HPM services and not PAs. Limitations do still exist for PAs. For example, PAs and NPs are unable to certify a terminal illness or admit a patient to hospice. Also, PAs are not permitted to provide the face-to-face encounter prior to recertification for hospice (this does not apply to physicians or NPs). For more information on status of PA practice in HPM, check out AAPA's website.

The unfortunate truth is that there are a lot of sick children, and there are not a lot of HPM providers. Imagine the impact we could have if PAs could help expand access to pediatric HPM! The field of HPM seeks a different kind of remedy. The aim is to discover your patient's goals, hopes, and worries, then you can help establish a plan of care that promotes wellbeing for the patient and their family. I hope that we will see pediatric PAs grow with the emerging field of HPM and seek to work together to provide optimal patient-centered care.

Special thank you to the team at Kourageous Kids of Hosparus Health.

# NEW PODCAST SERIES

*Gaining Ground: The Primary Care Pediatrician's Role in Public Health Systems of Care for Children and Youth with Special Health Care Needs*

Receiving care within a well-functioning system is essential for all children and youth, especially those with special health care needs. Developed by the National Resource Center for Patient/Family-Centered Medical Home, in partnership with the Association of Maternal and Child Health Programs, Family Voices, Bright Futures National Center, Healthy Tomorrows Partnership for Children Program, American Academy of Pediatrics (AAP) Council on Children with Disabilities, AAP Council on Community Pediatrics, [faculty in this 3-part podcast series discusses real-life examples, strategies, and opportunities to develop partnership between Title V MCH / CYSHCN programs, primary care pediatricians, and families.](#) The podcast provides an overview of the history and current functions of state Title V MCH / CYSHCN programs as well as benefits of multi-disciplinary partnerships. [Tools and resources discussed during the series have been compiled and are free and accessible to the public.](#)

National Resource Center

**FOR PATIENT/FAMILY-CENTERED MEDICAL HOME**

Formerly the National Center for  
Medical Home Implementation

# NEW STUDENT NEWSLETTER

*We will be starting a brand new student newsletter soon! Student newsletters will be sent to all SPAP student members. Newsletters will provide advice on how to ace your pediatrics rotation, tips on interacting with patients, and much more! Keep an eye out for the first edition release in a few weeks. If you have any questions about the newsletter or would like to get involved, please contact our student representative, Morgan Dailey at [medailey0805@email.campbell.edu](mailto:medailey0805@email.campbell.edu)*

# SPAP Member Spotlight

Wesley Patterson, MSPA, PA-C

*Wesley Patterson is currently a PA practicing medical genetics at the Greenwood Genetic Center (GGC) in Greenwood, South Carolina. He attended Clemson University for his undergraduate studies and Radford University Carilion (formerly Jefferson College of Health Sciences) for PA school. Wesley worked at the GGC for two years prior to going to PA school in the molecular diagnostic lab. He graduated from PA school in 2014, practiced in family medicine for three years, and then made his way back to the GGC to combine his love of genetics and pediatrics. Additionally, Wesley is currently pursuing a PhD in Healthcare Genetics from Clemson University. His dissertation work is focusing on PA education in regards to genetics.*



## **How did your career as a PA start?**

After graduating from PA school, I started out my career in family medicine. I worked in family medicine for three years prior to working in medical genetics. About two and a half years into working in family medicine, I received a life changing phone from the GGC telling me they were considering hiring a PA and wanted to know if I was interested. I jumped at the chance to be back at the GGC and in the world of genetics. Genetics has always been a passion of mine, and I love that I can make a career out of it. I love genetics so much that I am working on getting a PhD in Healthcare Genetics.

## **What does your average day at work look like?**

I work full-time, Monday through Friday, seeing patients in clinic three to four days per week. In a typical day, I see four to six patients. I work hand-in-hand with geneticists, genetic counselors, dieticians, and lab directors. I see mostly an outpatient population with the occasional NICU consult. My job consists of evaluating and treating individuals with suspected or known genetic disorders. My patient population consists of mostly children with developmental delay, intellectual disability, autism spectrum disorder, connective tissue disorders, epilepsy, metabolic disorder, and birth defects. Once the patient is evaluated, I order the appropriate genetic testing, if indicated. The days that I do not have clinic are spent interpreting genetic results and going through the literature to determine the significance of the results.

## **How did you first hear about SPAP?**

I first heard of SPAP while looking through the AAPA website. I was looking for an organization to become a part of that I felt represented me.

**Why pediatrics?**

The simple answer is “why not?” I think working with children is one of the most rewarding things a person can do. To be there for a child and advocate for them is so gratifying! I could not imagine being in another field right now.

**What is your favorite part of being a PA?**

There are so many great and amazing things about being a PA. My favorite part about being a PA is providing care and creating long-term relationships with my patients. In genetics, we serve a unique population and I am blessed to be a part of it.

**Any advice for new PAs or PA students?**

Wherever you end up, regardless of the specialty, find a mentor. Whether it is a supervising physician or fellow PA, having a mentor makes a huge difference in your first few years. As a new PA, having someone available that has more experience and to bounce ideas off of will help you become a better PA!