# Hospice Rotation Goals and Objectives

## Sample C: Generic Hospice

**Description of Rotation**

**Generic Hospice**

**Clinical Experiences**

This is a community-based clinical experience. The fellows will have a variety of experiences that include caring for patients at a free-standing inpatient hospice facility, making home visits for home care hospice patients, and visiting a variety of skilled nursing facilities and or residential care facilities to understand the range and different approaches of hospice care.

For the home hospice experience, fellows will function as a full-time team member and see patients on the team as consultant. In addition, for patients who do not have a primary physician, or whose primary physician wishes to transfer responsibility, the fellow will serve as the primary physician. Three-to-five home visits per day are expected when the fellow is assigned to home hospice rotation. Fellows will be expected to perform a history and physical on the patients they see including a detailed focused assessment, conduct family meetings, and interface with the primary care providers to ensure any recommendations are communicated.

During other rotations, the fellow will be available by telephone for continuity patients in the same way that other primary physicians are available. Patients will represent a mix of acute problems, consultations, assessments and ongoing care. The fellow is responsible for adequate documentation, communication with team members and attending physicians. The team will first direct medical questions about care to the fellow for the month rather than to the hospice attending. The hospice attending for that team is responsible for supervising the fellow and teaching. It is expected that some visits will be made jointly with the home hospice attending physician and with other team members.

During the long-term care experience, the hospice long term care teams provide care in more than many nursing homes, assisted living, and residential care facilities. Patients will represent a mix of acute problems, consultations, assessments and ongoing care. The fellow is responsible for adequate documentation, communication with team members and attending physicians, participating in teaching walk-rounds with the nursing home team members and nursing home staff members and providing an in-service on symptom management and end of life care. The team will first direct medical questions about care to the fellow for the month rather than to the hospice attending. The hospice attending for that team is responsible for supervising the fellow and teaching. An emphasis on learning about nursing homes, their function and culture, and the role of the physician and hospice team in the nursing home will be emphasized. Fellows work under the supervision of the attending physician faculty member assigned to the long-term care team who is responsible for teaching the fellows and other medical trainees.

**Specific Goals and Objectives**:

1. Develop all skills required to be a competent medical director in a Medicare-certified hospice. (Competencies: 1.2, 1.3, 2.1, 2.4, 2.5, 5.4, 5.5, 6.1, 6.4)
    - Identifying current gaps in end-of-life care
    - Understanding the relationship between "hospice" and "palliative care"
    - Understanding the interdisciplinary team (IDT) model
      Understanding the hospice and the Hospice Medicare Benefit
    - Understanding the different levels of hospice care

2. Learn appropriate clinical skills in the home care setting (Competencies: 1.8, 2.11) including:
    - Assessment (Competencies:1.1, 2.6, 2.13, 2.14)
        - Assessing goals of care
        - Assessing the patients' physical, psychological, social and spiritual needs
        - Assessing patients' functional ability
        - Assessing medical decision-making capacity
        - Assessing and managing pain
        - Assessing and managing non-pain symptoms (e.g., nausea, dyspnea, anxiety)
    - Communication (Competencies:1.7, 4.1, 4.5)
    - Decision-making and care planning (Competencies: 2.7, 2.8, 2.9, 2.10)

3. Obtain service delivery skills specific to the home care environment such as adapting to limitations of the home as a setting for care and facilitating continuity of care. (Competencies: 1.8, 1.13, 6.6)

4. Assist with transitions of patient care. (Competencies:1.15, 4.9, 6.3, 6.6)

5. Care for a panel of homecare patients longitudinally during the fellowship in order to develop a continuity experience. (Competencies: 1.11, 1.12, 4.9, 5.3)

6. Know the roles, responsibilities and potential contributions of all members of the team and develop skills at working together as a team on a level playing field. (Competencies: 2.2, 2.12, 2.13, 2.14, 4.8, 6.7)

7. Develop self-care strategies. (Competencies: 4.3, 5.1, 3.1, 5.8)

8. Recognize normal and pathologic grief. Recognize anticipatory grief. (Competency 2.19)

9. Lead patient/family meetings with other IDT members with attention to educating patients and families, goals of care, quality of life, and sharing of prognostic information if needed. (Competencies: 1.7, 1.12, 2.3, 4.2, 4.4, 4.5, 4.6, 4.7)

10. Demonstrate knowledge of the process and opportunities for research in HPM. Appropriately refer patients for active research studies. (Competencies 3.4, 5.6)

11. Know all aspects of mandated reporting. (Competencies: 2.21, 5.6)

12. Learn techniques to develop business within the community.

13. Perform geriatric assessments relevant to end-of-life care such as MMSE, CAM clock and three item recall, (I)ADL's, GDS, Braden pressure sore risk, fall risk, FAST dementia assessment, Karnofsky, ECOG and NYHA CHF classification. (Competencies: 1.1, 1.11)

14. Manage geriatric syndromes and diseases that are common in a hospice and palliative medicine patient population such as frailty, neuropsychiatric disorders, dementia, depression, delirium, falls, pressure ulcers, incontinence, pain, UTI and urinary retention, constipation, Parkinson's disease and stroke. (Competencies: 1.12, 2.11, 2.20, 6.1)

15. Practice effective and meaningful primary and consultative hospice and palliative care in the long term setting. (Competencies: 1.8, 1.15, 2.6, 2.7, 2.8, 2.9, 3.2, 4.5, 4.9, 5.3, 6.6)

16. Acquire the necessary knowledge of skilled nursing facility regulations that affect physician practice. (Competencies: 1.8, 1.15, 3.2, 6.3, 6.4, 6.5)

17. Participate in interdisciplinary team work focusing on older adults (IDG and PCC). (Competencies: 1.3, 1.7, 2.2, 2.16, 4.7, 4.8, 5.5)

18. Develop prescribing patterns appropriate for older adults. (Competencies: 2.9, 3.5)

19. Recognize common social issues in the geriatric population. (Competency 2.13)

20. Evaluate elderly patients for hospice services. Provide education to patients and families about medical, social, and psychological issues associated with life-limiting illness. (Competencies: 1.13, 1.15, 4.4, 4.5)

21. Assess and manage elder abuse and neglect. Demonstrate knowledge of ethics and law around withdrawal of therapies. (Competencies: 2.21, 3.5, 5.6)