Palliative Care Consult Service - KU
Internal Medicine Residency Program at University of Kansas Medical Center
Adapted from ABIM Developmental Milestones

PGY1 – standard text
PGY2 – standard and italicized text
PGY3 – standard, italicized and bold italicized text

Director(s): Lindy Landzaat, D.O., Lori Olson, M.D.
Contacts:
   KU –
   KC Hospice and Palliative Care –
Administrative Coordinators:
   KU – Allison Nutter, anutter@kumc.edu
   KC Hospice and Palliative Care – Cathy Peterson, cpeterson@kchospice.org

Duration: 3 week block
Supervision: Attending Responsible for the Palliative Care or Hospice Service
Facility:
   • University of Kansas Medical Center
   • Kansas City Hospice and Palliative Care

Required Didactics:
1. Core and Case Conferences - Monday, Tuesday, Thursday, and Friday at 12:00 PM
   • Location Varies Daily
2. Grand Rounds – Wednesday at 12:00 PM
   • School of Nursing Auditorium
3. Patient Safety Conference – Every Other Month - Sep, Nov, Jan, Mar, May at 12:00 PM
   • Clendening Auditorium
4. Clinicopathologic Conference – Quarterly - Sep, Dec, Mar, Jun at 12:00 PM
   • Clendening Auditorium

Educational Purpose:
The palliative medicine rotation offers residents a unique opportunity to learn pain and symptom management and end of life care in the context of a trans-disciplinary team. Through participation in team meetings, direct patient care, and time spent with our large community based hospice partner, residents will gain valuable experience which is designed to provide a foundation for competency in the care of patients who are approaching end of life. The rotation provides important growth opportunities in the areas of professionalism and interpersonal communication, as well as medical knowledge, patient care, and systems based practice. The rotation consists of time spent on the Palliative Care Inpatient Consultation service at KU as well as a week of interaction at Kansas City Hospice and Palliative Care, at the inpatient hospice unit (Hospice House) and doing home visits if desired.

Educational Methods:
Direct observation of patient care and bedside teaching occur in the setting of inpatient hospital consults at KU and KC Hospice House rounds with the attending. Residents evaluate and treat patients both in the capacity of follow-up as well as initial consultation or evaluation. The supervising attending reviews and critiques the resident’s interpretation of diagnostic studies and formulation of assessments and plans. Residents additionally attend a number of didactic conferences as indicated above. Residents participate in interdisciplinary patient management conference at both facilities. At the palliative care interdisciplinary conference on the last Wednesday of the month, the resident is expected to present/lead a brief discussion on an article of his/her choosing. The article topic should be drawn from the experience during the month.
(ideas might be a symptom management issue, a prognosis article, something about culture in EOL care, spiritual issues, etc). The discussion is meant to be low key but evidence based.

Recommended educational resources for this rotation include the following:

1. Computers with internet access to KU Med’s on line Dyke’s library, with a multitude of online journals is available at all computer terminals in the hospital.
2. UpToDate is recommended as a concise peer-reviewed source for on-the-spot information and is available on computers in the hospital bearing the icon.
3. UNIPAC series (short books covering core topics in Palliative Care) available for check out from Dr. Porter-Williamson’s office
4. Angel learning network Palliative Care Repository for articles and self study modules
5. Hospice & Palliative Medicine Core Competencies can be found at: http://www.acgme.org/outcome/implement/HPM_Competencies_Ver_2_1.pdf

Rotating Residents:

How You Fit in Here:
You are temporarily a member of our trans-disciplinary team- that means that you will sometimes function in the physician role, sometimes in a nursing role, sometimes in a social work role, and sometimes in a chaplaincy role. All of these roles are equally valuable and the superior resident will attempt to learn and excel in each of them. The other members of the team are your mentors and teachers- Please respect them as such for the wealth of information and experience they bring to the care of the team’s patients and families. I know I personally learn from them every day.

Logistics of Service operation (KU):

1. On the first day of your rotation you will meet with the team at 0900 outside the palliative care rooms on unit 42, where we will divide the patient list and do a quick care plan huddle. Subsequent days you should come to work and get some follow ups seen prior to going to morning report so that you can be ready to start rounding after the huddle on 42 (come after morning report). Your patient assignments will focus on the patients with active symptoms/goals issues and will attempt to maintain patient continuity as long as there continues to be good learning from the case. As well, we try to have residents see all of the new consults, as the most meaningful learning happens up front with getting the palliative plan into place.

2. On the first day of your rotation please contact Cathy Peterson at KCHPC to verify which week you are to be at hospice. We have already scheduled this week to be most logical in relation to any vacation time. Most residents have a 5 day experience, some have 3 if scheduling demands this. The hospice is located at 12000 Wornall, south off of I-435 by a few miles.

3. Documentation: There are Palliative Care template notes which are located in your smart lists, shared with you when you sign on to O2 and pick XDD-Palliative Care. The assessment and plan is a little different than for other services, as it is in a “whole person” framework. There are 4 sections: 1. physical symptoms listed individually with the planned intervention, 2. psychosocial needs/plan-goals of care issues go here, 3. spiritual issues/plan, and 4. practical aspects of illness/plan- disposition goes here. Other documentation notes of importance- Don’t delete smart lists as then the links do not carry forward. Please make sure that all elements of the note are completed, including the family history (reviewed noncontributory or no family history on file are not acceptable) and 8 exam elements on every patient. You will learn more about this when you are an attending, trust me, if they are just present a world of hurt goes away.

4. Call expectations: Most residents rotating on KU Consults will have 1 weekend of rounding, with availability to see new consults placed 4 pm or prior, and with no pager expectation from home at night. On your weekend please discuss who will need to be seen with the attending on call and plan to round/get notes completed on your patients in the am, with rounds time decided between you and your attending.
Logistics of Service Operation, (KCHPC)

1. Arrive at the Kansas City Hospice House (12000 Wornall Road, Kansas City MO) at 8:30 AM. Ask the receptionist to page the physician who will be working with you. You will be assigned some follow up patients and will see new admissions during the week. On the first day, you will shadow the attending physician for some visits to learn the Hospice House setup, and will have a tour and introduction to inpatient hospice care. There are two attending physicians at the Hospice House; you will see some patients with each of them.

2. On subsequent days, you will see your patients and document your findings in the chart prior to making rounds with the attending physicians. During your rounds, you should be prepared to speak with family members about their concerns and questions, as well as to assess the patient for medical issues, medication usage, etc. Your plan of care should include patient interventions and family needs for support.

3. As patients are admitted during the week, you will be assigned to do the initial assessment on some patients, who will also be seen by the attendings.

4. On Wednesday morning, you will attend the Hospice House interdisciplinary team meeting, when all the patients are reviewed by the various disciplines involved in their care.

5. On Friday, we will attempt to arrange home visits for at least a half-day with a physician who sees hospice patients at home or in long term care facilities.

KU Consult Weekly Schedule

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<th>DAY</th>
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<tr>
<td>Monday</td>
<td>Consult rounds</td>
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<td>Wednesday</td>
<td>Palliative Care IDT Meeting 9-10 am 5003 KU hospital 4th Wednesday= journal club, see below</td>
<td>Consult rounds</td>
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<td>Thursday</td>
<td>Didactic lecture series 0800-1000, Hospice House</td>
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<td>Friday</td>
<td>Consult rounds</td>
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Hospice Weekly Schedule

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<td>Hospice home visits</td>
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## KU Palliative Care Consult Rotation Overall Goals and Objectives

### Overall Competency Progression by Core Competency and PGY Level

(Adapted from ABIM Developmental Milestones)

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<thead>
<tr>
<th>PGY Level</th>
<th>Goal</th>
<th>Objectives</th>
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</table>
| 1         | History and Data Gathering | a. Acquire accurate and relevant history from the patient in an efficiently customized, prioritized, and hypothesis driven fashion  
b. Seek and obtain appropriate, verified, and prioritized data from secondary sources (e.g. family, records, pharmacy)  
c. Obtain relevant historical subtleties that inform and prioritize both differential diagnoses and diagnostic plans, including sensitive, complicated, and detailed information that may not often be volunteered by the patient  
d. Role model gathering subtle and reliable information from the patient for junior members of the healthcare team when applicable |
| 2         | Performing a Physical Examination | a. Perform an accurate physical examination that is appropriately targeted to the patient's complaints and medical conditions. Identify pertinent abnormalities using common maneuvers  
b. Accurately track important changes in the physical examination over time in the outpatient and inpatient settings  
c. Demonstrate and teach how to elicit important physical findings for junior members of the healthcare team  
d. Routinely identify subtle or unusual physical findings that may influence clinical decision making, using advanced maneuvers where applicable |
| 3         | Clinical Reasoning | a. Synthesize all available data, including interview, physical examination, and preliminary laboratory data, to define each patient's central clinical problem  
b. Develop prioritized differential diagnoses, evidence-based diagnostic and therapeutic plan for common inpatient and ambulatory conditions  
c. Modify differential diagnosis and care plan based upon clinical course and data as appropriate  
d. Recognize disease presentations that deviate from common patterns and that require complex decision making |
| 1         | Invasive Procedures | a. Awareness of indications, contraindications, risks and benefits of common invasive procedures |
### PGY LEVEL GOAL Diagnostic Tests

**OBJECTIVES**

| 1 | a. Make appropriate clinical decisions based upon the results of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids |
| 2 | b. Make appropriate clinical decision based upon the results of more advanced diagnostic tests |

### PGY LEVEL GOAL Patient Co-Management

**OBJECTIVES**

| 1 | a. Recognize situations with a need for urgent or emergent medical care including life threatening conditions |
| 2 | b. Recognize when to seek additional guidance |
| 2 | c. Provide appropriate preventive care and teach patient regarding self-care |
| 2 | d. With supervision, manage patients with common clinical disorders seen in the practice of inpatient and ambulatory internal medicine |
| 2 | e. With minimal supervision, manage patients with common and complex clinical disorders seen in the practice of inpatient and ambulatory internal medicine |
| 3 | f. Initiate management and stabilize patients with emergent medical conditions |
| 3 | g. Manage patients with conditions that require intensive care |
| 3 | h. Independently manage patients with a broad spectrum of clinical disorders seen in the practice of internal medicine |
| 3 | i. Manage complex or rare medical conditions |
| 3 | j. Customize care in the context of the patient’s preferences and overall health |

### PGY LEVEL GOAL: Consultative Care

**OBJECTIVES**

| 2 | a. Provide specific, responsive consultation to other services |
| 3 | b. Provide consultation for patients with more complex clinical problems requiring detailed risk assessment |

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**Evaluation Methods**

Faculty evaluation, Mini CEX, Direct Observation

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**CORE COMPETENCY: MEDICAL KNOWLEDGE**

| PGY LEVEL | GOAL | Core Content Knowledge |
**OBJECTIVES**

1. Understand the relevant pathophysiology and basic science for common medical conditions that prompt consultation
2. Demonstrate sufficient knowledge to diagnose and treat common conditions that prompt consultation
3. Demonstrate sufficient knowledge to evaluate common conditions that prompt consultation
4. Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions
5. Demonstrate sufficient knowledge to provide preventive care
6. Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care
7. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions
8. Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions
9. Demonstrate sufficient knowledge of socio-behavioral sciences including but not limited to health care economics, medical ethics, and medical education

**PGY LEVEL**

**GOAL** Diagnostic Tests

**OBJECTIVES**

1. Understand indications for and basic interpretation of common diagnostic testing, including but not limited to routine blood chemistries, hematologic studies, coagulation tests, arterial blood gases, ECG, chest radiographs, pulmonary function tests, urinalysis and other body fluids
2. Understand indications for and has basic skills in interpreting more advanced diagnostic tests
3. Understand prior probability and test performance characteristics

**Evaluation Methods**

Faculty evaluation, ITE, Case Conference evaluation, Direct Observation

**CORE COMPETENCY: PRACTICEBASED LEARNING AND IMPROVEMENT**

**PGY LEVEL**

**GOAL** Ask Answerable Questions for Emerging Information Needs

**OBJECTIVES**

1. Identify learning needs (clinical questions) as they emerge in patient care activities
2. Classify and precisely articulate clinical questions
3. Develop a system to track, pursue, and reflect on clinical questions

**PGY LEVEL**

**GOAL** Acquires the Best Advice

**OBJECTIVES**

1. Access medical information resources to answer clinical questions and library resources to support decision making
2. Effectively and efficiently search NLM database for original clinical research articles
3. Effectively and efficiently search evidence-based summary medical information resources
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<td>3d.</td>
<td>Appraise the quality of medical information resources and select among them based on the characteristics of the clinical question.</td>
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**PGY LEVEL**
Appraises the Evidence for Validity and Usefulness

**OBJECTIVES**

- **PGY LEVEL 1**
  - **a.** With assistance, appraise study design, conduct and statistical analysis in clinical research papers
  - **b.** With assistance, appraise clinical guideline recommendations for bias
  - **c.** With assistance, appraise study design, conduct, and statistical analysis in clinical research papers
  - **d.** Independently, appraise clinical guideline recommendations for bias and cost-benefit considerations

**PGY LEVEL**
Applies the evidence to decision-making for individual patients

**OBJECTIVES**

- **PGY LEVEL 1**
  - **a.** Determine if clinical evidence can be generalized to an individual patient
  - **b.** Customize clinical evidence for an individual patient
  - **c.** Communicate risks and benefits of alternatives to patients
  - **d.** Integrate clinical evidence, clinical context, and patient preferences into decision-making

**PGY LEVEL**
Improves Via Feedback

**OBJECTIVES**

- **PGY LEVEL 1**
  - **a.** Respond welcomingly and productively to feedback from all members of the health care team including faculty, peer residents, students, nurses, allied health workers, patients and their advocates
  - **b.** Actively seek feedback from all members of the health care team
  - **c.** Calibrate self-assessment with feedback and other external data
  - **d.** Reflect on feedback in developing plans for improvement

**PGY LEVEL**
Improves via self-assessment

**OBJECTIVES**

- **PGY LEVEL 2**
  - **a.** Maintain awareness of the situation in the moment and respond to meet situational needs
  - **b.** Reflect (in action) when surprised, applies new insights to future clinical scenarios, and reflects (on action) back on the process

**PGY LEVEL**
Participate in education of all members of the health care team

**OBJECTIVES**

- **PGY LEVEL 1**
  - **a.** Actively participate in teaching conferences
  - **b.** Integrate teaching, feedback, and evaluation with supervision of interns’ and students’ patient care
  - **c.** Take a leadership role in the education of all members of the health care team.
## Evaluation Methods

Faculty Evaluation, Patient Safety Conference evaluation, Case Conference evaluation

### CORE COMPETENCY: INTERPERSONAL & COMMUNICATION SKILLS

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| 1         | Communicate effectively | a. Provide timely and comprehensive verbal and written communication to patients/advocates and the primary team  
b. Effectively use verbal and non-verbal skills to create rapport with patients/families and the primary team  
c. Use communication skills to build a therapeutic relationship  
d. Engage patients/advocates in shared decision-making for uncomplicated diagnostic and therapeutic scenarios  
e. Engage patients/advocates in shared decision-making for difficult, ambiguous or controversial scenarios  
f. Appropriately counsel patients about the risks and benefits of tests and procedures highlighting cost awareness and resource allocation  
Role model effective communication skills in challenging situations |
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| 3         |         |  |

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| 1         | Intercultural sensitivity | a. Effectively use an interpreter to engage patients in the clinical setting including patient education  
b. Demonstrate sensitivity to differences in patients including but not limited to race, culture, gender, sexual orientation, socioeconomic status, literacy, and religious beliefs  
c. Actively seek to understand patient differences and views and reflects this in respectful communication and shared decision-making with the patient and the healthcare team |
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| 1         | Transitions of Care | a. Effectively communicate with other caregivers in order to maintain appropriate continuity during transitions of care  
b. Role model and teach effective communication with next caregivers during transitions of care |
| 2         |         |  |

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| 1         | Applies the evidence to decision-making for individual patients | a. Determine if clinical evidence can be generalized to an individual patient  
b. Customize clinical evidence for an individual patient  
c. Communicate risks and benefits of alternatives to patients  
Integrate clinical evidence, clinical context, and patient preferences into decision-making |
| 3         |         |  |

| PGY LEVEL | GOAL |  |
|-----------|------|  |

| 9 | REV 06/2019 |
### OBJECTIVES

| 1 | a. Deliver appropriate, succinct, hypothesis-driven oral presentations  
|   | b. Effectively communicate plan of care to all members of the health care team  
|   | **c. Engage in collaborative communication with all members of the health care team** |

#### PGY LEVEL GOAL Consultation

| 1 | a. Respond to consultation requests in an effective manner  
|   | b. Clearly communicate the role of consultant to the patient, in support of the primary care relationship  
|   | **c. Communicate consultative recommendations to the referring team in an effective manner** |

#### PGY LEVEL GOAL Health Records

| 1 | a. Provide legible, accurate, complete, and timely written communication that is congruent with medical standards  
|   | **b. Ensure succinct, relevant, and patient-specific written communication** |

### Evaluation Methods

Faculty Evaluation, 360 Evaluations, Patient Safety Conference Evaluation, Case Conference evaluation

### CORE COMPETENCY: PROFESSIONALISM

#### PGY LEVEL GOAL Adhere to basic ethical principles

| 1 | a. Document and report clinical information truthfully  
|   | b. Follow formal policies  
|   | c. Accept personal errors and honestly acknowledge them  
|   | **d. Uphold ethical expectations of research and scholarly activity** |

#### PGY LEVEL GOAL Demonstrate compassion and respect to patients

| 1 | a. Demonstrate empathy and compassion to all patients  
|   | b. Demonstrate a commitment to relieve pain and suffering  
|   | **c. Provide support (physical, psychological, social and spiritual) for dying patients and their families**  
|   | **d. Provide leadership for a team that respects patient dignity and autonomy** |

#### PGY LEVEL GOAL Provide timely, constructive feedback to colleagues
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11 REV 06/2019
a. Treat patients with dignity, civility and respect, regardless of race, culture, gender, ethnicity, age or socioeconomic status

b. Recognize and manage conflict when patient values differ from their own

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**PGY LEVEL**

**GOAL** Confidentiality

**OBJECTIVES**

1. a. Maintain patient confidentiality

2. b. Educate and hold others accountable for patient confidentiality

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**PGY LEVEL**

**GOAL** Recognize and address disparities in health care

**OBJECTIVES**

1. a. Recognize that disparities exist in health care among populations and that they may impact care of the patient

2. b. Embrace physicians’ role in assisting the public and policy makers in understanding and addressing causes of disparity in disease and suffering

3. c. Advocates for appropriate allocation of limited health care resources.

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**Evaluation Methods**

Faculty Evaluation, 360 Evaluations, EPA, Patient Safety Conference Evaluation, Case Conference Evaluation

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**CORE COMPETENCY: SYSTEMS BASED PRACTICE**

**PGY LEVEL**

**GOAL** Works effectively within multiple health delivery systems

**OBJECTIVES**

1. a. Understand unique roles and services provided by local health care delivery systems

2. b. Manage and coordinate care and care transitions across multiple delivery systems, including ambulatory, subacute, acute, rehabilitation, and skilled nursing.

3. c. Negotiate patient-centered care among multiple care providers.

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**PGY LEVEL**

**GOAL** Works effectively within an interprofessional team

**OBJECTIVES**

1. a. Appreciate roles of a variety of health care providers, including, but not limited to, consultants, therapists, nurses, home care workers, pharmacists, and social workers.

2. b. Work effectively as a member within the interprofessional team to ensure safe patient care.

3. c. Consider alternative solutions provided by other teammates
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| 1         | Recognizes system error and advocates for system improvement | a. Recognize health system forces that increase the risk for error including barriers to optimal patient care  
b. Identify, reflect upon, and learn from critical incidents such as near misses and preventable medical errors |
| 2         |  | c. Dialogue with care team members to identify risk for and prevention of medical error  
d. Understand mechanisms for analysis and correction of systems errors |
| 3         | e. Demonstrate ability to understand and engage in a system level quality improvement intervention.  
f. Partner with other healthcare professionals to identify, propose improvement opportunities within the system. |
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| 1         | Identify forces that impact the cost of health care and advocates for cost-effective care | a. Reflect awareness of common socio-economic barriers that impact patient care.  
b. Understand how cost-benefit analysis is applied to patient care (i.e. via principles of screening tests and the development of clinical guidelines) |
| 2         |  | c. Identify the role of various health care stakeholders including providers, suppliers, financiers, purchasers and consumers and their varied impact on the cost of and access to health care.  
d. Understand coding and reimbursement principles |
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| 1         | Practices cost-effective care | a. Identify costs for common diagnostic or therapeutic tests  
b. Minimize unnecessary care including tests, procedures, therapies and ambulatory or hospital encounters |
| 2         |  | c. Demonstrate the incorporation of cost-awareness principles into standard clinical judgments and decision-making |
| 3         | d. Demonstrate the incorporation of cost-awareness principles into complex clinical scenarios |

**Evaluation Methods**

Faculty Evaluation
**KU PALLIATIVE CARE CONSULTS**  
**ROTATION SPECIFIC GOALS and OBJECTIVES**

**ADDITIONAL COMPETENCY EXPECTATIONS SPECIFIC TO GENERAL IM CONSULTS ROTATION**

**CORE COMPETENCY: PATIENT CARE**

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<th>PGY LEVEL</th>
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<tr>
<td>1</td>
<td>c. Awareness of indications, contraindications, risks and benefits of common invasive procedures</td>
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<tr>
<td>2</td>
<td>d. Appropriately perform invasive procedures and provide post-procedure management for common procedures when applicable</td>
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**Evaluation Methods**

Faculty evaluation, EPA, Direct Observation

**CORE COMPETENCY: MEDICAL KNOWLEDGE**

**GOAL**  Develop Core Content Knowledge for medical conditions that prompt consultation including but not limited to:

1. Buchman’s 6 Step Process for sharing bad news
2. Dying Process  
   a. Education and Support of Loved Ones  
   b. Understanding of the Stages of the Dying Process  
   c. Recognition of Physical Signs of Stages of Dying Process  
3. Ethics surrounding decisions to limit or remove artificial life support
4. Goals of Care Conversation/Negotiation Elements
5. Grief Reactions
6. Medicare Hospice Benefit
7. Non-Pain Symptoms in End of Life Care  
   a. Constipation  
   b. Delirium  
   c. Depression  
   d. Dyspnea  
   e. Nausea/Vomiting  
8. Pain Symptoms in End of Life Care
9. Prognostic factors associated with illness progression
10. Resources/Venues for Palliative Care Services
### Evaluation Methods

Faculty evaluation, ITE, Case Conference evaluation, Direct Observation

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### PGY LEVEL | OBJECTIVES
--- | ---
**PGY1** | a. Understand the relevant pathophysiology and basic science for common medical conditions that prompt consultation  
b. Demonstrate sufficient knowledge to diagnose and treat common conditions that prompt consultation  
c. Demonstrate sufficient knowledge to evaluate common conditions that prompt consultation  
d. Demonstrate sufficient knowledge to diagnose and treat undifferentiated and emergent conditions  
e. Demonstrate sufficient knowledge to provide preventive care  
f. Demonstrate sufficient knowledge to identify and treat medical conditions that require intensive care

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### PGY2 | OBJECTIVES
--- | ---
g. Demonstrate sufficient knowledge to evaluate complex or rare medical conditions and multiple coexistent conditions  
h. Understand the relevant pathophysiology and basic science for uncommon or complex medical conditions  
i. Demonstrate sufficient knowledge of socio-behavioral sciences including but not limited to health care economics, medical ethics, and medical education

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### PGY3 | OBJECTIVES
--- | ---
a. Actively participate in teaching conferences

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### CORE COMPETENCY: PRACTICEBASED LEARNING AND IMPROVEMENT

**GOAL** Participate in education of all members of the health care team

**Required Didactics:**
1. **Core and Case Conferences** - Monday, Tuesday, Thursday, and Friday at 12:00 PM  
   - Location Varies Daily  
2. **Grand Rounds** – Wednesday at 12:00 PM  
   - School of Nursing Auditorium  
3. **Patient Safety Conference** – Every Other Month - Sep, Nov, Jan, Mar, May at 12:00 PM  
   - Clendening Auditorium  
4. **Clinicopathologic Conference** – Quarterly - Sep, Dec, Mar, Jun at 12:00 PM  
   - Clendening Auditorium
GMEC Resident Supervision

A. Supervision of Residents
   - Each patient must have an identifiable, appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by each Review Committee) who is responsible and accountable for that patient’s care.
   - This information must be available to residents, faculty members, other members of the health care team, and patients.
     - Inpatient: Patient information sheet included in the admission packet and listed on the “white board” in each patient room
     - Outpatient: Provided during introduction verbally by residents and/or faculty
   - Residents and faculty members must inform patients of their respective roles in each patient’s care when providing direct patient care.
   - The program must demonstrate that the appropriate level of supervision is in place for all residents who care for patients.

B. Methods of Supervision.
   - Supervision may be exercised through a variety of methods.
   - For many aspects of patient care, the supervising physician may be a more advanced resident or fellow.
   - Other portions of care provided by the resident can be adequately supervised by the immediate availability of the supervising faculty member, fellow or senior resident physician, and either on site or by means of telephonic and/or electronic modalities. Some activities require the physical presence of the supervising faculty member. In some circumstances, supervision may include post-hoc review of resident delivered care with feedback.
   - The program must demonstrate that the appropriate level of supervision in in place for all residents is based on each resident’s level of training and ability, as well as patient complexity and acuity.
   - Supervision may be exercised through a variety of methods, as appropriate to the situation.
   - The Review Committee may specify which activities require different levels of supervision.

C. Levels of Supervision Defined
To promote oversight of resident supervision while providing for graded authority and responsibility, the program must use the following classification of supervision:

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

**Indirect Supervision A (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.

**Indirect Supervision B (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 provided after care is delivered.

The privilege of progressive authority and responsibility, conditional independence, and as supervisory role in patient care delegated to each resident must be assigned by the program director and faculty members.

<table>
<thead>
<tr>
<th>RRC APPROVED LICENSED INDEPENDENT PRACTITIONER SUPERVISOR and this information must be available to the residents, faculty members, other members of the health care team and patients. (PR VI.A.2.a (1))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient's care.</td>
</tr>
<tr>
<td>Information regarding licensure for attending physicians is available via a publicly available database: <a href="http://docfinder.docboard.org/ks/df/kssearch.htm">http://docfinder.docboard.org/ks/df/kssearch.htm</a></td>
</tr>
<tr>
<td>Licensure data on resident physicians is kept up to date in the University of Kansas Health System GME Office.</td>
</tr>
<tr>
<td>VI.A.2.a). (1).(b.)Inform each patient of their respective roles in patient care, when providing direct patient care.</td>
</tr>
<tr>
<td>This information must be available to residents, faculty members, other members of the health care team, and patients.</td>
</tr>
<tr>
<td>Inpatient: Patient information sheet included in the admission packet and listed on the “white board” in each patient room. Provided during introduction verbally by residents and/or faculty.</td>
</tr>
<tr>
<td>Outpatient: Communicated to patient at time of appointing scheduling. Provided during introduction verbally by residents and/or faculty.</td>
</tr>
<tr>
<td>PGY – 1 residents must be supervised either directly or indirectly with direct supervision immediately available. Conditions and the achieved competencies under which a PGY -1 resident progresses to be supervised indirectly with direct supervision available: (PR VI.A.2.e.(1).(a))</td>
</tr>
</tbody>
</table>
Guidelines for circumstances and events in which residents must communicate with their supervising faculty member are delineated in the Housestaff Manual and in the rotational goals and objectives. PGY-1 residents are supervised, either directly or indirectly with direct supervision immediately available on site, by PGY-2 or PGY-3 residents or staff members on all rotations, including night float, at all training sites. During daytime inpatient, consult, and outpatient rotations, supervision is direct and occurs by an attending physician as well as a senior resident. On night float rotation at KU Hospital, a senior resident and a hospitalist faculty attending are present on location to immediately provide direct supervision. On night float rotation at Kansas City VA Hospital, a senior resident is present on location to immediately provide direct supervision and a faculty attending is available by pager and is available to provide Direct Supervision. Residents are not responsible for nighttime coverage at the Leavenworth VA Hospital.

<table>
<thead>
<tr>
<th>The privilege of progressive authority and responsibility, conditional independence, and a supervisory role in patient care delegated to each resident must be assigned by the Program Director and faculty members. (PR VI.A,2,d, (1,2,3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The program has adapted the American Board of Internal Medicine’s Milestones of Competency to delineate our overall and rotational goals and objectives. Our evaluation system provides data on the ACGME reporting milestones. This data along with review of the resident’s portfolio of work allows the Program Director and faculty members to make determinations on a resident’s ability to gain progressive authority and responsibility. The program director must evaluate each resident’s abilities based on specific criteria, guided by the Milestones. Faculty members functioning as supervising physicians must delegate portions of care to residents based on the needs of the patient and the skills of each resident. Senior residents or fellows serve in a supervisory role to junior residents in recognition of their progress toward independence, based on the needs of each patient and the skills of the individual resident or fellow.</td>
</tr>
<tr>
<td>RARE CIRCUMSTANCES WHEN RESIDENTS may elect to stay or return to the clinical site : (PR VI.F)</td>
</tr>
<tr>
<td>In rare circumstances, after handing off all other responsibilities, a resident, on their own initiative, may elect to remain or return to the clinical site in the following circumstances: to continue to provide care to a single severely ill or unstable patient; to attend to humanistic attention to the needs of a patient or family; or, to attend unique educational events. The program monitors circumstances in which residents stay beyond scheduled periods of duty through the institutional work hours monitoring system in MedHub. The program leadership reviews the resident work hours report weekly, and residents are instructed to</td>
</tr>
</tbody>
</table>
enter a comment in their work hours report indicating the reason for their work hours violation. In addition, the chief residents contact all residents with reported work hours violations to inquire about the cause and impact of the violation. This data is reviewed and discussed during weekly program leadership meeting, and trends are carefully sought and addressed.

### DEFINED MAXIMUM NUMBER OF CONSECUTIVE WEEKS OF NIGHT FLOAT AND MAXIMUM NUMBER OF MONTHS PER YEAR OF IN-HOUSE NIGHT FLOAT (PR VI.F. 6.)

Maximum Frequency of In-House Night Float

Residents must not be scheduled for more than six consecutive nights of night float.

VI.G.7. Maximum In-House On-Call Frequency

PGY-2 residents and above must be scheduled for in-house call no more frequently than every-third-night (when averaged over a four week period).

VI.G.7.a) Internal Medicine residency programs must not average in-house call over a four-week period.

All call for the program occurs on a night float schedule except for Sunday night intern call on inpatient services, which is a 16-hour shift performed on a rotation about once to twice per month per intern.

### Program-specific guidelines for circumstances and events in which residents must communicate with appropriate supervising faculty (PR VI.A.2.e)

1. Admission to Hospital
2. Transfer of patient to a higher level of care
3. Clinical deterioration, especially if unexpected
4. End-of-life decisions
5. Change in code status
6. Red Events
7. Change in plan of care, unplanned emergent surgery or planned procedure that does not occur
8. Procedural complication
9. Unexpected patient death
# Red Event Definition

**Title:** Red Event Definition  
**Date:** 12/21/2016

<table>
<thead>
<tr>
<th>Departments who must adopt:</th>
<th>Operators who must adopt:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The University of Kansas Health System (TUKH)</td>
<td>All TUKH employees</td>
</tr>
</tbody>
</table>

**NOTE:** THIS IS A CONTROLLED DOCUMENT THAT SUPPORTS A SPECIFIC PROCESS

## Red Events - Death and Serious Injury and/or Near Miss

- Serious blood transfusion reaction
- Contaminated drug, device or biologic
- Equipment related injury
- Falls resulting in major injury
- Fire, flame, smoke or heat during patient care
- Electric shock or burn during patient care
- Infection: Patient to patient and/or visitor exposure
- Maternal/Perinatal
  - Unexpected peri-natal death
  - Unexpected infant death
  - Unexpected maternal death or serious disability
- Medication error with serious injury and/or death
- Elopement of patient lacking capacity, danger to self or others, or involuntarily admitted
- Radiation overdose
- Restraint or bedrail use causing death or serious injury
- Serious iatrogenic injury
- Unexpected deaths in ambulatory settings (excluding Emergency Department)

- Procedural and perioperative events
  - Procedure performed on wrong body part or wrong patient
  - Wrong procedure performed
  - Unexpected intraoperative/postoperative death
  - Death during elective surgery or procedure
  - Unintentionally retained foreign object
  - Wrong donor sperm or egg
- Security:
  - Disruptive behavior that causes harm or injury to patient or impedes patient care
  - Sexual assault or rape of a patient, visitor or employee
  - Infant discharged to the wrong family
  - Impersonation of a health care professional
  - Patient abduction
- Suicide/Homicide of patient, employee, visitor on health system premises campus
- Any defect that has the potential to cause harm across the health system
<table>
<thead>
<tr>
<th>LEVEL of SUPERVISION</th>
<th>ACTIVITIES /PROCEDURES (as defined by RRC &amp; Program)</th>
</tr>
</thead>
</table>
| DIRECT               | ACLS  
Arterial blood draw  
Arterial line  
Arthrocentesis  
Bone marrow aspiration  
Bone marrow biopsy  
Bronchoscopy  
Cardioversion  
Chest tube placement  
Intubation, elective  
Intubation, emergent  
Laryngeal mask airway  
Lumbar puncture  
Nasogastric tube placement  
Pap smear (until at least one performed)  
Paracentesis  
Thoracentesis  
Ultrasound for central line placement |
| INDIRECT A (with direct supervision immediately available) | Electrocardiogram interpretation (preliminary interpretation)  
Peripheral IV  
Radiology interpretation (preliminary interpretation)  
Venous blood draw |
<p>| INDIRECT B (with direct supervision available-as determined by program) | N/A |</p>
<table>
<thead>
<tr>
<th>LEVEL of SUPERVISION</th>
<th>ACTIVITIES /PROCEDURES (as defined by RRC &amp; Program)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIRECT</td>
<td>Bone marrow aspiration</td>
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<tr>
<td></td>
<td>Bone marrow biopsy</td>
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<td></td>
<td>Bronchoscopy</td>
</tr>
<tr>
<td></td>
<td>Cardioversion</td>
</tr>
<tr>
<td></td>
<td>Chest tube placement</td>
</tr>
<tr>
<td></td>
<td>Intubation, elective</td>
</tr>
<tr>
<td></td>
<td>Intubation, emergent</td>
</tr>
<tr>
<td></td>
<td>Laryngeal mask airway</td>
</tr>
<tr>
<td>INDIRECT A (with direct supervision</td>
<td>ACLS</td>
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<tr>
<td>immediately available)</td>
<td>Electrocardiogram interpretation</td>
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<tr>
<td></td>
<td>Incision and drainage of an abscess</td>
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<tr>
<td></td>
<td>Nasogastric tube placement</td>
</tr>
<tr>
<td></td>
<td>Pap smear</td>
</tr>
<tr>
<td></td>
<td>Periphereal IV</td>
</tr>
<tr>
<td></td>
<td>Radiology interpretation</td>
</tr>
<tr>
<td></td>
<td>Venous blood draw</td>
</tr>
</tbody>
</table>

Each of the procedures below can be performed with Indirect supervision with direct supervision immediately available provided that quantitative and qualitative assessment metrics have been met AND that procedural certification supervision requirements have been updated in Medhub by the program director:

Arterial blood draw
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Approval Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arterial line placement</td>
<td>N/A</td>
</tr>
<tr>
<td>Arthrocentesis</td>
<td>N/A</td>
</tr>
<tr>
<td>Central venous line placement</td>
<td>N/A</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>N/A</td>
</tr>
<tr>
<td>Paracentesis</td>
<td>N/A</td>
</tr>
<tr>
<td>Thoracentesis</td>
<td>N/A</td>
</tr>
<tr>
<td>Ultrasound for central line placement</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**INDIRECT B (with direct supervision available)**: N/A

**OVERSIGHT (with direct supervision available)**: N/A