

## **Palliative Care Educational Goals & Objectives**

Primary care physicians are involved with patients over the course of their lives. Many of these patients will develop serious and/or life-threatening illnesses that affect their quality of life. In this setting, presenting complaints and goals of care may differ from those of patients for whom the focus is curative treatment. The Palliative Care rotation will provide the resident with an opportunity to gain experience treating patients with serious or advanced illnesses, often at the end of life. Focus will be on developing skills that allow residents to discuss death and dying with patients and families, address grief and loss, arrange for spiritual and psychosocial support, and treat symptoms to improve quality of life. Residents will gain a practical understanding of hospice as well as the ethical and legal issues involved in end of life care. Finally, residents will learn to respect patient dignity, advance their comfort, and allow them to retain as much control as possible at the end of life.

Faculty will facilitate learning in the 6 core competencies as follows:

### **Patient Care and Procedural Skills**

- I. All residents must be able to provide compassionate, culturally-sensitive, patient-centered care for their palliative care and hospice patients.
  - PGY1s should seek directed and appropriate specialty consultation when necessary to ensure symptom relief.
  - PGY2s should supervise and ensure seamless transitions between inpatient and outpatient care.
  - PGY3s should be able to coordinate input from multiple sources, including the patient and family, primary care physician, specialists, and nurses and manage conflicting recommendations.
  
- II. Residents will demonstrate the ability to take a symptom-driven history and perform a focused physical exam.
  - PGY1s should be able to assess a patient's decision-making capacity and discuss advanced directives with patients and their families.
  - PGY2s should be able to identify patients in whom further treatment would be considered medically futile.
  - PGY3s should be able to identify barriers to patient and/or family acceptance of a patient's medical condition and prognosis.
  
- III. Residents will demonstrate knowledge of and be able to counsel patients and/or families regarding the indications and contraindications for the following procedures:
  - Intrathecal drug delivery
  - Neurolytic block
  - Patient-controlled analgesia

## Medical Knowledge

- I. All residents will be able to cogently discuss the difference between palliative care and hospice and become familiar with applying the concepts of palliative care from diagnosis throughout the course of a patient's illness.
  
- II. PGY1s will become skilled in the timely triage of and approach to the following conditions:
  - Anorexia
  - Anxiety
  - Constipation
  - Cough
  - Delirium
  - Depression
  - Diarrhea
  - Dyspnea
  - Encopresis
  - Excess secretions
  - Fatigue
  - Gastroesophageal reflux
  - Incontinence
  - Insomnia
  - Mucositis
  - Nausea and/or vomiting
  - Oral candidiasis
  - Oral herpes
  - Pain, acute and chronic, as well as social, psychological, and spiritual suffering
  - Seizures
  - Wasting syndrome
  - Weight loss
  - Xerostomia

PGY2s should be able to

- assess pain accurately and identify and treat common pain syndromes, including bony metastases, epidural metastases and spinal cord compression; neuralgia, neuropathies and plexopathies; muscle spasms, and migraine headaches.

PGY3s should understand

- the indications, contraindications, risks and limitations of the use of WHO's pain ladder for adults with cancer pain
- the indications, contraindications, risks and limitations of treatments for other end-of-life symptoms in the context of cancer and other illnesses
- special circumstances associated with children requiring end of life care or as direct family members of dying patients

- III. Residents should understand the natural history chronic life-limiting diseases, such as cancer; chronic kidney, liver, and lung disease; congestive heart failure, neurodegenerative disease, dementia, and HIV, and recognize appropriate candidates for hospice.
- IV. Residents will become familiar with indications, contraindications, dosing, dose equivalents and alternate routes of administration for commonly used drugs in the practice of palliative medicine and hospice care, including:
  - Antacids
  - Anticholinergics
  - Antidepressants
  - Antiemetics
  - Antispasmodics
  - Anxiolytics
  - Corticosteroids
  - Laxatives
  - NSAIDs
  - Opioids
  - Psychostimulants
  - Stool softeners
- V. Residents will understand the effective use and interpretation of scales to assess the effect of a patient's disease on their daily activities and their prognosis:
  - ECOG Performance Status
  - Karnofsky Performance Scale
  - Palliative Performance Scale
- VI. Residents will understand the ethical, medical, and legal implications of and be able to counsel patients with serious illness and their families on the following issues:
  - Advanced directives and POLST
  - Artificial feeding and intravenous fluids
  - Durable Power of Attorney for health care and next of kin
  - Ethical issues, such as autonomy, beneficence, decision-making capacity, informed consent, self-determination
  - Medical futility
  - Respite care
  - Withholding care and withdrawal of care
- VII. Residents will become familiar with complementary and alternative medicine treatments used commonly to alleviate symptoms at the end of life.
- VIII. Residents will become familiar with the required exam elements to pronounce death and with the necessary components to complete a death certificate.

## **Practice-Based Learning and Improvement**

- I. Residents should be able to access current clinical practice guidelines to apply evidence-based strategies to patient care.
- II. PGY2s should develop skills in evaluating studies in published literature, through Journal Club and independent study.
- III. All residents should learn to function as part of a team, including the primary care physician, hospice nurse, home health aide, pharmacist, caregiver, spiritual advisor, and social worker to optimize patient care, with PGY3s taking a leadership role.
- IV. All residents should respond with positive changes to feedback from members of the health care team.

## **Interpersonal and Communication Skills**

- I. PGY1s must
  - demonstrate organized and articulate electronic and verbal communication skills that build rapport with patients and families, convey information to other health care professionals, and provide timely documentation in the chart.
  - engage with patients and families in a way that demonstrates empathy and understanding and does not take away hope.
- II. PGY2s must also develop interpersonal skills that allow them to
  - lead family conferences to share clinical information
  - present bad news, such as a new life-limiting diagnosis, change in status, or notification of a death
  - elicit patient and family preferences and goals at the end of life
  - show respect for cultural beliefs, customs, and spiritual and religious preferences at the end of life
- III. PGY3s should demonstrate skill
  - transitioning patients and families to withdrawal of life-sustaining treatments, including antibiotics, artificial hydration and nutrition, blood products, and dialysis
  - identifying and working with the power of attorney or surrogate decision maker in situations where the patient lacks decision-making capacity
  - dealing with family-physician conflicts or conflicts among family members with disparate wishes concerning goals of care

## **Professionalism**

- I. All residents must demonstrate strong commitment to carrying out professional responsibilities as reflected in their conduct, ethical behavior, attire, interactions with colleagues and community, and devotion to patient care.

- II. All residents should be able to educate patients and their families in a manner respectful of gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation on choices regarding their care.
- III. PGY2s should be able to use time efficiently to see patients and chart information during clinic, hospital, nursing home, or home visits.
- IV. PGY3s should be able to provide constructive criticism and feedback to more junior members of the team.

### **Systems-Based Practice**

- I. PGY1s must have a basic understanding that their diagnostic and treatment decisions involve cost and risk and affect quality of care.
- II. PGY2s must be able to discuss alternative care strategies ranging from full treatment to palliative care to hospice, taking into account the social, economic, and psychological factors that affect patient decisions.
- III. PGY2s should
  - be aware of laws regulating use of controlled substances in terminally ill patients
  - understand the cost of hospice care at home, in the hospital, and in a nursing home
  - become familiar with the referral process for hospice and the impact of insurance status on a patient's ability to access palliative care services and hospice
  - be aware of the availability of case workers, counseling services, transportation services, and other community resources to maximize care.
- IV. PGY3s must demonstrate an awareness of and responsiveness to established quality measures, risk management strategies, and cost of care within our system.
- V. Residents will become familiar with issues pertinent to the practice of palliative medicine and hospice care, such as coding and reimbursement, liability, and the costs and legal issues involved.

### **Teaching Methods**

- I. Supervised care in the hospital and for patients on hospice at home or in the nursing home
  - Residents will initially be directly observed with patients, to facilitate the acquisition of appropriately focused history taking and physical exam skills.
  - As residents become more proficient, they will interact more independently with patients and present cases to faculty.
    - For PGY1s, initial emphasis will be on basic symptom management.
    - For more senior residents, focus will be on communication with patients and families, understanding ethical and legal issues, and medical decision-making.
    - All residents will work with supervising physicians to finalize a care plan.
- II. Conferences
  - Specialty-specific didactics

### III. Independent study

- Journal and textbook reading, clinical guidelines, and online resources
  - American Academy of Family Practice Guideline on End-of-Life Care [www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=57](http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=57)
  - American Academy of Hospice and Palliative Medicine. *Primer of Palliative Care*. 7<sup>th</sup> ed. AAHPM; 2019.
  - American Geriatrics Society Ethics Committee and Clinical Practice and Models of Care Committee. American Geriatrics Society Feeding Tubes in Advanced Dementia Position Statement. *Journal of the American Geriatrics Society*. 2014;62(8):1590-1593.
  - Broglio K, Portenoy R. Pain Assessment and Management in the Last Weeks of Life. In J. Abram (Ed.), UpToDate. Retrieved May 29, 2019 from <https://www.uptodate.com/contents/pain-assessment-and-management-in-the-last-weeks-of-life>
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  - Kreher, M. Symptom Control at the End of Life. *Medical Clinics*. 2016;100(5):1111-1122.
  - National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care. 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. <https://www.nationalcoalitionhpc.org/ncp> <http://www.nationalconsensusproject.org/>
  - NEJM Knowledge+ Pain Management and Opioids [https://knowledgeplusoffers.nejm.org/special53a/?utm\\_source=nejm&utm\\_medium=email&utm\\_campaign=pmmlaunch](https://knowledgeplusoffers.nejm.org/special53a/?utm_source=nejm&utm_medium=email&utm_campaign=pmmlaunch)
  - Strand J, Kamdar M, and Carey E. Top 10 Things Palliative Care Clinicians Wished Everyone Knew About Palliative Care. *Mayo Clin Proc*. 2013;88:859-65.
  - Van de Vathorst, S (2014). Artificial nutrition at the end of life: Ethical issues. *Best Practice & Research: Clinical Gastroenterology*. 2014;28(2):247-253.
  - VitalTalk <https://www.vitaltalk.org/resources/>
  - Pain management and addiction: <https://www.who.int/cancer/palliative/painladder/en/>
- Additional information can be found via Clinical Key and UpToDate

### Evaluation

- I. Case logs
- II. Verbal mid-rotation individual feedback
- III. Palliative care Knowledge and Self-assessment pre- and post-tests

- IV. Attending written evaluation of resident at the end of the month, based on observations and chart review.

### **Rotation Structure**

- I. Residents should contact Dr. Scibetta the day prior to confirm start time and location.
- Residents are the primary care providers for patients and will be involved in discussion of patient presentation, assessment of pain and other symptoms, development of a treatment plan with emphasis on symptom control and psychosocial needs, and patient follow up.
  - When doing palliative care consults, the resident should understand the question asked and provide a concise answer.
  - Residents should spend their time in the clinic, hospital, nursing home, or on home visits as appropriate to achieve the above educational goals. Detailed information is listed below:

#### **PC Interdisciplinary Team Rounds**

Rounds are conducted in the PC office on the 6<sup>th</sup> floor of the Ocean Tower room 6241 in Community Memorial Hospital. The team discusses new and existing cases with discussions regarding prognosis for survival and recovery, long term care planning, POLST, symptom management, and end of life care.

#### **Inpatient PC consults**

The team sees inpatient medical consults in the ED, ICU, and Medical Surgical Floors. Consults are conducted with team members from Spiritual Care, Nursing, Social Services, and Case Management. The team coordinates the consult outcome with referring physician, including education, goals of care discussion, end of life care, and symptom management. All consults are performed under the direct supervision of a Palliative Care physician.

#### **Outpatient PC Clinic**

Outpatient clinic focuses primarily on goals of care, symptom management, education and completion of POLST / Advanced Directives, symptom management, and long-term care planning. All visits are performed under the direct supervision of a Palliative Care physician.

#### **Nursing Home Consults**

These consults include meetings with patients and families to address goals of care and advanced care planning. Our goal is to achieve 100% completion of POLST documents and Advanced Directives. Visits to nursing homes occur primarily in the Ventura area. All visits performed are under the direct supervision of a Palliative Care Physician.

### **II. Study**

- Case-based learning is most effective; residents are encouraged to do nightly reading/study based on patients seen during the day.
- Residents may be asked to do focused reading, literature searches, or presentations during the course of the rotation.

### III. Schedule

Resident should contact with Dr. Scibetta **by 1300 on Friday prior** to starting the rotation.

- **Monday**

8:30-9 AM: Interdisciplinary Team Rounds

9 AM-12 PM: Inpatient PC consultation Service

1 PM-5 PM: Inpatient PC consultation Service

**Tuesday**

8:30- 9 AM: Interdisciplinary Team Rounds

9 AM-12 PM: Inpatient PC outpatient Service

1 PM-5 PM: Didactics

**Wednesday**

8: 30 – 9 AM: Interdisciplinary Team Rounds

9 AM-12 PM: Didactics

1 PM-5 PM: Inpatient PC consultation Service

**Thursday**

8: 30- 9 AM: Interdisciplinary Team Rounds

9 AM-12 PM: Inpatient PC consultation Service

1 PM-5 PM: Inpatient PC consultation

**Friday**

8:30- 9 AM: Interdisciplinary Team Rounds

9 AM-12 PM: Inpatient PC Consultation Service

1 PM -5 PM: Inpatient PC consultation Service

- Call and weekend responsibilities TBD by Dr. Scibetta.
- Hours worked must be consistent with ACGME requirements and are subject to approval by the Program Director.
- Residents have specialty-specific didactics and should be excused in a timely fashion to attend.