Indiana University Palliative Medicine Fellowship Curriculum: Goals and Objectives

I. Overview

Hospice and palliative medicine is comprehensive, interdisciplinary care for patients with advanced, progressive, life-threatening illnesses and their families. The Palliative Medicine Fellowship at Indiana University is designed to educate residents to provide expert palliative care to diverse populations. The fellowship also provides fellows with the skills required to disseminate the principles of palliative medicine through teaching and research.

This curriculum closely follows the Hospice and Palliative Medicine Core Competencies Version 2.3 from September 2009. Fellows will participate in a wide range of experiences. This includes inpatient consult services, inpatient hospice/palliative care units, long-term care facilities, a palliative medicine ambulatory clinic, a general oncology clinic, home hospice programs, and a hospice home for the dying poor. Fellows participate in an interdisciplinary approach aimed at helping patients and their families achieve the best possible quality of life throughout the course of a life-threatening illness.

Fellows have the opportunity to participate in variety of electives that include the medical ICU, radiation oncology, anesthesia pain service, oncology clinic or inpatient oncology consultation, geriatrics, specialty clinics (i.e. advanced CHF, ALS/neuromuscular disorders), ethics and ethics consultation, pediatric palliative care, and interventional radiology.

The fellowship's affiliation with four hospital systems optimizes the number and diversity of fellow-patient encounters. The four hospitals include Wishard Health Services; IU Health Hospitals: Methodist, University Hospital and Riley Hospital for Children; St. Vincent Hospital and Health System and the Richard L. Roudebush VA Medical Center. Furthermore, these institutions all have coordinated relationships with community hospices, clinics, and nursing facilities. This helps ensure that fellows obtain experience managing patients longitudinally and across settings.

During the one year fellowship, fellows will gain expertise in the following domains:

- Communication
- Ethical and legal decision making
- Pain in cancer and non-cancer patients
- Management of non-pain symptoms
- Medical co-morbidities and complications in populations with life threatening diseases
- Neuro-psychiatric co-morbidities in populations with life-threatening diseases
- Psychosocial and spiritual support

- Death and dying
- Bereavement
- Quality improvement in populations with advanced illnesses
- The hospice and palliative approach to care
- Interdisciplinary team work

Outlined in the sections below are the goals, objectives and activities of each core experience during the one year fellowship. The options for elective experiences are listed at the end of this document. Over the course of a year, the following overall goals will be met:

- Fellows will demonstrate competency in six main areas, including patient care, medical knowledge, practice-based learning, communication skills, professionalism, and systems based practice (See Appendix on HPM Core Competencies, Version 2.3, September 2009).
- Fellows will evaluate at minimum 100 new patients over twelve months.
- Fellows will follow at minimum 50 patients longitudinally and across settings.
- Fellows will perform home visits, seeing a minimum of 25 patients in this setting.
- Fellows will manage the care of at least 25 patients in a long-term care facility.
- Fellow will be available by pager to address on-call needs of their patients. The program director, faculty and hospice medical directors will be available for backup and coverage or when fellow is not available.
- Fellows will participate in weekly palliative care conferences and monthly journal clubs.
- Fellows will meet regularly with the interdisciplinary team members to discuss their performance and self-care.

II. <u>Outline of Required Clinical Practice Settings and Experiences</u>

A. Community Home Hospice and Long Term Care Programs

1. Visiting Nurse Service (VNS) Hospice
    a. Home Hospice Program
    b. Abbie Hunt Bryce Home for the Dying Poor
2. IU Health Hospice
3. St. Vincent Hospice
4. Various Nursing Facilities (Alpha, American Village, Briarwood, Eagle Creek, North Capitol, Northwest Manor, Rosewalk)

B. Inpatient Palliative Care and Hospice Units

1. IU Health Hospice Yellow Rose Unit at Methodist Hospital
2. St. Vincent Inpatient Hospice Unit (free-standing)

C. Palliative Medicine Consultation

1. Wishard Hospital Palliative Care Consult Team
2. Richard L. Roudebush Palliative Care Consult Service
3. St. Vincent Hospital Supportive Care Teams (Adult and Pediatric)
4. IU Health Methodist Hospital Palliative Care Consult Team

D. Ambulatory Palliative Care Clinics

1. Palliative Care Clinic at the Center for Senior Health, Wishard
2. Palliative Care Clinic at the Roudebush VA Medical Center
3. General Oncology Clinic at Regenstrief Health Center, Wishard

LONG TERM CARE —PRIMARY PALLIATIVE CARE AND CONSULTATION

Location:

Various Area Nursing Homes

Wishard Patients: Alpha Home, American Village, Briarwood Health and Rehabilitation Center, Eagle Creek Health and Rehab, North Capitol, Northwest Manor, Rosewalk.

VA Patients: Eagle Creek Health and Rehab, Northwest Manor.

Main Faculty:

For Wishard Patients: Drs. Gramelspacher, Fettig and Rosario.
For VA Patients: Drs. Gramelspacher, McNamara and Newton.

Competency-Based Educational Goals

I. Patient Care (Evaluation methods: Global assessments, formative evaluations, Mini-CEX, medical record assessment, self- evaluation)
   a. Understand barriers to the implementation of palliative care plans which may have been developed in the hospital prior to hospital discharge to an extended care facility.
   b. Be familiar with the role of providing primary palliative care in a nursing home setting.
   c. Be familiar with the role of providing palliative care consultation in a nursing home setting.
   d. Effectively assess a resident's decision-making capacity.
   e. Apply principles of geriatric pharmacology in choosing, dosing and monitoring medications.
   f. Coordinate and facilitate family meetings in the nursing home to negotiate a plan of care.

II. Medical Knowledge (Evaluation methods: Formative evaluation, self-evaluation)
   a. Diagnose and treat common geriatric syndromes in chronically ill frail older patients including pain and other symptoms, depression, dizziness, gait/immobility, nutritional needs, pressure ulcers, falls and incontinence.
   b. Define barriers to palliative care in the nursing home setting.
   c. Describe how to assess and communicate prognosis.
   d. Describe the use of opioids in pain management for older adults, including non-pharmacologic modalities.
   e. Describe the etiology, diagnosis and management of dementia, stroke and traumatic brain injury.

III. Interpersonal and Communication Skills (Evaluation method: Global assessment, mini-CEX, self-evaluation

a. Effectively communicate with other health professionals (nurses, social workers, therapists, dietician, chaplain and psychologists) who are members of the IDT.
b. Effectively communicate with patient's family, friends and surrogate decision makers.
c. Negotiating care goals with patients and surrogate decision makers.

IV. Professionalism (Evaluation Methods: Global assessment, self-evaluation, formative evaluation, medical record assessment)
a. Demonstrate respect and compassion through interactions with colleagues, patients, families and other members of the IDT.
b. Demonstrate a commitment to the ethical principles to the provision or withholding of life sustaining care, confidentiality of patient information, informed consent and business practices in the nursing home setting.

V. Practice Based Learning and Improvement (Evaluation Methods: Formative evaluation, self- evaluation)
c. Learn to administer care in a less technological setting.
d. Locate, appraise and assimilate evidence from scientific studies related to the care of nursing home patients, especially those with dementia.

VI. Systems Based Practice (Evaluation Methods: Formative evaluation, medical record evaluation)
a. Improve the fellow's ability to create a plan of care for hospitalized patients who are being discharged to nursing facilities.
b. Recognize the role of the nursing home in the spectrum of patient care and what types of patients may benefit from this level of care.
c. Work effectively with Nurse Practitioners as members of IDT.
d. Understand reimbursement mechanisms in the nursing home, especially the role of Medicare and Medicaid.
e. Understand the role of hospice in the care of nursing home residents.
f. Be aware of the OBRA and JACHO rules and regulations that the nursing home has to follow and learn about the operations of the long term care facility.

Routine Educational Activities:

I. Patient visits/consultation with one-on-one mentoring by Palliative Medicine faculty
II. Self-study
III. Regular didactics.

Logistics of the Rotation:

Palliative Care Consultation at some of the area nursing homes that serve Wishard or the VA Hospital. Follow-up visits and continuity after hospital consultation.

Evaluation of Rotation:

I. Evaluation of Fellow: Written evaluation monthly discussed with fellow at close of the month, addressing the 6 core competencies: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. 360 evaluations done by members of the IDT.

II. Evaluation of rotation by fellow: Fellow evaluates program AND each rotation once/year, evaluates attending each month via MedHub. Faculty evaluates fellow at the end of each rotation and the faculty evaluates the rotation yearly via MedHub.

References:

1. Berger, A. Portenoy, R., Weissman, D. Principles and Practice of Palliative Care and Supportive Oncology, 2002.
2. Doyle, D., Hanks, D., Cheny, G, Calman, K. Oxford Textbook of Palliative Medicine. Oxford University Press, 2004.
3. UNIPAC (third edition), Fast Facts (MCW web site EPERC).
4. Capello, C., Morrison, R.S., Meier, D. Geriatric Palliative Care. Oxford University Press, 2003.
5. Ham, R., Sloane, P., Warshaw, G. Primary Care Geriatrics, A Case-based Approach. Fourth Edition, 2002. Gloth, F.M. Handbook of Pain Relief in Older Adults An Evidence-Based Approach, 2004.
6. Geriatrics at your Fingertips www.geriatricsatyourfingertips.org
7. Geripal at: http://www.geripal.org/

COMMUNITY HOME HOSPICE EXPERIENCE

Visiting Nurse Service (VNS) Hospice of Central Indiana
4701 N. Keystone
Indianapolis, IN 46205
(317) 722-8200

Abbie Hunt Bryce Home for the Dying Poor
4760 Pennwood Dr.
Indianapolis, IN 46205
(317) 860-0484

IU Health Hospice
1801 N. Capitol
Indianapolis, IN 46202
(317) 962-0800

St. Vincent Hospice
8450 N. Payne Rd, Suite 100
Indianapolis, IN 46268
(317) 338-4040

Physician Faculty:

Gregory Gramelspacher, M.D.
Lyle Fettig, M.D.
Rafael Rosario, M.D.
Michael Graham, M.D.
Michael Buran, M.D.
Emily Giesel, M.D.

Time requirement: varies but 15 % total over 12 months

Educational Goals and Objectives for Community Hospice Experience

Goal: Fellows will demonstrate excellence in hospice care as delineated by the core competencies

Objectives: see below

Competencies: Patient & Family Care, Medical Knowledge, Practice-Based Learning & Improvement, Interpersonal & Communication Skills, Professionalism, and Systems-Based Practice

Time/Location: according to block rotation schedule, elective schedule and protected half-days for a total of 8 weeks during the training year.

Supervision: Physician faculty as listed above as well as other members of the hospice interdisciplinary team.

Narrative: Fellows will receive comprehensive training in community home hospice care. During their orientation weeks, fellows will make home visits with IDT members and faculty. Then throughout the year, they will perform independent visits once observed visits and competencies are met. They will continue to care for their patients for the remainder of the year. Fellows will also see hospice patients in a long term care facility (as above). Fellows will manage home hospice patients while on their VA and Wishard rotations. They might also follow home hospice patients as part of their other electives or when on the inpatient palliative care units (either Methodist or St. Vincent).

Evaluation: Quarterly faculty evaluations.

Resident responsibilities for patient care: see check list attached

Level of responsibility: see fellowship training sequence

Objectives:

Patient and Family Care

A. Describe and manage complex patient symptoms including physical, psychosocial and spiritual suffering utilizing an interdisciplinary approach for patients on hospice.
B. Recognize bereavement needs and initiate treatment for complicated grief issues in patients or caregivers.
C. Accompany members of the interdisciplinary team during home visits.
D. Complete 25 home hospice visits that include:
    1. Gathering comprehensive clinical information from all disciplines regarding the patient's history and reason for the visit.
    2. Providing care that is respectful of age, developmental stage, gender, sexual orientation, culture, belief system, physical disabilities, family dynamics, and socioeconomic status.
    3. Seeking to maximize patient's level of function and quality of life.
    4. Providing appropriate patient and family education.
    5. Collaborating effectively with other physicians and members of the Interdisciplinary Team by communicating orders appropriately and assuming primary palliative care follow up on home visit patients.
E. Function as primary hospice attending for a panel of patients referred to hospice from in-patient or out-patient settings and thus develop longitudinal relationships with these patients and families.

Medical Knowledge

A. Describe the pharmacological and non-pharmacological approaches to pain and non-pain symptoms.
B. Recognize, assess, and initiate treatment for common psychological, spiritual, and social stressors facing patients and caregivers on hospice.
C. Develop appropriate treatment plans sensitive to the diverse cultural values and customs of patients and caregivers.
D. Recognize the imminently dying and provide appropriate care for both the patients and caregivers.
E. Describe ethical and legal issues regarding hospice care and apply those in an interdisciplinary manner.

Practice-Based Learning

A. Apply evidence-based medicine to the clinical practice of hospice-based medicine.
B. Demonstrate competency as an educator by presenting two in-services to hospice staff on a relevant topic.

Interpersonal and Communication Skills

A. Demonstrate empathy in relationships to patients, caregivers and staff.
B. Demonstrate ability to recognize and respond to one's own emotions.
C. Use age, gender, and culturally appropriate concepts and language when communicating with patients and caregivers.
D. Collaborate effectively with members of the interdisciplinary team to develop a treatment plan.
E. Establish effective relationships with referring physicians and other Interdisciplinary Team members by communicating orders effectively.
F. Complete comprehensive and legible medical write ups of home visits within 24 hours of visit.
G. Attend at least two hospice Interdisciplinary Team meetings.

Professionalism

A. Demonstrate accountability to patients, society, and the profession and exhibit a commitment to excellence.
B. Describe the role of hospice medical director after working with the Hospice Medical Directors.
C. Demonstrate respect and compassion toward all patients, caregivers, and other health care providers.
D. Fulfill professional commitments to fellowship while on hospice rotation, i.e., Fellow Case Conference and Journal Club.
E. Demonstrate a balance of responsibility to patient/caregiver/team and meeting ones' own needs for self care.

Systems-Based Practice

A. Demonstrate care that is cost effective and represents best practices.
B. Integrates knowledge of health care system in developing a plan of care.

C. Demonstrate knowledge of hospice organization, regulations, and financing after listening to the AAHPM Hospice Medical Directors Course (audio CD).
D. Collaborate with all elements of the palliative care team when transitioning patients between hospital, palliative care unit, nursing home, and home hospice.

INPATIENT PALLIATIVE CARE AND HOSPICE UNIT

IU Health Methodist Hospital Yellow Rose Unit (YRU)
or
St. Vincent Inpatient Hospice Unit

Location:

Methodist Hospital
1701 N. Senate Blvd.
Indianapolis, IN 46202

St. Vincent Hospice
8450 N. Payne Road
Indianapolis, IN 46268

Time requirement: One four week rotation (at either Methodist YRU or St. Vincent)

Methodist Faculty:

Michael Graham, M.D. – Medical Director
Tim Broach, M.D.
Shilpee Sinha, M.D.

St. Vincent Faculty:

Michael Buran, M.D.
Emily Giesel, M.D.

Rotation Goals:

1) Gain understanding and skill in the inpatient care of end-of-life patients.
2) Develop skill in comprehensive inpatient assessment of the physical, psychosocial, cognitive, and spiritual elements of life-threatening disease.
3) Learn how to use pharmacologic and non-pharmacologic modalities for the treatment of complications and symptoms at the end of life, including but not limited to pain, dyspnea, bowel obstruction, anorexia, delirium, and restlessness.
4) Learn advanced skills in the pharmacologic and non-pharmacologic treatment of psychological symptoms in the terminally ill patient.
5) Gain understanding and skill in the effective use of an interdisciplinary team.
6) Improve skills in family communication at end-of-life, including conflict management and families in crisis.
7) Improve skills in communication with professional colleagues, especially communication with referring physicians.
8) Improve insight into the role of cultural factors in the psychosocial dynamic of dying patients and their families.
9) Gain skill in the education of colleagues.
10) Gain skill in the billing and code of hospice care.
11) Gain skill in the administrative activities of a hospice program within a larger institution.
12) Understand bereavement issues and follow-up.

Educational activities:

1) Initial assessment of new patient admissions to the unit. Fellow will perform initial evaluation of the majority of patients admitted to the medical director. This will amount to approximately 25-30 patients of wide diagnostic variety, including cancer, COPD, CHF, trauma, terminal extubations, and others.
2) Daily rounds with medical director. The YRU has capacity for twelve patients and at St. Vincent, there are 25 beds. The fellow will directly manage an average of four to eight patients daily.
3) Fellow will be available for consultation on unit patients managed by other physicians.
4) Fellow will write notes daily.
5) Twice weekly, fellows will attend an inpatient interdisciplinary meeting to discuss inpatients. Unit nurses and social worker regularly attend this meeting.
6) Fellow will help organize and direct family meetings.
7) Fellow will share night and weekend call responsibilities with the medical director. This will include one weekend call per month and approximately 10 nights of home call.
8) Fellow will attend weekly IDT meetings, during which both home care and inpatients are discussed.
9) Fellow may assume the primary responsibility for care of four to five hospice patients per month after discharge from the unit. This responsibility will extend longitudinally and include home visits as needed.
10) Fellow will attend hospice administrative meetings when available.
11) Fellow will attend weekly hospital ethics committee meetings when they do not conflict with longitudinal activities.
12) Billing session – fellow will meet with billing specialist to review process.
13) Fellow will spend time with bereavement counselor.

Evaluation:

Fellows will receive a written evaluation at the end of the rotation by the medical director, a nurse, a social worker, and a chaplain. Each discipline will meet with the fellow to discuss this evaluation. The evaluation will focus on the six competencies required of the fellow, including patient care, medical knowledge, practice-based learning, communication skills, professionalism, and system-based practice. Written evaluations will be sent to the program director.

Fellows will evaluate the rotation at the end of each one-month rotation. This will include a written evaluation. Based on this written evaluation, fellows may initiate a continuous quality improvement project to be undertaken after the rotation is completed and/or during a second month rotation.

Palliative Care Fellowship Program Curriculum—Inpatient Hospice Competencies

Competencies	Content	How Evaluated
Patient Care	Provides an appropriate comprehensive history and physical; perform appropriate patient-family centered care at the end-of-life. Recognize signs of impending death and provide care for the imminently dying. Demonstrates care that shows respectful attention to cultural, spiritual and family interactions	Global assessments, formative evaluations, Mini-CEX, medical record assessment, self- evaluation
Medical Knowledge	Describe the scope and practice of palliative care and hospice in the Methodist or St. Vincent system. Describe effective strategies to communicate prognostic information to patients and families. Describe common complications of malignancies: hypercalcemia, brain metastasis, cord compression and seizures Describe the role of the Hospice Medical Director on the IDT.	Formative evaluation, self-evaluation
Practice based Learning and Improvement	Demonstrate the ability to actively seek and utilize feedback Develop competence as a teacher	Formative evaluation, self- evaluation
Interpersonal and Communication Skills	Demonstrate communication skills that foster relationships with patients/families and colleagues Document discussion in the medical record	Global assessment, mini-CEX, self-evaluation
Professionalism	Describes the role of hospice medical director in terms of quality of care, compliance and communication with other professionals Fulfills professional commitments with timely response to request from patients, families and colleagues	Global assessment, self-evaluation, formative evaluation, medical record assessment
Systems Based Practice	Review pertinent patient/family satisfaction data Review hospice polices to integrate knowledge of the health system Demonstrate the ability to work with varying disciplines to improve patient safety	Formative evaluation, medical record evaluation

Educational purpose	• Describe the role and functions of the Hospice Medical Director

	• Recognize signs of impending death and provide care for the imminently dying • Bases care on patient/family preferences and values • Communicate prognostic information to patients and families • Recognize common complications of malignancies, hypercalcemia, brain metastasis, cord compression and seizures • Demonstrate the ability to supervise trainees and give feedback • Demonstrate the ability to communicate effectively with patients/families and colleagues • Document discussions regarding care goals and wishes in the medical record • Fulfill professional commitments and serve as a role model • Describe the philosophy of the hospice, admission criteria, range of service and structure. • Partner with the Hospice Medical Director to provide continuous quality improvement
Teaching methods	Self-study, one-on-one mentoring by Hospice and Palliative Medicine faculty, weekly didactics
Mix of diseases	Cancer and non- cancer diagnosis, chronic diseases and catastrophic illnesses
Patient characteristics	Adult (or children) with life limiting illness including cancer, chronic and catastrophic illness.
Types of clinical encounters	Inpatient 10 bed hospice and palliative care unit at Methodist and 25 bed inpatient unit at St. Vincent.
Procedures	History and Physical, IV or subq catheter placement, paracentesis, thoracentesis.
Reading list	Berger, A. Portenoy, R., Weissman, D. Principles and Practice of Palliative Care and Supportive Oncology, 2002. Doyle, D., Hanks, D., Cheny, G, Calman, K. Oxford Textbook of Palliative Medicine. 2005. UNIPAC, Fast Facts
Other educational resources	Up-to-Date, Pub Med, and MD Consult searches on various disorders seen.
Method of evaluation of fellow performance	Ongoing informal evaluation by attending during month. Formative evaluation done every 3 months based on close observation of fellow's interpersonal and leadership skills, teaching, clinical knowledge and patient care. Specific emphasis on 6 competencies: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice.

Required educational and clinical experiences	With increasing independence throughout the year, evaluate patient fully and develop management strategy for each patient with close follow-up and re-evaluation, ongoing discussion with the attending physician.
Level of supervision by faculty members	One-on-one, with faculty providing supervision for each patient seen. Attending faculty available at all times.
Integration of health promotion, & cultural, socio-economic, ethical, occupational, environmental, & behavioral issues	Considerable teaching related to palliative medicine by the fellow for the IDT and learners on the service (medical students, residents). Integration of other disciplines such as nursing, social work, psychology and chaplain. Ongoing socioeconomic considerations with careful attention to autonomy and confidentiality during counseling regarding goals of care and end-of-life needs. Significant attention to psychosocial issues with these seriously and/or critically ill patients and their families.
Teaching rounds & conferences	Daily teaching rounds. Weekly 1 hour didactic conference. Weekly IDT
Range of clinical problems	Common advanced chronic disease including Alzheimer's, Parkinson disease and cancer. End-of-life care needs and symptom management. Advance care planning including grief planning.
Stages of illness encountered	Advanced and terminal stage of disease
Humanistic qualities	Demonstrate empathic responses and communicates effectively with patients, families and colleagues. Personal and humanistic care of each patient and family, with special attention to education and counseling for patients. All cultures embraced. Special attention to conduct on the inpatient units with respect to interpersonal skills, answering initial calls, willingness to be of assistance, provide counsel and service to consulting inpatient services. Fellows closely observed for professional, collegial behavior, compassion, respect and courtesy in dealing with peers, colleagues, and patients.
Method of evaluation of fellow	Informal ongoing with discussion and formative discussed with fellow every 3 months. Evaluations address the 6 core competencies: patient care; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. Mini CEX, 360 evaluations done members of the IDT.
Method of evaluation of rotation	Fellow evaluates program AND each rotation once/year, evaluates attending each month through MedHub.

PALLIATIVE CARE CONSULTATION SERVICES

Wishard Health Services' Palliative Care Program
Orientation and Educational Goals for Fellows

Faculty:

Gregory P. Gramelspacher, MD
Lyle P. Fettig, MD
Rafael D. Rosario, MD
Mary Smith-Healy, RN – Clinical Nurse
Judy Hetzel, MSW, LSW – Social Worker
Karen Estle, MAPCC, LMHC – Spiritual Advisor

Program Manager: Tom Whitehead

Administrative Specialist: Brenda Mason

Educational Goals (Competency Based):

I. Patient Care and Medical Knowledge
   a. Core Knowledge – By completion of the rotation, residents should
      i. Understand indications and eligibility guidelines for hospice care.
      ii. Recognize and understand the dying process
      iii. Describe assessment methods and treatments for common physical symptoms of advanced disease – pain, dyspnea, nausea, vomiting, constipation, diarrhea, delirium, and anorexia.
      iv. Describe assessment and treatment of psychiatric symptoms associated with advanced disease - depression, anxiety, delirium, and dementia.
      v. Describe and recognize common pain syndromes - bony metastases, plexopathies, peripheral neuropathies, epidural metastases/spinal cord compression, bowel obstruction, and muscle spasms.
      vi. Understand the indications, limitations, side effects, and technical aspects of pain management including:
         1. The WHO Analgesia Ladder
         2. NSAIDS and steroids
         3. Opioids, including dosage titration, conversion between routes of administration, conversion between opioids, and management of side effects.
         4. Adjuvant drugs (e.g. anticonvulsants, antidepressants, antineoplastic therapies)
         5. Interventional techniques (e.g. neurolytic plexus blocks, intrathecal pumps)

vii. Understand appropriate use of nonpharmacologic pain treatment modalities
    1. Physical (e.g. cutaneous stimulation – massage, TENS, acupuncture)
    2. Psychosocial (e.g. relaxation and imagery, mindfulness techniques, distraction and reframing, patient education, psychotherapy and structured support, hypnosis, peer support groups, pastoral counseling)
viii. Develop prognostication skills (both disease specific and non-specific)

b. History, Physical Examination, and Medical Management
    i. Write a consultation note focusing on palliative care needs, including relevant psychosocial needs and goal setting.
    ii. Perform an accurate assessment, initial and ongoing, of pain, using appropriate techniques to assess the adequacy of pain management, including patient and family satisfaction.
    iii. Construct an appropriate care plan for management of other symptoms

II. Interpersonal and Communication Skills
    a. Establish rapport with dying patients and their families or surrogates, using patient centered communication.
    b. Adapt history-taking skills to the mental status, demeanor, and psychosocial presentation of the patient and family.
    c. Engage patients and their families or advocates in shared decision-making regarding treatment options in the end of life setting, using family meetings as needed.
    d. Effectively and considerately communicate with palliative care and hospice team staff in a manner that promotes care coordination.
    e. Communicate with referring physicians in a manner that supports the primary care relationship.

III. Professionalism
    a. Understand and compassionately respond to issues of culture, age, sex, sexual orientation, and disability for all dying patients and their families.
    b. Appreciate the effects of cultural and religious background on a patient's approach to decision making, to their disease, and to treatment.
    c. Recognize the importance of psychological and spiritual support for patients and their families during the dying process.
    d. Reflect awareness of common ethical issues facing patients, their families and caregivers related to end of life care.

e. Sensitively respond to patient and family questions and decisions regarding advanced directives, DNR status, futility, and withholding/withdrawing therapy.

IV. Practice-Based Learning and Improvement
   a. Exhibit self-directed learning through patient-centered learning and independent use of recommended resources.
   b. Use information technology to access and retrieve materials for self-education.
   c. Utilize clinical practice guidelines and current literature to generate appropriate palliative care plans.
   d. Develop a brief didactic session for presentation to the interdisciplinary team near the end of the rotation for the purpose of expanding knowledge and practicing presentation skills

V. Systems-Based Practice
   a. Demonstrate understanding of a spectrum of palliative care delivery systems, including hospital based palliative care teams and hospice.
   b. Develop awareness of how hospice services are provided in various settings, including home, nursing home, and hospital.
   c. Participate within multidisciplinary care, including hospice nurses, chaplains, social workers and other providers in team settings.
   d. Develop understanding the appropriate use and limitations of various advance directives, including:
      i. Indiana Living Will Declaration Form
      ii. Indiana Durable Power of Attorney and Health Care Representative Forms
      iii. Indiana Out of Hospital DNR Form
   e. Provide cost effective care, cognizant of the limitations of hospice funding.

Routine Educational Activities: An individualized schedule will be provided to you at the start of your rotation which will include the activities listed below.

I. Clinical Activities
   a. Inpatient Palliative Care Consultation Rounds (Mon-Fri daily with one weekend call per month-either a Saturday or Sunday)
   b. VNS Hospice interdisciplinary team (IDT) at 8:30 AM on Thursdays at the VNS Hospice office, 4701 N. Keystone, 4th floor conference room. (Fellows are expected to attend one meeting during the month.)
   c. Visit to Abbie Hunt Bryce Hospice Home, which is around the corner from the VNS office. (Fellows will visit this home to see 1-3 continuity patients after the VNS IDT meeting.)
   d. Home visits (Fellows will be assigned to make home visits with one of the faculty physicians for a half a day each week. Notify attending ahead of

time if there are specific patients you have seen in the hospital who you wish to see at home.)

e. Monthly Wishard Ethics committee meeting chaired by Dr. Meg Gaffney (First Monday of each month, Room T 2012)
f. Optional: Attend and help precept Introduction to Clinical Medicine: Patient-Doctor Relationship, Special Section on Palliative Care for MS1 on Thursday afternoon from 1-4 PM (August to April).

II. Routine Didactics (other relevant sessions may be added to calendar as available)
    a. Weekly Palliative Care Fellowship Noon Conference & Didactics (Tuesdays at Noon in the Rose Room next to the Palliative Care Office Rm. U2001)
    b. Palliative Care Internal Medicine Morning Report (First Friday of each month, morning report room, Myers 4th floor)
    c. Resident Presentation: Residents will select a palliative care topic of interest to briefly present to the team during the last week of the rotation. The presentation need not be lengthy (ten minutes is sufficient) and PowerPoint is entirely optional.
    d. Department of Medicine Grand Rounds (Fridays at Noon in Myers Auditorium)
    e. Schwartz Rounds: Oncology Psychosocial Grand Rounds (Typically Last Friday or each Month, IU Cancer Center RT 101)
    f. Fellows are expected to attend all other relevant educational sessions during the month such as Oncology Journal Club (IUSCC), Hospice/Palliative Care Grand Rounds (Pettigrew Auditorium), and Geriatric Academic Half-Day sessions or Wednesday morning conferences.
    g. Routine Residency Didactics-i.e. 15-20 minutes on the following topics
        i. Pain Management
        ii. Hospice Medicare Benefit
        iii. Non-pain symptom management
        iv. Communication
        v. Ethics/Advance Directives/Goals of Care

Logistics of the Rotation:

I. Inpatient Rounds:

a. Description of the consultation service: The daily census of the service is typically 15-20 patients including 2-3 new consults per day with significant variability (some days with zero consults and we've had a few rare days when we've received requests for as many as 10 consults). Our service is constructed to attempt to deal with this variability (bearing in mind that many of our consults are time-intensive) and to provide continuity of care to patients and families. Thus, the inpatient service is

divided into two "virtual" services ("A" and "B") to attempt to better meet the needs of patients and families through improved continuity of care.

i. "A" Physician: Designated attending physician spends two weeks seeing most of the new consults and following up on those consults.
ii. "B" Physician: Designated attending physician spends two weeks following-up on patients seen during the physician's two weeks on the "A" Service. The "B" physician will see new consults occasionally if the patient is well known to the physician or if consult volume dictates that backup of the "A" physician is necessary.
    1. The "B" Physician has other clinical responsibilities that may affect availability (Monday afternoon Palliative Care clinic, Wednesday morning Oncology Clinic, Thursday morning VNS IDT, teaching duties, and home visits)
iii. "C" physician: Focuses on outpatient, administrative, and other activities. Also serves as back-up to the "A" and "B" physician.
iv. Nurse, social worker, and chaplain will round with either the "A" or "B" physician depending on the week.

b. Resident participation in rounds (Monday-Friday)
    i. 7:30-7:45 AM: Report to Mary Smith-Healy's office (6 North, Room W 6132 and her phone number is 630-6357, pager 310-6094) to learn of any new consults or urgent patient updates.
    ii. 7:30-9:00 AM: Pre-Round on new consult and any urgent follow-ups (as time permits)
    iii. 9:00 AM: Meet in Mary's office with attending physician and interdisciplinary team for brief meeting to review patient list.
    iv. 9:15 AM- Noon: Formal Rounds. Typically, the resident will do walk rounds with the "A" physician and report to the "B" physician if there are patients the resident has seen with that physician. We will let you know if there are any deviations from this schedule.
    v. Afternoons: See new consults obtained during morning and attend to urgent follow-up issues.
c. Family Meetings: While not every patient will need a family meeting, this is a fairly routine service we provide. If you schedule a family meeting, please notify the attending physician on the consult service, other members of the interdisciplinary team, and invite members of the primary team as well as key co-consultants. Please be mindful of the primary team's call schedule when scheduling meetings (although occasionally, family is only available at a time when the primary team is unavailable).
d. Expectation of Patient Volume and Rounding Responsibilities for Fellows
    i. As fellows accumulate consults, you are generally expected to follow 6-10 patients at a time and participate in 1-2 new consults per day.

ii. When consult volume is high, residents should "triage" which follow-ups are most urgent based on review of the chart, discussion with primary team, and discussion with palliative care team members. While not every patient needs to be seen every day, it is rare that we will formally "sign-off" on a patient's case.

e. Documentation of Patient Visits
    i. Initial Consult: We have a Gopher template that fellows are expected to use. In order to access the template, go to user preferences and change options for "patient list" and "preferred specialty" to "PALLIATIVE.CARE". Thereafter, the template will be an option for you when you write a note in Gopher.
    ii. Follow-up visits: No template. Write SOAP note.

VA Palliative Care Program
Orientation and Educational Goals for Palliative Care Fellows

Faculty:

Marian McNamara, M.D.
Erin Newton, M.D.
Gregory P. Gramelspacher, M.D.
Samantha Outcalt, PhD Palliative Care Clinical Psychologist
Rachelle Fuetter, R.N., Palliative Care Inpatient Nurse
Andrea Wooley, R.N., Palliative Care Outpatient Nurse
Bonnie Morrow, MSW Palliative Care Social Worker
Rev. William Overby or other Palliative Care Chaplain
Lisa Dovey, Palliative Care Nutritionist

Educational Goals (Competency Based):

VI. Patient Care and Medical Knowledge
- a. Core Knowledge – By completion of the rotation, residents should
  - i. Understand indications and eligibility guidelines for hospice care.
  - ii. Recognize and understand the dying process
  - iii. Describe assessment methods and treatments for common physical symptoms of advanced disease – pain, dyspnea, nausea, vomiting, constipation, diarrhea, delirium, and anorexia.
  - iv. Describe assessment and treatment of psychiatric symptoms associated with advanced disease - depression, anxiety, delirium, dementia and PTSD in veterans
  - v. Describe and recognize common pain syndromes - bony metastases, plexopathies, peripheral neuropathies, epidural metastases/spinal cord compression, bowel obstruction, and muscle spasms.
  - vi. Understand the indications, limitations, side effects, and technical aspects of pain management including:
    1. The WHO Analgesia Ladder
    2. NSAIDS and steroids
    3. Opioids, including dosage titration, conversion between routes of administration, conversion between opioids, and management of side effects and toxicity
    4. Adjuvant drugs (e.g. anticonvulsants, antidepressants, antineoplastic therapies)
    5. Interventional techniques (e.g. neurolytic plexus blocks, intrathecal pumps)
  - vii. Understand appropriate use of nonpharmacologic pain treatment modalities
    1. Physical (e.g. cutaneous stimulation – massage, TENS, acupuncture)

2. Psychosocial (e.g. relaxation and imagery, mindfulness techniques, distraction and reframing, patient education, psychotherapy and structured support, hypnosis, peer support groups, pastoral counseling)

viii. Develop prognostication skills (both disease specific and non-specific)

b. History, Physical Examination, and Medical Management
   i. Write a consultation note focusing on palliative care needs, including relevant psychosocial needs and goal setting.
   ii. Perform an accurate assessment, initial and ongoing, of pain, using appropriate techniques to assess the adequacy of pain management, including patient and family satisfaction.
   iii. Construct an appropriate care plan for management of other symptoms

VII. Interpersonal and Communication Skills
   a. Establish rapport with dying patients and their families or surrogates, using patient centered communication.
   b. Adapt history-taking skills to the mental status, demeanor, and psychosocial presentation of the patient and family.
   c. Engage patients and their families or advocates in shared decision-making regarding treatment options in the end of life setting, using family meetings as needed.
   d. Effectively and considerately communicate with palliative care and hospice team staff in a manner that promotes care coordination.
   e. Communicate with referring physicians in a manner that supports the primary care relationship.

VIII. Professionalism
   a. Understand and compassionately respond to issues of culture, age, sex, sexual orientation, and disability for all dying patients and their families.
   b. Appreciate the effects of cultural and religious background on a patient's approach to decision making, to their disease, and to treatment.
   c. Recognize the importance of psychological and spiritual support for patients and their families during the dying process.
   d. Reflect awareness of common ethical issues facing patients, their families and caregivers related to end of life care.
   e. Sensitively respond to patient and family questions and decisions regarding advanced directives, DNR status, futility, and withholding/withdrawing therapy.

IX. Practice-Based Learning and Improvement
   a. Exhibit self-directed learning through patient-centered learning and independent use of recommended resources.

b. Use information technology to access and retrieve materials for self-education.
c. Utilize clinical practice guidelines and current literature to generate appropriate palliative care plans.
d. Develop a brief didactic session for presentation to the interdisciplinary team near the end of the rotation for the purpose of expanding knowledge and practicing presentation skills

X. Systems-Based Practice
   a. Demonstrate understanding of a spectrum of palliative care delivery systems, including hospital based palliative care teams and hospice.
   b. Develop awareness of how hospice services are provided in various settings, including home, nursing home, and hospital.
   c. Participate within multidisciplinary care, including hospice nurses, chaplains, social workers and other providers in team settings.
   d. Develop understanding the appropriate use and limitations of various advance directives, including:
      i. Indiana Living Will Declaration Form
      ii. Indiana Durable Power of Attorney and Health Care Representative Forms
      iii. Indiana Out of Hospital DNR Form
   e. Provide cost effective care, cognizant of the limitations of hospice funding.

Routine Educational Activities: An individualized schedule will be provided to you at the start of your rotation which will include the activities listed below.

III. Clinical Activities

Inpatient Palliative Care Consultation Rounds (Mon-Fri daily, One weekend call per 4 week rotation

IV. Routine Didactics (other relevant sessions may be added to calendar as available)

a. Weekly Palliative Care Fellowship Noon Conference & Didactics (Tuesdays at Noon at Wishard Hospital, WOP, M200 in the Rose Room next to the Palliative Care Office Rm. U2001)
b. Fellow Presentation: Fellows will select a palliative care topic of interest to briefly present to the team during the last week of the rotation. The presentation need not be lengthy (ten minutes is sufficient) and PowerPoint is entirely optional.
c. Department of Medicine Grand Rounds (Fridays at Noon via telecast in 8th floor conference room).
d. Schwartz Rounds: Oncology Psychosocial Grand Rounds (Typically Last Friday or each Month, IU Cancer Center RT 101)

Logistics of the Rotation:

II. Inpatient Rounds:

i. Description of the consultation service: The daily census of the service is typically 10-15 patients including 2-3 new consults per day with significant variability (some days with zero consults and we've had a few rare days when we've received requests for as many as 10 consults). Our service is constructed to attempt to deal with this variability (bearing in mind that many of our consults are time-intensive) and to provide continuity of care to patients and families. An attempt is made to select consultations for Fellow participation which will provide a maximal learning opportunity and variety.

b. participation in rounds (Monday-Friday)
   i. 8:00 to 8:30 AM: Report to Marian McNamara, MD Office C 7036
   ii. 8:30-9:30 AM: Round on patients on service with Palliative Care RN and Social Worker
c. 10:00 AM-3:00PM: See new consults obtained during morning and attend to urgent follow-up issues.
d. Family Meetings: While not every patient will need a family meeting, this is a fairly routine service we provide. If you schedule a family meeting, please notify the attending physician on the consult service, other members of the interdisciplinary team, and invite members of the primary team as well as key co-consultants. Please be mindful of the primary team's call schedule when scheduling meetings (although occasionally, family is only available at a time when the primary team is unavailable).
e. Expectation of Patient Volume and Rounding Responsibilities for Fellows
   i. As Fellows accumulate consults, you are generally expected to follow 5-6 patients at a time and participate in 1-2 new consults per day.
   ii. When consult volume is high, Fellows should "triage" which follow-ups are most urgent based on review of the chart, discussion with primary team, and discussion with palliative care team members. While not every patient needs to be seen every day, it is rare that we will formally "sign-off" on a patient's case.
f. Documentation of Patient Visits
   i. Initial Consult: We have a VA Template that all fellows, residents and staff are expected to use
   ii. Follow-up visits: No template but you can construct your own or simply write a SOAP note.

AMBULATORY PALLIATIVE CARE CLINICS

Palliative Medicine Fellowship Longitudinal Experience: Ambulatory Palliative Care Clinics

Locations:

Regenstrief Center for Senior Health
1050 Wishard Blvd.
Indianapolis , IN 46202

Faculty:

Palliative Care Clinic-Center for Senior Health, Regenstrief Health Center-4th floor

Gregory Gramelspacher, M.D.
Lyle Fettig, M.D.
Rafael Rosario, M.D.
Mary Smith-Healy, RN
Judith Hetzel, MSW, LSW – Social Worker
Karen Estle, MA, – Chaplain and Spiritual Advisor

Palliative Care Clinic-Roudebush VA Medical Center-2nd floor

Marian McNamara, M.D.

Wishard Oncology Clinic-Regenstrief Health Center-2nd floor

Lyle Fettig, M.D.
Rafael Rosario, M.D.
Gregory Gramelspacher, M.D.
Romnee Clark, M.D.
Joyce Loyal, R.N.

Time Requirement: 12 Months, every other week when at Wishard or during Oncology elective.

Educational Goals (Competency Based):

I. Patient and Family Care
   a. Improve abilities to perform comprehensive assessment of patients with chronic and terminal illness, including physical, cognitive, functional, social, psychological, and spiritual domains.

b. Improve ability to evaluate suffering and quality of life.
c. Understand the role of the palliative care physician as primary care clinician
d. Appreciate the importance of continuity of care for patients with serious illness

II. Medical Knowledge
a. Enhance pharmacological knowledge of medicines commonly used for the treatment of symptoms.
b. Enhance knowledge of non-pharmacologic modalities used to treat symptoms.
c. Learn role of palliative chemotherapy for patients with incurable cancer.
d. Examine barriers to effective chronic pain management
e. Improve prognostication skills, including refinement of prognosis longitudinally as patient's course evolves

III. Interpersonal and Communication Skills
a. Improve the ability to address advance directive issues in patients who are chronically or terminally ill but not acutely ill or actively dying.
b. Improve communication skills with patients, families, and professional colleagues.
c. Present verbal history and physical information to the clinic attending in a concise and organized manner

IV. Professionalism
a. Demonstrate respect towards patients/ family and colleagues
b. Describe effective strategies for responding to emotions

V. Practice-Based Learning and Improvement
a. Demonstrate knowledge of best practices in prescribing opioids on a chronic basis

VI. Systems Based Practice
a. Improve ability to function as a consultant in outpatient setting.
b. Learn how to make a timely referral to hospice from an ambulatory setting.
c. Learn criteria for admission from ambulatory setting.
d. Collaborate with multidisciplinary specialists to provide appropriate palliative care
e. Understand outpatient billing and coding

Routine Educational Activities/Logistics:

1. Fellow will attend one-half day clinic every other Monday afternoon at the Center for Senior Health and every Wednesday morning in the Oncology Special Medicine Clinic at the Regenstrief Health Center during Wishard rotations or when on Oncology consult rotation. When fellows are at the VA Hospital, they

will attend the Palliative Medicine Clinic every Thursday afternoon unless they have urgent inpatient consultations.

2. Fellow will evaluate 1-2 new patients each clinic session under supervision of faculty listed above. This group of patients will include both referrals for assumption of primary care and requests for consultation from a variety of specialties.
3. Fellow will see 2-3 follow-up patients each session.
4. Fellow will be responsible for documenting each patient encounter in the electronic medical record system. At Wishard, fellows may type notes in the Medical Gopher EMR or dictate notes by calling 686-7286 (select Clinic 96 for palliative care then option 40 if it is a new evaluation, 41 for re-evaluation).
5. Fellow will be responsible for completing a billing sheet and proper coding.
6. Fellow will communicate results of encounter with referring physician in a timely fashion.

Evaluation:

Fellows will receive a semiannual written evaluation by each medical director and two other individuals from each interdisciplinary team. The evaluation will focus on the six competencies required of the fellow, including patient care, medical knowledge, practice-based learning, communication skills, professionalism, and system-based practice. Written evaluations will be sent to the program director.

Fellows will evaluate the experience on a semiannual basis. This will include a written evaluation as well as a review with the program director.

ELECTIVE ROTATIONS

Fellows will have four to five elective rotations during their twelve month fellowship. Electives will be planned based on the fellow's individual goals and learning objectives.

Listing of Electives:

A. Anesthesia Pain Service

1. Location: Indiana University Hospital
2. Time requirements: Two to four weeks
3. Faculty: Dr. Joshua Wellington
4. Goals:
    a) Improve skills in pharmacologic treatment of chronic pain
    b) Learn indications for common anesthetic procedures
    c) Enhance office anesthetic techniques
    d) Improve physical exam skills related to chronic pain
5. Activities:
    a) Participate in anesthesia pain clinic
    b) Observe/participate in operating procedures, including common block procedures and intrathecal/epidural pump placements
6. Elective might also be done at St. Vincent Hospital, St. Francis Hospital or the VA. Must arrange this with the program director.

B. Radiation Oncology

1. Location: Indiana University Simon Cancer Center (or VA Hospital)
2. Faculty: Mark Langer, M.D. (IUSCC) or Helen Fosmire, M.D. (VA)
3. Time Requirements: Two to four weeks
4. Goals:
    a) Learn common indication of palliative radiation
    b) Increase awareness of patient experience
    c) Learn common adverse effects of radiation and the palliation of those effects
    d) Enhance consultative skills
5. Activities:
    a) Participate in physician evaluation of patients actively undergoing radiation therapy. Fellow will spend time with various radiation oncology services.
    b) Follow two to three patients on a daily basis who are actively undergoing radiation therapy
    c) Participate in inpatient radiation oncology consultation
    d) Participate in physician follow-up visits
    e) Attend radiation oncology didactic conferences

C. Interventional Radiology

1. Location: Indiana University Hospital or Wishard Hospital
2. Faculty: Drs. Matthew Johnson (UH) or Himanshu Shah (Wishard)
3. Time Requirements: One to two weeks, may be combined with anesthesia pain rotation or other short rotation.
4. Goals:
    a) Learn indications and adverse effects for common radiologic palliative procedures, including biliary stents, vertebroplasty, kyphoplasty, percutaneous gastrostomy/jejunostomy, etc.
    b) Increase awareness of palliative medicine amongst non-internal medicine specialties and enhance communication
5. Activities:
    a) Observe above procedures
    b) Review cases with interventional radiology team

D. Ethics, including ethics consultation (February only)

1. Location: Wishard Hospital
2. Faculty: Dr. Margaret Gaffney, Course Director and other faculty including Drs. Gramelspacher and Fettig.
3. Time Requirement: Month of February, approximately 4 hours/day.

Objectives:

1. To broaden fellows' understanding of major bioethical theories, principles and problem-solving approaches
2. To help fellows develop skills in applied ethics in common medical settings
3. To review major trends in legal ethics as related to medicine
4. To practice ethical dilemma resolution and the consultation process
5. To explore ethical issues through literature and film
6. To examine major ethical issues in various healthcare arenas, including research, genetics, end of life, pediatrics, public health, psychiatry and emergency medicine
7. To foster appropriate self awareness and self care
8. To appreciate conscience-sensitive ethics teaching and practice
9. To closely examine ethical and professional values in medicine
10. To prepare fellows to serve on hospital ethics committees

E. Oncology Rotation (Erin Newton, M.D.)—VA

Obtain curricular goals and objectives from Rakesh Mehta or Dr. Erin Newton. Also, see notes from 10/20/10 meeting with Noah Hahn and Marian McNamara at the VA.

OUTPATIENT HEMATOLOGY/ONCOLOGY CURRICULUM

Welcome to your oncology rotation at Indiana University. You are receiving this curriculum if you have chosen this outpatient Hematology/Oncology elective.

During your 2 or 3 week long rotation with us, we do not expect you to become an expert, but would like you to become familiar with several topics while on your rotation. Your learning will come in different ways: 1) Seeing patients with Attending staff and Fellows 2) Literature searches and reading articles relevant to your cases 3) Reading literature provided to you and also on Angel 4) on-line lectures and other learning materials on Angel and 5) attending conferences.

Optional conferences you may wish to attend:

1. Monday: Oncology Fellow Case Conference, RT 425, 5-6pm (except 2nd Monday of each month).
2. Monday (2nd of each month): Oncology Journal Club, RT 101, 5-6pm
3. Friday: Hematology/Oncology Grand Rounds, RT 101, 7:30-8:30am
4. Friday: Hematology/Oncology Lecture series, RT 425, 1:15-2:15pm

You are expected to be proficient in the different competencies listed below. We are glad to have you with us and look forward to your participation.

PATIENT CARE

Fellows must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Fellows are expected to:

a) communicate effectively and demonstrate caring and respectful behaviors when - interacting with patients and their families
b) gather essential and accurate information about patients
c) understand how informed decisions about diagnostic and therapeutic interventions are made based on patient information and preferences, up-to-date scientific evidence, and clinical judgment
d) understand hoe patient management plans are established and carried out
e) assist in counseling and educating patients and their families
f) use information technology to support patient care decisions and patient education
g) provide health care services aimed at preventing health problems or maintaining health
h) work with health care professionals, including those from other disciplines, to provide patient-focused care

MEDICAL KNOWLEDGE

Fellows must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Fellows are expected to:

a) demonstrate an investigatory and analytic thinking approach to clinical situations
b) know and apply the basic and clinically supportive sciences which are appropriate to oncology.

We hope that you to will be exposed to most of the following specific topics during your rotation:

The Principles of Chemotherapy
Bladder cancer
Breast cancer
Cervical cancer
CNS cancer
Colon cancer
Endometrial cancer
Esophageal cancer
Germ cell cancer
Head/Neck cancer
Liver cancer
Lung cancer
Melanoma
Ovarian cancer
Pancreatic cancer
Prostate cancer
Renal cancer
Sarcoma
Supportive care oncology
Thymoma
Thyroid cancer
Hematologic malignancies (leukemia, multiple myeloma, and lymphoma)

PRACTICE-BASED LEARNING AND IMPROVEMENT

Fellows must be able to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Fellows are expected to:

a) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems
b) obtain and use information about their own population of patients and the larger population from which their patients are drawn
c) apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness

d) use information technology to manage information, access on-line medical information; and support their own education
e) facilitate the learning of students and other health care professionals

INTERPERSONAL AND COMMUNICATION SKILLS

Fellows must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Fellows are expected to:

a) create and sustain a therapeutic and ethically sound relationship with patients
b) use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills
c) work effectively with others as a member of a health care team

PROFESSIONALISM

Fellows must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Fellows are expected to:

a) demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development
b) demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices
c) demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities

SYSTEMS-BASED PRACTICE

Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Fellows are expected to:

a) understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice
b) know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources
c) practice cost-effective health care and resource allocation that does not compromise quality of care
d) advocate for quality patient care and assist patients in dealing with system complexities

e) know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance

ASSESSMENT METHODS

You will be expected to present 1 journal article to your team in a critical manner and will need to demonstrate that proficiency to your attending.

You are also expected to present at least one case discussion to your Attending and/or Fellow during the rotation.

You will be evaluated on the 6 key competencies above.

You will also be asked to complete an evaluation form at the end of the rotation. We take this very seriously as we are constantly striving to improve your educational experience.

SUPERVISION

You will be directly supervised by the Hematology/Oncology attending physician as well as the Hematology-Oncology Fellow if applicable.

If you have any questions about the rotations, you may contact me directly:

Erin Newton, MD
evnewton@iupui.edu
Phone 317-948-5980
Pager 312-1982

Revised December 23, 2011

F. Geriatrics/Acute Care for Elders Inpatient Consultation Service

Background: Overview and Goals of Rotation

Acute Care for the Elderly, or "ACE," is a model of care established in the mid-1990s to target frail hospitalized elderly adults. It utilizes at its core an interdisciplinary team specialized in providing care for this vulnerable population in our society. There are very few ACE units and ACE consult teams in existence, partly a reflection of the shortage of geriatric providers across the nation, but the idea is definitely catching on in many hospitals. The organization of the interdisciplinary team and actual team members may vary from hospital to hospital depending on available resources and hospital structure, but the overall goals are the same – to prevent functional decline in the elderly during acute hospitalization, and improve the transition from the hospital to the site of post-acute

care, be it the patient's home or some form of rehabilitation unit. The ACE team at Wishard is comprised of a geriatrician, a geriatric nurse practitioner, a registered nurse-case manager, a social worker, a geriatric pharmacist, a physical or occupational therapist, and just as importantly – YOU!

One of the unique aspects of the ACE team at Wishard is that once we perform an initial consultation on a patient, in most cases we will actually take over the case management of that patient, and coordinate every aspect of their disposition from that moment until they are discharged from the hospital. Moreover, we are conducting post-discharge phone call surveys and have developed new protocols that enable us to follow up on ACE patients for even weeks after they are discharged to hopefully improve care at the hospital to home transition. This is both a very innovative as well as exciting role for us to play in the ever-growing concern with problems in transitional care across our healthcare system in the United States – and a potential role for you to get involved if you have any interest in designing your own research project during your post-graduate training.

Wishard, Methodist, and VA Hospitals Acute Care for Elders Rotations

	Competencies					
Learning Objectives At the end of this rotation, the fellow will be able to do the following:	Patient Care	Medical Knowledge	Practice Based Learning	Interpersonal Communicatio	Professionalis	Systems Based Practice
Describe the presentation, differential diagnosis, etiology, work up and common management strategies for older adults who have delirium	X	X				
Describe a minimum of three iatrogenic complications with strategies to prevent them (including deconditioning, adverse drug reactions and pressure ulcers)	X	X	X			
Describe alternative to restraint use	X	X	X			
List community resources that would be helpful for older adults discharged from the inpatient setting	X			X		X
Describe patients who are appropriate for institutional long term care placement and describe community-based alternatives to institutional long term care	X		X			X
Describe common atypical presentations of disease in the older patient	X	X				
Describe key principles of pain management in older inpatients	X	X				
Demonstrate respect for the role of each interdisciplinary team member				X	X	X
Assess older adults' cognitive and psychosocial status, gaining awareness about their decision-making capacity	X			X		

Evaluate older adults who have common geriatric syndromes (dementia, depression, immobility, pressure sores, incontinence, sleep disorders, failure to thrive, osteoporosis, elder mistreatment, and drug-induced illness)	X	X				
Participate in resident and medical student teaching				X	X	

Educational Techniques
The fellow will work closely with the geriatrician as well as the ACE interdisciplinary team. The faculty will provide one-on-one teaching and supervision of case-based learning. The fellow will participate in teaching rotating residents in specific geriatrics topics.

Assigned Readings
Palmer, Robert M., Steven R. Counsell, and Seth C. Landefeld. Acute Care for Elders Units: Practical Considerations for Optimizing Health Outcomes. Dis Manage Health Outcomes 2003; 11(8).

Evaluations
- Faculty evaluation
- 360 Degree Evaluation

Your goals on this rotation include:

1. Gain an appreciation of the functional problems an elderly patient faces during hospitalization
2. Understand how a patient's baseline comorbidities and function can affect their care and outcomes during hospitalization
3. Learn the primary geriatric functional syndromes, including: difficulty walking and falling, cognitive impairment and dementia, delirium, depression, polypharmacy, constipation, urinary incontinence, and development of pressure ulcers
4. Learn to incorporate advance care planning and discussing advance directives as part of the evaluation of EVERY hospitalized elder
5. Gain an understanding and appreciation of the roles of geriatric interdisciplinary team members, how that team functions as an integrated unit, when to consult that team, and the geriatrician's role on that team.
6. Develop an understanding and proficiency with performing comprehensive inpatient geriatric assessment that includes generating a complete problem list with appropriately focused recommendations for the primary team
7. Enhance your proficiency with communicating with your colleagues when you are functioning as a specialist inpatient consultant

8. The **palliative medicine fellow** has the additional goals of learning to coordinate and direct palliative medicine interventions for the elderly hospitalized patient. This includes initiating a post-discharge palliative care plan.

G. Pediatric Palliative Care (St. Vincent)

H. IU-Kenya Elective in International Hospice and Palliative Care (in resource constrained setting).

Curriculum for the IU-Kenya Partnership
Goals and Objectives for IU Palliative Medicine Rotation in Kenya

Faculty:

Gregory P. Gramelspacher, MD
Juli McGowan, NP

Educational Goals (Competency Based):

I. Patient and Family Care
   a. Appreciate the influence of Kenyan culture in health and illness as well as contrast the Kenyan perspective with the perspective of the learner's own culture.

II. Medical Knowledge
   a. Grow knowledge and proficiency in history and physical examination skills of palliative care patients in a setting where advanced laboratory and radiologic diagnostic technology is often not available.
   b. Gain knowledge related to the diagnosis and management of HIV/AIDS, as well as associated complications.

III. Interpersonal and Communication Skills
   a. Demonstrate effective cross-cultural communication skills, knowledge, and attitudes.
   b. Develop a rudimentary ability to speak Kiswahili.
   c. Develop collegial relationships with Kenyan health care professionals and students
   d. Improve bedside teaching skills as well as ability to develop presentations

IV. Professionalism
   a. Dress in a culturally appropriate manner e.g., men will usually wear shirts and ties and sport coats/white coats, women will wear dress slacks or dresses below the knee/white coats.
   b. Demonstrate respect for the Kenyan medical officer/intern who is the primary care physician responsible for the management of patients at the Moi Teaching and Referral Hospital.

V. Practice-Based Learning and Improvement
   a. Update ongoing needs assessment for hospice and palliative medicine services at MTRH, AMPATH and Moi University School of Medicine.

VI. Systems-Based Practice
   a. Understand the structure of medical care delivery and education in Kenya.

b. Reflect on differences and similarities in the American and Kenyan systems of health care delivery and education, especially as it relates to hospice and palliative care.
c. Understand governmental restrictions and other factors which limit the availability of opioids in Kenya.
d. Understand barriers to implementation of palliative care in Kenya

Preparation/Brief Tips

- Participate in orientation program prior to traveling to Kenya.
- Avoid traveling after dark or in unsafe vehicles.
- Take all recommended immunizations and malaria prophylaxis
- Purchase or ensure the ownership of evacuation insurance prior to departure.
- While on elective in Kenya, Fellows should travel in Indiana University vehicles. Travel in non-university vehicles to destinations outside Eldoret may be done only with authorization from the Medical Liaison. While on vacation in Kenya, Fellows will travel at their discretion.

Routine Educational Activities

I. Clinical Activities
   a. Participate in consultation for Oncology, Palliative Care or Hospice patients Monday through Friday mornings.
   b. Evaluate, manage, and participate in the care of patients admitted to the Medicine or Pediatrics service on the wards of the Moi Teaching and Referral Hospital as a Palliative Medicine consultant.
   c. Participate in relevant inpatient teaching rounds.
   d. Evaluate, manage, and participate in the care of patients presenting to the relevant Ambulatory clinics at the Moi Teaching and Referral Hospital (i.e. Oncology and HIV/AIDS).
   e. Meet daily with Dr. Gramelspacher when he is in Eldoret and then meet with him (via phone call) at least weekly during the time he is not in Eldoret.
   f. As available, meet with on-site faculty such as the Team Leader, Director of Pharmacy, Directors of Research and others to review and discuss progress, perspectives, and insights.
   g. Participate in the delivery of Palliative Care services at rural health center in Kipkaren, Kenya with Juli McGowan, NP

II. Didactics/Other
   a. Participate in relevant conferences and seminars.
   b. Engage in self-directed learning. A significant portion of evening hours Monday through Friday should be dedicated to self-directed learning.
   c. Each fellow will participate in the teaching of Kenyan students and residents in clinical venues.

d. Lead or facilitate teaching sessions/discussions concerning palliative care patients and issues in Kenya. This may include school or department Grand Rounds on Palliative Care services.
e. **S**ubmit a written report at the end of the rotation (i.e. updated needs assessment). Discuss with Dr. Gramelspacher the dissemination of lessons learned/needs assessment.

Evaluation:

Fellows will receive a written evaluation at the end of the rotation by the medical director and other members of the interdisciplinary team. Each discipline will meet with the fellow to discuss this evaluation. The evaluation will focus on the six competencies required of the fellow, including patient care, medical knowledge, practice-based learning, communication skills, professionalism, and system-based practice. Written evaluations will be sent to the program director. Fellows will evaluate the rotation at the end of each one-month rotation. This will include a written evaluation.