



SCOPE OF PRACTICE

Hospice & Palliative Medicine
Director of Program: Howard Tuch, MD
USF Health Morsani College of Medicine
University of South Florida

This document pertains to PGY-4 rotations under the auspices of the Hospice & Palliative Medicine at James A. Haley VA, Moffitt Cancer Center & Tampa General Hospital. All Accreditation Council of Graduate Medical Education (ACGME), Joint Commission (JC), Agency for Health Care Administration (AHCA), and CMS guidelines pertaining to graduate medical education apply to this scope of practice.

The purpose of this policy is to ensure that residents are provided adequate and appropriate levels of supervision during the course of the educational training experience and to ensure that patient care continues to be delivered in a safe manner. The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident is assigned by the program director and faculty members to ensure effective oversight of resident supervision.

Each resident must know the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence. Residents are responsible for asking for help from the supervising physician if uncertain of diagnosis, how to perform a diagnostic or therapeutic procedure, or how to implement an appropriate plan of care. Supervision may be provided by more senior residents in addition to attendings. However, all patient care must be provided under a credentialed and privileged attending physician. The attending physician is ultimately responsible for management of the individual patients and the supervision of the residents involved in the care of the patient. Supervision must be documented in the medical record in accordance with the Hospice & Palliative Medicine Program at the University of South Florida compliance guidelines.

The program follows the ACGME classification of supervision as noted below. The supervising physician can refer to a faculty, fellow, or resident that who has been given supervisory privilege. These supervisory levels are used throughout the Scope of Practice document.

Direct Supervision The supervising physician is physically present with the resident and patient.

Indirect Supervision

1) With Direct Supervision Immediately Available – The supervising physician is physically within the hospital or other site of patient care and is immediately available to provide direct supervision.

2) With Direct Supervision Available – The supervising physician is not physically present within the hospital or other site of patient care but is immediately available by means of telephonic and/or electronic modalities and is available to provide direct supervision.

Oversight The supervising physician is available to provide review of procedures/encounters with feedback after care is delivered.

The residency program has a curriculum for providing knowledge and performance competence that includes: *No procedures are required, except that fellows must see at least 100 new patients over the course of the program and follow at least 10 patients longitudinally across the settings. The fellows long-term care experience comprises of a minimum of one month or 100 hours, and provide access to meaning care of patients on either a consultation team or hospice or palliative care unit. Additionally, there should be a pediatric rotation for minimum of one week at the pediatric hospice and palliative medicine site under the direction of a board certified palliative medicine pediatrician, child/adolescent neurologist, and/or child adolescent psychiatrist will be Supervised by the hospice and palliative medicine program director or designee.* Annual decisions about competence are made by the program's clinical competency committee to ensure a successful transition and preparation for the next PGY level. All residents need to maintain current ACLS training.

	Supervising Physician present (Direct)	Supervising Physician in hospital and available for consultation (Indirect but direct supervision immediately available)	Supervising Physician out of hospital but available by phone or can come in (Indirect but direct supervision available)	The trainee may perform the procedure without supervising Attending/resident (oversight)		
Designated Levels	1	2	3	4		
CORE PROCEDURES					PGY-4	PGY-5
The fellow must serve both as a primary care provider and a palliative medicine consultant					2	2
The fellow must have experience in functioning as a member of an interdisciplinary team. Members of the interdisciplinary team must include a physician, a nurse, a social worker and a psychosocial clinician (such as a psychologist), and a chaplain or pastoral counselor.					2	2
Supervised clinical experience in bereavement counseling shall be documented.					2	2
SEDATION					PGY-4	PGY-5
Local anesthesia					NA	NA

The subspecialty of Hospice and Palliative Medicine represents the medical component of the broad therapeutic model known as palliative care. These subspecialists reduce the burden of life-threatening conditions by supporting the best quality of life throughout the course of an illness, and by managing factors that contribute to the suffering of the patient and the patient's family. Palliative care addresses physical, psychological, social, and spiritual needs of patients and their families, and provides assistance with medical decision-making.

“Palliative care” is the comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients (of all ages) and their families with serious and/or life-threatening illness. Palliative care may be complementary to curative or life-prolonging therapies that are being used to meet patient-defined goals of care.

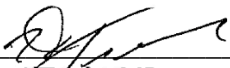
A. The palliative care team will work to:

- Optimize symptom control
- Optimize functional status when appropriate
- Promote the highest quality of life for patient and family
- Educate patients and family to promote understanding of the underlying disease process and expected future course of the illness
- Establish an environment that is comforting and healing
- Plan for discharge to the appropriate level of care in a timely manner
- Assist actively dying patients and their families in preparing for and managing life closure
- Serve as educators and mentors for staff
- Promote a system of care that fosters timely access to palliative care services

B. The process of providing palliative care services includes:

- Understanding epidemiology, natural history, and treatment options for patients with serious illness and life-limiting medical conditions.
- History of the development of the discipline of hospice and palliative medicine.
- Performance of age-appropriate comprehensive palliative medicine assessment including physical exam, cognitive, functional, social, psychological, and spiritual domains using history, examination, and relevant laboratory evaluation.
- Understanding of the physician's role and contribution to the function and development of the interdisciplinary team in the practice of palliative medicine.
- Management of common co-morbidities, including neuro-psychiatric problems, in patients with life-limiting illnesses.
- Management of palliative medicine symptoms including pain and other forms of physical distress utilizing pharmacologic and non-pharmacologic modalities with an emphasis on the role of osteopathic manipulative medicine for symptom relief. An understanding of the pharmacodynamics of approved agents and relevant use of invasive procedures is essential.
- Recognition of forms of suffering other than physical complaints, including spiritual and existential suffering. Management should include patient and family education, psychosocial and spiritual support, and referrals for other modalities.
- Management of palliative medicine emergencies including but not limited to spinal cord compression and suicidal ideation.
- Recognition of the role of the family for psychosocial and spiritual support for palliative medicine patients.
- Management of grief, bereavement and knowledge of the role of the interdisciplinary team in providing support to bereaved family members.
- Assessment and management of patients in community settings such as the home, assisted living centers, inpatient hospice or respite care and extended care facilities.
- Care of the dying patient including managing terminal symptoms, patient/family education, bereavement, and organ donation. m. Ethical aspects of hospice and palliative medicine.

- Competency in the cultural aspects of palliative medicine including geographic location, ethnicity, religious belief, and socioeconomic status.
 - Development of enhanced communication skills including professional discussion of diagnosis, interaction with patients, families and colleagues. Clear communication of treatment plan and prognosis as well as providing continued professional assistance and guidance are required.
 - Scholarship including familiarity with research methodologies enabling interpretation of the medical literature relevant to end of life care.
 - Skills in quality improvement methodologies applicable to end of life care.
- C. Initial and subsequent assessments are carried out through patient and family interviews, review of medical records, discussion with other providers, physical examination, and review of laboratory, diagnostic tests and procedures. Assessment includes documentation of:
- Disease status/treatment history
 - Functional status and expected prognosis
 - Co morbid medical and psychiatric disorders
 - Physical, psychological and spiritual symptoms and concerns
 - Advance care planning preferences/surrogate decision maker(s)
 - All initial and ongoing assessments data are reviewed on a regular basis. Assessment findings are the basis for the care planning process.
 - Reassessment is performed as needed by the clinical situation.



Howard Tuch, MD
Program Director, Hospice & Palliative Medicine

11-8-18
Date