# Working with the Hospice Team

## When One of Your Patients is in Hospice

Medical Resident/Oncology Fellow Competency Assessment Tool  
Palliative Care Domain: Psychosocial/Cultural/Spiritual Aspects of Care; Hospice Care and Referrals

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Introduction for the Learner (Resident/Fellow)

Prior to your evaluation of competency

• Complete the web-based palliative care training program “Medical Resident Training in End-of-Life and Palliative Care” before you undergo this competency assessment. The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp
  - Review Part 1 (Learning Objectives), Part 2 (Teaching Outline) and Part 3 (Evaluation Checklist) of this document THOROUGHLY so that you are aware of what is required of you.
  - Review Unit VI Hospice Care of the Web-based palliative care training program.
  - Ascertain that the attending/faculty member is certified to conduct the Palliative Care Competency Evaluation.

Field evaluation of competency

• During the course of your clinical training, it is anticipated that you will have opportunities to refer patients to hospice, and once referred, to demonstrate your competency in working with the hospice team when one of your patients is in hospice.

• IF THIS IS THE CASE, ASK THE CARE TEAM AT THE HOSPICE TO REVIEW THIS COMPETENCY ASSESSMENT TOOL AS SOON AS POSSIBLE SO THAT THEIR MEMORY WILL BE REFRESHED AS TO THE DESIRED CHARACTERISTICS OF PERFORMANCE THEY WILL BE EVALUATING.

• After a month or so, or after the patient dies, ask the hospice team to complete the Evaluation Checklist (Part 3) of this document, and share it with you.

• You will also complete the self-evaluation portion of the Evaluation Checklist as a measure of competency in practice based learning.

• Evaluation Checklist must be signed by the Clinical Faculty Evaluator/attending and you (Resident/Fellow).

• Return Evaluation Checklist to Dr. Susan Wolfsthal, Internal Medicine Residency Director or Dr. Heather Manuel, Medical Oncology Fellowship Director.

Introduction for the Clinical Faculty Evaluator

How to perform this competency assessment

A Medical Resident or Oncology Fellow has requested that you assess their competency in a selected palliative care domain during the time you are the Clinical Faculty Evaluator/attending physician on this service. To assist you with this evaluation, please do the following.

Preparing for field evaluation of competency

• Review this Competency Assessment Tool thoroughly including the Learning Objectives (Part 1), Teaching Outline (Part 2) and Evaluation Checklist (Part 3) prior to pre-discussion counseling with Resident (required).

• Review Unit VI – “Hospice Care” of the Web-based palliative care training program, “Medical Residents Training in End-of-Life and Palliative Care.” The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp (optional).

Format of competency evaluation

• Pre-discussion counseling:
  - Review with the Resident/Fellow the circumstances of the patient situation – check veracity of patient medical data, diagnostic tests, significance of diagnosis.

• While patient is in hospice care:
  - Based on the Learning Objectives, Teaching Outline and Evaluation Checklist in this document and the content in Unit VI (Hospice Care) of the palliative care training website, evaluate how the Resident or Fellow follows a patient who has been referred to hospice care. Suggested behaviors include:
    - Identifies self to the hospice service as the primary physician responsible for ongoing medical management of the patient in cooperation with the hospice team.
    - Demonstrates appropriate communication skills in discussing hospice care with hospice staff, especially the primary hospice nurse for the patient.
    - Responds appropriately and empathetically to patient/family concerns raised by hospice care provisions.
    - Appropriately evaluates patient management issues, including, when necessary, visiting the patient in house calls, and documents evaluations and interventions.
    - Has contact information, including back-up physician coverage, recorded by the hospice agency for the purpose of providing continuity of care.

• Post rotation feedback:
  - Review strengths and weaknesses of competency evaluation with Resident/Fellow
  - Provide constructive feedback to improve Residents/Fellows’ performance and patient outcomes.
Complete Evaluation Checklist (Part 3 of this document)

- Share with Resident/Fellow; allow Resident/Fellow to make his/her own self-assessment of competency performance
- Clinical Faculty Evaluator/attending and Resident/Fellow must sign this Evaluation Checklist (Part 3)
- Resident/Fellow is responsible for returning Evaluation Checklist to Dr. Wolfsthal (Residents) or Dr. Manuel (Fellows)
Part 1: Learning Objectives

Note to learner and Clinical Faculty Evaluator: The Learning Objectives are listed in terms of fulfilling the six ACGME core competencies, listed below; these are reflected in Evaluation Checklist in Part 3 of this document.

LEGEND to ACGME core competencies: http://www.acgme.org/Outcome

<table>
<thead>
<tr>
<th>OBJECTIVES – A competent Medical Resident or Oncology Fellow will be able to:</th>
<th>ACGME Competencies</th>
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<tbody>
<tr>
<td>Recognize the need for the physician to take a leadership role in managing patients in conjunction with the hospice team.</td>
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<td>Continue to have an active presence in patient care once a patient is enrolled in a hospice program.</td>
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<td>Use as appropriate, the consultative services of the hospice medical director for the care of the patient.</td>
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<td>Differentiate hospice and palliative care.</td>
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<td>Discuss the benefits of being in a hospice program to patient and family.</td>
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<td>List the members and functions of the hospice core team.</td>
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<td>Describe the patient care responsibilities of the referring physician and the hospice medical director.</td>
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<td>Recognize the role of the attending physician in developing the “plan of care” with the hospice team.</td>
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<td>Explain the key features of the Medicare Hospice Benefits.</td>
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<td>Compare illness trajectories for cancer end stage heart disease, lung disease and dementia.</td>
<td>X</td>
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<tr>
<td>Identify common patient/family reactions to ongoing hospice care.</td>
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<tr>
<td>Demonstrate appropriate communication skills in discussing hospice care provisions with a patient/family.</td>
<td>X</td>
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<tr>
<td>Respond appropriately to patient/family concerns during care by the hospice team.</td>
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<tr>
<td>Maintain contact with the hospice team during ongoing care of the patient.</td>
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LEGEND:
PC – Patient Care
MK – Medical Knowledge
PBL&I – Practice-Based Learning and Improvement
IPCS – Interpersonal and Communication Skills
P – Professionalism
SBP – Systems-Based Practice

Part 2: Teaching Outline for Learner and Clinical Faculty Evaluator

- Recommend reviewing Unit VI – Hospice Care of “Medical Residents Training in End-of-Life and Palliative Care.” The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp

Background
Hospice is a philosophy of care for dying patients and their families — focusing on control of distressing physical symptoms, psychological and spiritual support for the patient-family unit and bereavement care after the patient’s death. Hospice is not a physical place although it may be. Hospice utilizes the concept of interdisciplinary care, realizing that no single health care professional can meet the needs of dying patients and families.

The National Hospice and Palliative Care Organization states there are three major goals for care of dying patients:

1) Self-determined life closure
2) Safe and comfortable dying
3) Effective grieving

Hospice meets these goals for each patient through the mechanism of a plan of care based upon a multidisciplinary evaluation and discussion of the particular patient and family’s needs and available services. The attending physician has an active role in providing such services by giving information to the team in the initial referral, by discussing (usually on the telephone) with the primary hospice nurse for the patient and, sometimes with other members of the hospice team, and by signing care orders and returning these to the hospice agency in a timely manner.

After the patient dies, the attending physician is responsible for completing and signing the death certificate. The hospice provides family/significant other assessment of the grieving process. Interventions are offered when necessary for the next year after the patient’s death. The presence of documentation by the hospice is regularly assessed by government surveyors under the provisions of Title 18.

Who Provides Hospice Services and Where

- Medicare certified home hospice agency
  - Most common setting in US
  - Often combined with a home health agency
  - A Medicare certified hospice agency must provide 80% of total care days per year in the home setting (all agency patients combined)
  - Under the Medicare benefit, patients are eligible for inpatient care for symptoms that cannot be managed in the home (e.g., pain that is out-of-control) or for respite care (up to 5 day inpatient stay)
- Non-Medicare certified home hospice agency: typically small, rural hospice programs.

- Inpatient beds within an acute care hospital
  - These may be beds used by a Medicare certified home hospice agency for inpatient or respite care, or
  - An acute care hospital may provide non-Medicare certified hospice services, often by staffing a dedicated geographic nursing unit for care that follows the hospice philosophy.
- Nursing home
  - May serve as a patient’s primary place of residence and provide Medicare certified hospice care when a contract for services exists between the nursing home and a Medicare certified home hospice agency.
- Free-standing dedicated inpatient hospice facility.

Eligibility for Hospice Services
To be eligible for hospice services under the Medicare Benefit (see below), patients must meet the following criteria:

- physician-certified prognosis less than 6 months assuming “the terminal illness runs its normal course”; any terminal diagnosis is appropriate
- treatment goals are palliative rather than curative
- a physician is willing to be identified as the physician-of-record

NOTE:
- Other eligibility criteria may exist, determined solely by the particular hospice agency (see below: Miscellaneous Care Issues).
- Medicare certified hospice agencies may not use DNR status as a criterion for hospice admission per the Center for Medicare Services (CMS).

Hospice Services
- Physical symptom control
  - pain
  - nausea, vomiting
  - dyspnea
  - constipation, diarrhea
- Home health aide services
  - bathing
  - dressing
  - feeding
- Psychological counseling
  - patient
  - family
  - community
- Preparation for death
  - completion of advanced directives
  - preparation of wills
  - funeral planning
- Spiritual support
  - patient and family before death
family after death
- Volunteers to assist patient and family
- Bereavement program for family after death

Hospice Reimbursement

Medicare Hospice Benefit

1. When eligible (see above), patient’s sign off of Medicare Part A (hospital payment) and sign on (elect) the Medicare Hospice Benefit.

2. There are 3 hospice benefit periods
   - The first two periods are each 90 days.
   - The third benefit period is indefinite, consisting of unlimited 60 day periods.
   - At the start of each benefit period, the patient must be re-certified as hospice eligible, meeting the criteria listed above.
   - During any benefit period patients may revoke their Hospice Benefit and return to Medicare Part A; they may subsequently return to the Hospice Benefit if they meet criteria (see above).

3. The Medicare-certified hospice agency is responsible for the Plan of Care; all treatment decisions must be discussed and approved by the hospice care team, which includes representatives from the following mandated services:
   - hospice physician medical director
   - skilled nurse
   - social worker
   - chaplain
   - volunteer program coordinator
   - bereavement program coordinator

4. The Medicare Hospice Benefit does not provide 24 hour custodial care.

5. Patients may continue to utilize services of their primary physician for in-office or at-home visits; the primary physician can bill for services under Medicare Part B. The hospice physician medical director is available for consultation but does not assume direct care responsibilities and cannot bill Medicare for services to individual hospice patients.

6. Each day the patient is enrolled in the Medical Hospice Benefit, the hospice agency receives reimbursement (approx. $140/day). This is used to support the salaries of the core team and the additional services listed below:
   - home health aide visits, as often as daily
   - all drugs related to the terminal illness
   - all durable medical equipment (bed, commode, etc.)
   - any ordered physical therapy, dietary counseling, etc.
   - payment for other medical services approved by the hospice team such as: palliative radiation, parenteral hydration, etc.

Other Payment Sources

- Most states administer a Medicaid Hospice program that is similar to the Medicare Benefit.
- Many private health insurers/HMO’s have a hospice benefit which may include some or all of the features of the Medicare Benefit; for insurers without a hospice benefit, payment for per diem hospice services to a hospice agency can usually be negotiated on a case by case basis.

Miscellaneous Care Issues

Beyond good physical, psychological and spiritual care, there are a number of “gray” areas of palliative support services which can arise. These include the use of expensive and/or invasive treatment approaches for which the palliative value is often not clear. Each hospice agency is free to develop its own policy regarding the acceptability of these services for its patients. These services include:

- blood products; cancer chemotherapy or hormonal therapy
- non-oral feeding (NG tube, G-tube, TPN); parenteral hydration
- kidney dialysis or mechanical ventilation
- antibiotics — oral or parenteral
- use of anti-retroviral HIV medications

Bridge Programs

Recently developed “Bridge Programs” provided by a hospice in collaboration with a home health agency or other health care provider provides pain and symptom management as well as emotional support during a period when a patient with a life-limiting condition may still want to pursue active treatment of the disease or is not yet ready to elect the hospice benefit and its restrictions criteria. These programs are considered “pre-hospice” but are usually staffed by hospice nurses.

References


Section 4: The Interdisciplinary team.
- Haugen DF, Nauck F, Caraceni A. The core team and the extended team, pp. 167-176.
- Sherman DW. Nursing and palliative care, pp 177-183.
- Monroe B. Social work in palliative medicine, pp. 184-196.
- Harper JM, Rudnick JE. The role of the chaplain in palliative care, pp. 197-205.
- Miller J, Cooper J. The contribution of occupational therapy to palliative medicine, pp. 206-213.
- O’Callaghan C. The contribution of music therapy to palliative medicine, pp. 214-221.
4.7 Richardson R, Davidson I. The contribution of the dietitian and nutritionist to palliative medicine, pp. 222-226.
4.8 Robinson D, English A. Physiotherapy in palliative care, pp. 227-233.
4.9 MacDonald A, Armstrong L. The contribution of speech and language therapy to palliative medicine, pp. 234-242.
4.10 Wood MJM. The contribution of art therapy to palliative medicine, pp. 243-249.
4.11 Barr JE. The contribution of the stoma nurse specialist in palliative care, pp. 250-257.
4.12 Cathcart F. The contribution of clinical psychology to palliative care, pp. 258-264.


The hospice team. Available at www.caringinfo.org/livingwithillness/hospice/thehospiceteam.htm.


Part 3: Evaluation Checklist

Learner name: ___________________________  Evaluator/Attending: ___________________________

- [ ] Resident PGY Level: 1 2 3 4 5
- [ ] Fellowship Year: 1 2 3 4 5
- Rotation Site: Inpatient Cancer Center  Inpatient GIM  Oncology Clinic  Continuity GIM clinic  Other

Please rate the trainee's competency/skills/knowledge/attitude using the following scales:

<table>
<thead>
<tr>
<th>For competency/skills</th>
<th>For knowledge and attitudes (e.g. Medical Knowledge)</th>
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<tbody>
<tr>
<td>4 = Competent to perform independently</td>
<td>4 = Superior</td>
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<tr>
<td>3 = Competent to perform with minimal supervision</td>
<td>3 = Satisfactory</td>
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<tr>
<td>2 = Competent to perform with close supervision / coaching</td>
<td>2 = Below average</td>
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<tr>
<td>1 = Needs further basic instruction</td>
<td>1 = Insufficient – needs further learning</td>
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<td>n/o = not observed</td>
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**OBJECTIVES**

**Patient Care**

- [ ] 4 = Continued as an active presence in patient care once a patient is enrolled in a hospice program.

**Overall Performance:**

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<tr>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
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**Medical Knowledge**

- [ ] 4 = Differentiated hospice and palliative care.
- [ ] 4 = Listed the members and functions of the hospice core team.
- [ ] 4 = Described the patient care responsibilities of the referring physician and the hospice medical director.
- [ ] 4 = Compared illness trajectories for cancer end stage heart disease, lung disease and dementia.
- [ ] 4 = Identified common patient/family reactions to ongoing hospice care.

**Overall Performance:**

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**Interpersonal and Communication Skills**

- [ ] 4 = Demonstrated appropriate communication skills in discussing hospice care provisions with a patient/family.
- [ ] 4 = Responded appropriately to patient/family concerns during care by the hospice team.

**Overall Performance:**

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**Systems Based Practice**

- [ ] 4 = Appropriately used the consultative services of the hospice medical director for the care of the patient.
- [ ] 4 = Recognized the role of the attending physician in developing the “plan of care” with the hospice team.
- [ ] 4 = Explained the key features of the Medicare Hospice Benefits.

**Overall Performance:**

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Professionalism

- Recognized the need for the physician to take a leadership role in managing patients in conjunction with the hospice team.
- Maintained contact with the hospice team during ongoing care of the patient.
- Discussed the benefits to patient and family of being in a hospice program.

Overall Performance:

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Resident/Fellow strengths:


Resident/Fellow areas for improvement:

Overall impression: Did the Resident/Fellow demonstrate competency in a manner so as to do no harm?

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Resident/Fellow self-evaluation of performance: May comment on any of the above checklist items or other reflections on performance; perceived strengths, and need for improvement and learning.