The Coleman Palliative Medicine Training Program

Sean O’Mahony MD
Stacie Levine MD
Objectives

1. Review history of palliative care (PC)
2. Describe palliative care and its components
3. Discuss healthcare imperatives and how PC helps
4. Describe growth of PC and workforce shortage
5. Discuss benefits of the Coleman Palliative Medicine Training Program for Interdisciplinary Providers
All of hospice is palliative care, but not all of palliative care is hospice.
Palliative Care, Why?

#1 Reason
Medical Progress...

...has changed the way we live
...has changed the way we are sick
...has changed the way we die
Current State of Care for Seriously Ill Patients and their Families

• High degree of unmanaged or under-managed symptoms in patients with chronic and/or debilitating illnesses
• Poor to non-existent communication regarding patient goals of care
• Lack of coordination with patient and family preferences-need for advanced care planning
Symptom Prevalence Last Year of Life

http://painconsortium.nih.gov/
Self-Reported Symptom Experience of Critically Ill Cancer Patients Receiving Intensive Care


![Symptom Experience Graph]

- Discomfort: 75%
- Thirst: 71%
- Sleeping: 68%
- Anxiety: 63%
- Pain: 56%
- Hunger: 55%
- Depression: 39%
- SOB: 34%

Percent of patients with symptoms at moderate or severe level.
The Reality of Advance Directives

• 50% of terminally ill patients have advance directives in their medical records
• 29% of patients change their minds about life-sustaining treatment over time
• 30% of surrogates incorrectly interpret their loved ones' written instructions
• 64% of dying patients' living wills do not cover the clinical realities they face
• 78% of patients with life-threatening illnesses prefer to leave decisions about resuscitation to their physicians and families

What do Seriously Ill Patients Want?

- Appropriate treatment of pain and other symptoms
- Achieve a sense of control
- Communication regarding their care
- Coordinated care throughout the course of illness
- Avoid inappropriate prolongation of the dying process
- Relieve burdens on family
- Strengthen relationships with loved ones
- Sense of safety in the healthy care system
What Do Family Caregivers Want?

Study of 475 family members 1-2 years after bereavement

- Loved one’s wishes honored
- Inclusion in decision processes
- Support/assistance at home
- Practical help (transportation, medicines, equipment)
- Personal care needs (bathing, feeding, toileting)
- Honest information
- 24/7 access
- To be listened to
- Privacy
- To be remembered and contacted after the death

Tolle et al. Oregon report card. 1999 www.ohsu.edu/ethics
Why Healthcare Delivery Needs to Improve

• Chronically ill, aging population is growing
  - The 63% of Medicare patients with 2 or more chronic conditions account for 95% of Medicare spending (CDC)

  - The number of people over age 85 will double to 9 million by the year 2030 (CDC)

  - Nursing home population expected to double from 1.5 million to 3 million by 2030

  - >25% of Americans will die in NH
The Cost of Cancer Care

The growing cost of cancer care

Patients, taxpayers and insurers increasingly are struggling with the cost of care for many diseases. Cancer treatment in particular has outpaced other diseases. New drugs often cost $100,000 a year and typically buy a few more months or years of life – not a cure.

The cost of treating cancer in the U.S. continues to escalate. Breast cancer is the single biggest contributor.

Insurers and Medicare pay most of the cost of cancer in the U.S. (2008 data)

How one group of patients coped with the cost of medication or treatment:

In a study of about 250 cancer patients, all but one had insurance, two-thirds were covered by Medicare, 83 percent also had prescription drug coverage, yet out-of-pocket expenses averaged $712 a month for copays, medicine, lost wages and travel.

Enrolled in a medication copay assistance program
Spent less on food and clothes
Borrowed money or used credit to pay for medicines
Did not fill a prescription
Took less than the prescribed amount
Sold property or possessions
Did not have a recommended procedure
Missed a chemotherapy or clinic appointment.

Sources: SEER-Medicare data, Agency for Healthcare Research and Quality; Dr. Amy Abernethy, Duke University; National Cancer Institute; AP
Inpatient Hospital Spending per Capita

Adjusted for Differences in Cost of Living

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Spending per Capita</th>
</tr>
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<tbody>
<tr>
<td>United States</td>
<td></td>
<td>$1,636</td>
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<td>France</td>
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<td>OECD Median</td>
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<tr>
<td>Japan</td>
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Source: The Commonwealth Fund, calculated from OECD Health Data 2006.
National Health expenditures US 2000-2013

2000-2007 Average = 7.6%

2008-2013 Average = 4.0%

2013 National Health Expenditures = $2.9 trillion (17.4% of GDP)

Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary
# International Health Care Systems Overall Rankings 2013

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<th>COUNTRY RANKINGS</th>
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Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

Source: Commonwealth Fund, *Mirror, Mirror on the Wall*, June 2014
Our Health Care System has incented the wrong outcomes

- volume, not value
- silos, not integration
- episodic care, not preventive care
- institutional care, not community-based care
- specialty care, not primary care
- utilization management, not care management
Health Care Expenditure Growth will continue to drive deficits

Source  September 2014
Patient Protection and Affordable Care Act March 23 2010
Performance Based Purchasing
Expected to Accomplish 3 Aims

Current Fee-for-Service Payment System

• Care is fragmented instead of coordinated.
• Each provider is paid for doing work in isolation.
• No one is responsible for coordinating care.
• Quality can suffer, and costs rise.

Patient-Centered Global Payment System

• Performance-based payments made to a group of providers for all care.
• Providers are put at risk for the amount and cost of services provided.
• The performance-based payment is expected to produce efficiencies and more coordinated care.
Performance Related Value Cuts

**Readmissions** – up to 3% cut to hospitals with higher than expected 30-day readmission rates for 5 measures – heart failure, heart attack, pneumonia, chronic obstructive pulmonary disease (COPD), and hip/knee arthroplasty

**Value Based Purchasing (VBP)** – up to 2% cut to hospitals based on 33 measures: 12 process (20%), 8 patient satisfaction (30%), 12 mortality (30%), and one Medicare spending per beneficiary (20%)

**Hospital Acquired Conditions (HACs)** – 1% cut to hospitals in bottom quartile of HAC rates for 10 measures

**Health Information Technology (HIT)** – price cuts for hospitals and doctors failing to achieve “meaningful use”
Accountable Care Organization

“An organized network of health care providers

- that provides, or arranges
- a full, coordinated continuum of services
- to a defined population;
- and is willing to be held fiscally and clinically accountable
- for the health status and costs of caring for the population served.”
The Good News: Palliative Care Can Help
Old vs New Approach

Old

Life Prolonging Care

Disease Progression

Life Prolonging Care

Palliative Care

Hospice Care

Bereavement

Diagnosis of serious illness

Death

New

Medicare Hospice Benefit
Factors that are Promoting Hospital Based Palliative Care

- Demographic shift
- Shift to accountable care: avoidance of hospital readmissions, HCAHPS scores
- Cost avoidance and enhanced operational efficiencies
- Ranking of hospitals based on utilization of hospice and demonstration of provision of palliative care (V66.7 code) by payers and CMS
Palliative Care Benefits to Hospitals

- Improved patient and family satisfaction
- Improved quality of care for patients and their families
- Meets the needs of an aging population
- Assists in compliance with hospital care quality (Joint Commission)
- Transition of patient to appropriate level of care—often reducing length of stay, especially in the ICU
- Decreased hospital costs and resource utilization
- Improved staff satisfaction and retention
Palliative Care Improves Quality

Data demonstrate that palliative care:

- Relieves pain and distressing symptoms
- Supports on-going re-evaluations of goals of care and difficult decision-making
- Improves quality of life, satisfaction for patients and their families
- Eases burden on providers and caregivers
- Helps patients complete life prolonging treatments
- Improves transition management

Palliative Care Is Cost-Saving,

Supports transitions to more appropriate care settings

- Palliative care lowers costs (for hospitals and payers) by reducing hospital and ICU length of stay, and direct (such as pharmacy) costs.
- Palliative care improves continuity between settings and increases hospice/homecare/nursing home referral by supporting appropriate transition management.

Palliative Care Benefit to Ambulatory Setting:
“Concurrent Care”

- “Early Palliative Care of Patients with Metastatic Non-Small-Cell Lung Cancer” Temel, J, NEJM 363;8
- 151 patients with new diagnosis metastatic NSC Lung Cancer
- Randomized to Onc Care OR Onc Care + Palliative Care
Hospital palliative care is associated with significant hospital cost savings.

Researchers found:

- For palliative care patients who were discharged alive, there was a savings of $1,696 in direct costs per admission and $279 in direct costs per day.

- For palliative care patients who died in the hospital, there was a savings of $4,908 in direct costs per admission and $374 in direct costs per day.

Source: Cost Savings Associated with U.S. Hospital Palliative Care Consultation Programs, R. Sean Morrison, Joan D. Penrod, J. Brian Cassel, Melissa Caust-Ellenbogen, Ann Litke, Lynn Spragens, Diane E. Meier, for the Palliative Care Leadership Centers' Outcomes Group, *Arch Intern Med.* 2008;168(16):1783-1790
Growth in number of palliative medicine teams in U.S. hospitals

Growth of Palliative Care

Source: 2002 to 2012 American Hospital Association Annual Hospital Surveys for FY 2000 to 2010; and data from the Center to Advance Palliative Care’s (CAPC) National Palliative Care Registry.

Growth of palliative care has occurred primarily in response to the increasing number of Americans living with serious and chronic illnesses and to the caregiving realities faced by their families.
But...

- Number of palliative care programs, specialists not sufficient to meet patient need
- Only approximately 200 Physicians get ACGME fellowships each year.
- Very few advanced training programs for APNs, SWs or Chaplains in palliative care
- In absence of comprehensive palliative care programs and PC specialists, physicians need basic PC clinical skills
Team based care

• A prerequisite for coordinated care across the continuum that addresses psychosocial and spiritual well being of patients and families
• Essential to ameliorate the financial impact on patients and families of chronic illnesses
• 2013 IOM report emphasized the need to include chaplains and social workers into the care of people living with serious life threatening illnesses
• Very few programs exist for advanced training for social workers and chaplains
Palliative Care and Hospice Education and Training Act

- **Academic Career Awards**: aimed at junior faculty in academic medical centers who will spend a majority of their funded time teaching and developing skills in interdisciplinary education in palliative care.

- **Palliative Care and Hospice Education Centers**: are aimed at improving the training of interdisciplinary health professionals in palliative care.

- **Career Incentive Awards**: funding for advanced practice nurses, clinical social workers, pharmacists, students of psychology who are pursuing a doctorate or other advanced degrees in palliative care or related fields in an accredited health professions school.
Workforce Shortage & Its Impact

- Shortage of physician specialists in PM
- Many hospitals trying to start or grow existing programs with limited resources, lack of knowledge
- MDs and mid-level providers hired to fill the gap with little training and administrative support
- Low-income and minority patients disproportionately affected by access
- Biggest gaps are in the smaller hospitals and community hospitals

Hospital Quality Measures

- Percent of decedents enrolled in hospice in the last 6 mos. of life
- Percent of deaths associated with ICU admission
- Percent of deaths occurring in hospital
- Patient rating of hospital overall
- Hospice days per decedent during the last 6 mos. of life

http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2944
The Original Chicagoland HPM Physician Collaborative

• Regional non-profit hospices
  - Rainbow, Midwest, Hospice of Northeastern IL, Fox Valley, Horizon

• Major academic medical centers
  - Rush, University of Chicago, Northwestern, Lurie Children’s, Loyola, University of Illinois

• Other established PC/teaching hospitals
  - Cook County, NorthShore, Central DuPage, Lutheran General, Advocate IL Masonic
The Coleman Palliative Medicine Training Program

GOALS

• Improve the quality of and access to palliative care services for patients with cancer and other life threatening illnesses

• Build a supportive network of palliative care providers across Chicago and outlying areas
Intermediate Outcomes

- Establish permanent local provider network to share resources and quality data
- Expand pool of Chicago attending physicians and nurse practitioners with clinical competency in palliative care
- Increase hospice utilization, discussion of advance care plans, palliative care consultations, and reduce costs of care
- Increase patient, caregiver, and consumer satisfaction with quality of care
- Develop a core set of metrics for benchmarking palliative care service and hospice activities across Chicago communities
Long Term Outcomes

- Improve practice patterns to result in
  - fewer deaths in ICUs
  - earlier referrals to hospice
  - Increased hospice utilization
  - improvements in HCAPS scores
  - greater patient/family satisfaction

- Reevaluate practice patterns for continued improvements in these domains
Data that we will need to collect

- HCAHPS survey data from hospital quality improvement offices annually
- Provide data on health service utilization: hospice enrollment, ICU admissions, consultation volume for palliative medicine, hospital deaths annually, identifiers for patients who receive palliative medicine consultations
- Provide data for the local palliative care registry: team composition, consultation volume, clinical characteristics of patient population, services provided by the palliative team for 2012 and 2014
- Data will be housed within REDCap, a secure web-based application designed specifically to quickly and securely build and manage online surveys (http://project-redcap.org/).
- Supply contact information for relevant hospital leaders and financial analysts/decision support staff to Aliza Baron and Tricia Johnson
Data Collection Process

- Fellows and Junior Mentors Provide **Key Contacts** at respective sites
- For the Outcomes Study – **Quality Manager** is the key contact
- For the Local Palliative Care Registry Study – **Palliative Care Program Director** is key contact
- Contact information will be requested via online form
- Faculty and Program Coordinator from the Coleman Palliative Medicine Training Program will work with each institution to facilitate the data collection.
Training Program Overview

- 2 year commitment
- Fellows Agreement - Responsibilities
  - $5000 stipend
- Year 1: Educational experiences
  - 2-day Opening Workshop & 1-Day Workshop in the Fall 2015
  - Learner needs assessment surveys and tests
  - E-learning curriculum (20 hours)
  - Experiential training (40 hours direct contact)
  - Social worker and chaplain seminar series
- Year 1: Project Efforts
  - Intent to Change Contract
  - Designing and implementing practice improvement project
  - Baseline data collection
  - Monthly contact with designated mentor
Training Program Overview: Year 2

- Educational components
  - 2-day bi-annual workshops
  - Junior Mentors attend 1-day sessions
- Focus on practice improvement projects
  - implementing
  - evaluating
  - sustaining
- Culminating in poster presentations at Winter 2017 Conference
- Plans for sustainment
- Cost $20,000/fellow (vs $110,000 ACGME)
The Coleman Palliative Medicine Training Program

An educational initiative for physicians, nurses, social workers and chaplains across the Chicago area led by regional leaders in palliative care to improve the quality of and access to palliative care for patients with cancer and other life threatening illnesses.

- 2013-2017
- Supported by a grant from the Coleman Foundation
E-Learning in Palliative Care

Many excellent educational materials exist on topics in palliative and end-of-life care. The following have been selected by Coleman program directors, with acknowledgements and thanks to the authors, institutions and organizations who produced these outstanding works for public access. LEARN ABOUT E-LEARNING REQUIREMENTS AND OPTIONS. Instructional levels vary. Please explore and select the materials best suited for you.

ALL PEDIATRICS Here...

RED = FREE E-LEARNING OPPORTUNITIES

INTERACTIVE PATIENT CARE SIMULATION IN PALLIATIVE CARE. By the Iowa Geriatric Education Center, University of Iowa. ENTER HERE

VIRTUAL GERIATRIC PATIENT CASES: PAIN MANAGEMENT IN THE ELDERLY. 6 cases. 2 hrs. each. Save and return option. CME credit available for a fee. Harvard University School of Medicine. VIEW TOPICS. ENTER HERE (Click “View Course List.” Select “GERI1” and “GERI2.”).

CE CREDITS ON A WIDE SPECTRUM OF PALLIATIVE CARE TOPICS FOR NURSES. Over 40 courses. On administrative, clinical, pediatrics, psychosocial, cultural and spiritual issues, and more. By the Hospice and Palliative Nurses Association (HPNA). Free for members. Fee-based for others. VIEW TOPICS. ENTER HERE

CANCER PALLIATION. Video lectures. 1 hr each. By Stanford School of Medicine eCampus CancerPEN. VIEW TOPICS. ENTER HERE

PALLIATIVE AND END-OF-LIFE CARE FOR PATIENTS WITH HIV/AIDS (Adults and Pediatric). Training modules provide Powerpoint slides with speaker’s notes. Video triggers available and more. By the Center for Palliative Care Education. VIEW TOPICS. ENTER HERE
CORE WORK GROUP

Sean O’Mahony, MB BCh BAO, MS -- Director, Section of Palliative Medicine, Rush University Medical Center

Stacie K. Levine, M.D. -- Director of Geriatrics and Palliative Medicine Fellowship; Director of Hospice and Palliative Medicine Education; Co-Director of Palliative Medicine Program University of Chicago

Aliza R. Baron, M.A. -- Education Coordinator, Section of Geriatrics and Palliative Medicine, University of Chicago

Aziz Ansari, M.D. -- Associate Director of the Division of Hospital Medicine, and Medical Director of Loyola’s Home Hospice program.

George Fitchett, D.Min., Ph.D. -- Professor and the Director of Research in the Department of Religion, Health, and Human Values at Rush.

Joel E. Frader, M.D. -- A. Todd Davis Professor of Academic General Pediatrics and Professor of Medical Humanities and Bioethics at Northwestern University’s Feinberg School of Medicine

Ileana M. Leyva, M.D., F.A.A.P., F.A.A.H.P.M. -- board certified in both pediatrics and hospice and palliative medicine and Medical Director of the Palliative Medicine Service at Northwestern Medicine Central DuPage Hospital since 2003.

Holly Nelson-Becker, Ph.D., L.C.S.W. -- Professor & Hartford Faculty Scholar Loyola University Chicago School of Social Work
Program Mentors

Responsibilities

- 2-year commitment
- Paired with 1-3 Fellows each
- Provide experiential learning to Fellows through direct observation of practice
- Guide Fellows in practice improvement projects
- Mentors Agreements
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<th>Time Frame</th>
<th>Objectives</th>
<th>Tools  and Recommendations</th>
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<tr>
<td></td>
<td>Determine Fellow’s Palliative Care Learning Needs</td>
<td>Learning needs and opportunities may include administrative, leadership, teambuilding, and networking skills and responsibilities as well as clinical.</td>
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<tr>
<td>Next 6 months</td>
<td>Facilitate Learning through Direct Observation</td>
<td>Use case based teaching approaches</td>
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<td>Direct fellow to educational resources including those on the Coleman Website</td>
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<td>Ongoing with At least monthly check in calls</td>
<td>Support Fellow in “Implementing &amp; Evaluating a PIP and making adjustments in response to institutional change and potential roadblocks”</td>
<td>Provide on-going feedback and advice</td>
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<td>Facilitate trouble shooting</td>
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<td>Advocate for fellow with institutional feedback</td>
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Junior Mentors

• Will complete intent-to-change agreements
• Provide guidance to new fellows as they implement their projects
• Help coordinate meetings with institutional leaders and fellows
• Participate in didactic activities connected with the project
• Facilitate the development of curricula
Fellows’ Learning Objectives

- Teach and model the fundamentals of palliative care to health care professionals at respective hospitals and care settings.
- Disseminate new methods and means of improving palliative care to patients and families.