Table of Contents

Introduction for the Learner (Resident/Oncology Fellow) .......................................................... 2
Introduction for Clinical Faculty Evaluator .................................................................................. 2
Part 1: Learning Objectives ........................................................................................................... 3
Part 2: Teaching Outline .................................................................................................................. 4
Part 3: Evaluation Checklist ............................................................................................................ 7
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.
- 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 Mannuel, 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

- During the rotation:
  - 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 identifies a patient and family who would benefit from hospice care and appropriately makes the hospice referral. Suggested behaviors include:
    - Evaluating a patient for referral to hospice using appropriate eligibility criteria.
    - Demonstrating appropriate communication skills in discussing hospice care with a patient/family.
    - Responding appropriately and empathetically to patient/family concerns raised by a hospice referral.
    - Contacting a hospice agency for the purpose of patient referral.
- 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. Mannuel (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>
</tr>
</thead>
<tbody>
<tr>
<td>Recognize the need for physicians to take a leadership role in referring patients for hospice care.</td>
<td>PC MK PBL&amp;I IPCS P SBP</td>
</tr>
<tr>
<td>Acknowledge the need for physicians to continue to have an active presence in patient care once the patient is enrolled in a hospice program.</td>
<td>X</td>
</tr>
<tr>
<td>Define hospice.</td>
<td>X</td>
</tr>
<tr>
<td>Differentiate hospice and palliative care.</td>
<td>X</td>
</tr>
<tr>
<td>Discuss the benefits of being in a home hospice program for the patient and their family.</td>
<td>X</td>
</tr>
<tr>
<td>List the members and responsibilities of the hospice core team.</td>
<td>X</td>
</tr>
<tr>
<td>Describe the patient care responsibilities of the referring physician and the hospice medical director.</td>
<td>X</td>
</tr>
<tr>
<td>Describe the role of the referring physician in developing the patient's &quot;plan of care&quot; with the hospice team.</td>
<td>X</td>
</tr>
<tr>
<td>Explain the key features of the Medicare Hospice Benefit.</td>
<td>X</td>
</tr>
<tr>
<td>Compare prognostic factors for cancer end-stage heart disease, lung disease and dementia.</td>
<td>X</td>
</tr>
<tr>
<td>Identify common patient and family reactions to the concept of hospice care.</td>
<td>X</td>
</tr>
<tr>
<td>Demonstrate empathetic communication skills in discussing hospice care with a patient and family.</td>
<td>X</td>
</tr>
<tr>
<td>Respond appropriately to patient and family concerns raised by hospice referral.</td>
<td>X</td>
</tr>
<tr>
<td>Complete required documentation to facilitate referral to hospice.</td>
<td>X</td>
</tr>
</tbody>
</table>

**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

**Definition**

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. Hospice utilizes the concept of interdisciplinary care, realizing that no single health care professional can meet the needs of dying patients and families.

**Who Provides Hospice Services and Where**

1. 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)
2. Non-Medicare certified home hospice agency - typically small, rural hospice programs.
3. Inpatient beds within an acute care hospital
   - These may be beds used by a Medicare certified home hospice agency for inpatient or respite care
   - 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.
4. 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.
5. 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**

1. Physical symptom control
   - Pain
   - Nausea, vomiting
   - Dyspnea
   - Diarrhea, constipation
2. Home health aide services
   - Bathing
   - Dressing
   - Feeding
3. Psychological counseling
   - Patient
   - Family
   - Community
4. Preparation for death
   - Completion of advanced directives
   - Will preparation
   - Funeral planning
5. Spiritual support
   - Patient and family before death
   - Family after death
6. Volunteers to assist patient and family
7. 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 or 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 and meet the criteria listed above.
   - During any benefit period patients may revoke their Hospice benefit and return to Medicare Part A.
   - Patient may subsequently return to the Hospice Benefit if they meet criteria (see above).

**NOTE:** 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

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

4. 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.

5. Each day the patient is enrolled in the Medical Hospice Benefit, the hospice agency receives reimbursement used to support the salaries of the core team and additional services (http://www.cms.hhs.gov/Hospice/downloads/hospicerates10correction.pdf).

- Routine home care - $143.10
- Continuous home care - $834.43
- Inpatient hospice care - $635.74
- Inpatient respite care - $155.61

6. Additional services may include

- 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 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 their 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

Prognostic Indicators to Assist in Determining Hospice Eligibility

< 14 Days - Actively Dying: Syndrome of Imminent Death

- Anuric - no dialysis planned
- Delirium
- Minimal or no oral intake
- Cheyne-Stokes respirations, mottled skin, cool extremities
- Pooled oropharyngeal secretions (death rattle)

3 Months or Less

- In bed > 50% time (Performance Status: ECOG < 3; Karnofsky < 50)
- Hypercalcemia (cancer) - except newly diagnosed Multiple Myeloma or Breast Cancer
- Dyspnea - HIV, cancer
- Carcinomatous Meningitis or Malignant Pericardial Effusion
- Liver metastases with jaundice

6 Months or Less

- Brain metastases
- Metastatic solid cancers - no treatment planned or none effective (except breast/prostate cancer)
- Malignant ascites or pleural effusion
- Severe Dementia - no speech, bed bound, incontinent
- CNS Lymphoma - HIV
- CHF / COPD
  - Symptomatic despite maximal treatment
  - Weight loss
  - Frequent hospitalization
  - Dyspnea at rest/tachycardia

References


Section 4: The Interdisciplinary team.

4.1 Haugen DF, Nauck F, Caraceni A. The core team and the extended team, pp. 167-176.

4.2 Sherman DW. Nursing and palliative care, pp 177-183.

4.3 Monroe B. Social work in palliative medicine, pp. 184-196.
4.4 Harper JM, Rudnick JE. The role of the chaplain in palliative care, pp. 197-205.

4.5 Miller J, Cooper J. The contribution of occupational therapy to palliative medicine, pp. 206-213.

4.6 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.


## Part 3: Evaluation Checklist

<table>
<thead>
<tr>
<th>Learner name:</th>
<th>________________________________</th>
<th>Evaluator/Attending: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident PGY Level:</td>
<td>[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
<td>Fellowship Year: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5</td>
</tr>
<tr>
<td>Rotation Site:</td>
<td>[ ] Inpatient Cancer Center [ ] Inpatient GIM [ ] Oncology Clinic [ ] Continuity GIM clinic [ ] Other</td>
<td></td>
</tr>
</tbody>
</table>

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

**For competency/skills**

- 4 = Competent to perform independently
- 3 = Competent to perform with minimal supervision
- 2 = Competent to perform with close supervision / coaching
- 1 = Needs further basic instruction
- n/o = not observed

**For knowledge and attitudes (e.g. Medical Knowledge)**

- 4 = Superior
- 3 = Satisfactory
- 2 = Below average
- 1 = Insufficient – needs further learning
- n/o = not observed

### OBJECTIVES

**Medical Knowledge**

1. Defined hospice.
2. Differentiated hospice and palliative care.
3. Discussed the benefits of being in a home hospice program for the patient and their family.
4. Listed the members and responsibilities of the hospice core team.
5. Described the patient care responsibilities of the referring physician and the hospice medical director.
6. Described the role of the referring physician in developing the patient’s “plan of care” with the hospice team.
7. Compared prognostic factors for cancer end-stage heart disease, lung disease and dementia.
8. Identified common patient and family reactions to the concept of hospice care.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3</th>
<th>4 to 6</th>
<th>7 to 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory</td>
<td>Satisfactory</td>
<td>Superior</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Interpersonal and Communication Skills**

1. Demonstrated empathetic communication skills in discussing hospice care with a patient and family.
2. Responded appropriately to patient and family concerns raised by hospice referral.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3</th>
<th>4 to 6</th>
<th>7 to 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory</td>
<td>Satisfactory</td>
<td>Superior</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Systems Based Practice**

1. Completed required documentation to facilitate referral to hospice.
2. Explained the key features of the Medicare Hospice Benefit.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3</th>
<th>4 to 6</th>
<th>7 to 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unsatisfactory</td>
<td>Satisfactory</td>
<td>Superior</td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
**Professionalism**

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>n/o</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>n/o</th>
</tr>
</thead>
</table>

Recognized the need for physicians to take a leadership role in referring patients for hospice care.

Acknowledged the need for physicians to continue to have an active presence in patient care once the patient is enrolled in a hospice program.

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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?

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.