# Tools to Assess Palliative Care Knowledge and Practices

Many teams that participated in the CHCF generalist palliative care initiative used surveys, tests, and chart reviews before and after training to assess changes in provider practices, knowledge, or comfort with foundational palliative care topics and tasks. The following examples can be adopted or adapted for other generalist palliative care projects.

## Emergency Medicine Resident Comfort with Goals of Care Discussions

**PROJECT TEAM:** ALAMEDA HEALTH SYSTEM

Scoring: 5-point Likert scale (1 = strongly agree, 5 = strongly disagree)

**Self-report question stems:**

- I can identify patients who could benefit from palliative care services
- I feel uncomfortable leading code status discussions
- I feel comfortable delivering bad news to patients
- I know how to properly document decisions for the end of life in the electronic health record
- I know when to call for a family meeting
- I feel comfortable making treatment recommendations
- I feel comfortable speaking to a patient surrogate, and know how to guide them in centering a patient's wishes
- I know what to do when patients are reluctant to engage in goals of care discussions
- I am comfortable eliciting goals of care at the end of life

## Cardiology Provider Comfort with Advance Care Planning

**PROJECT TEAM:** HARBOR-UCLA MEDICAL CENTER

Scoring: 5-point Likert scale (1 = very uncomfortable, 5 = very comfortable)

**Self-report question stems:**

- Starting an advance care planning (ACP) discussion with a patient
- Eliciting a patient's understanding of their illness
- Sharing prognostic information with a patient
- Responding when a patient shows high level of emotion
- Eliciting a patient's big-picture goals and values for future care
- Making a recommendation about future care, based on elicited goals and values
- Helping a patient to identify a surrogate decisionmaker
- Completing a POLST form with a patient
- Discussing an advance directive with a patient
- Discussing hospice with a patient
- Documenting an ACP discussion in the patient's medical record
- Overall comfort having an ACP discussion with a patient

## Neurology Resident Comfort with and Knowledge of End-of-Life Care for Neurology Patients

**PROJECT TEAM:** UNIVERSITY OF CALIFORNIA, SAN DIEGO HEALTH SYSTEM

Scoring: 5-point Likert scale (1 = not at all comfortable, 5 = extremely comfortable)

**Self-report question stems:**

- Describing difference between palliative care and hospice
- Performing pain assessment and management at end of life
- Communication with patient and family at end of life
- Management of non-pain symptoms at end of life
- Withdrawing life-prolonging therapies at end of life

**Knowledge test questions:**

- 15mg oral morphine is equianalgesic to __mg IV morphine
- 5mg IV morphine is equianalgesic to __mcg IV fentanyl
- An opioid infusion will reach steady state approximately __hours after initiation
- 1 mg IV lorazepam is equivalent to __mg IV midazolam
- All comfort care patients should be started on an opioid infusion (true/false)
- Breathing changes at end of life are inherently uncomfortable and should be medicated (true/false)
- It is possible for code status to be "ok CPR — no intubation" (true/false)
- Glycopyrrolate crosses the blood-brain barrier poorly (true/false)

## Radiation Oncology Resident Knowledge and Confidence with Pain Management

**PROJECT TEAM:** LAC+USC MEDICAL CENTER

Scoring: 5-point Likert scale (1 = never, 5 = always)

**Self-report question stems:**

- I assess patients' pain using a comprehensive approach
- I use appropriate nonopioid measures in management of pain, including co-analgesics and nonpharmacologic measures
- I understand appropriate indications for referral for interventions to help with pain
- I start patients on laxatives when opioids are started
- I educate patients and/or family on appropriate use of pain medications
- I feel confident in my abilities to comprehensively evaluate a patient with cancer-related pain
- I feel confident in my pharmacologic pain management skills
- I feel comfortable initiating or modifying an opioid regimen
- Pharmacologic pain management is within the scope of practice of radiation oncology physicians

**Items in chart review to assess completeness of pain assessments and plans:**

### Patient History

- Inquired about pain characteristics
  - Location
  - Intensity
  - Quality
  - Timing (intermittent, constant)
  - Duration
  - Exacerbating factors
- Inquired about current analgesics
- Inquired about constipation

### Assessment and Plan

- Characterized pain
  - Chronicity (acute, subacute, chronic)
  - Mechanism (nociceptive, neuropathic, mixed)
- Addressed type of analgesics
  - Nonopioid analgesics
  - Adjuvants for neuropathic pain
  - Sustained-release opioids
  - Immediate-release opioids
- Addressed constipation
- Addressed nausea

## Trauma Provider Impressions Around Eliciting Goals for Care in Critically Ill Trauma Patients

**PROJECT TEAM:** ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

**Survey questions:**

In your experience, when trauma patients are admitted to the critical care units, how frequently does the Trauma team attempt to identify patients' proxies (families or surrogates) within the first day of admission?

- ☐ Never (0%)
- ☐ Some of the time (≤25%)
- ☐ Half of the time (50%)
- ☐ Most of the time (≥75%)
- ☐ Always (100%)

Additional comments:

In your experience, when trauma patients are admitted to the critical care units, how often are patients' proxies (families or surrogates) identified within the first day of admission?

- ☐ Never (0%)
- ☐ Some of the time (≤25%)
- ☐ Half of the time (50%)
- ☐ Most of the time (≥75%)
- ☐ Always (100%)

Additional comments:

In your experience, when trauma patients are admitted to the critical care units, how frequently are patients' prior advance care planning (ACP) information or documentation (e.g., advance directives, POLSTs, etc.) routinely accessible in the medical record?

- ☐ Never (0%)
- ☐ Some of the time (≤25%)
- ☐ Half of the time (50%)
- ☐ Most of the time (≥75%)
- ☐ Always (100%)
- ☐ Don't know / I haven't checked before

Additional comments:

If prior ACP materials or documentation is not readily accessible, how frequently is an attempt at locating these materials documented in the chart within the first day after admission?

- ☐ Never (0%)
- ☐ Some of the time (≤25%)
- ☐ Half of the time (50%)
- ☐ Most of the time (≥75%)
- ☐ Always (100%)
- ☐ Don't know / I haven't checked before

Additional comments:

In your experience, how frequently does the Trauma Service use a standardized process for assessing the prognosis for trauma patients admitted to the Surgical ICU (SICU)?

- ☐ Never (0%)
- ☐ Some of the time (≤25%)
- ☐ Half of the time (50%)
- ☐ Most of the time (≥75%)
- ☐ Always (100%)

Additional comments:

For patients who do receive a prognostic evaluation, when does this evaluation take place?

- ☐ Within the first day of admission
- ☐ Within the first week of an admission
- ☐ Within the first 2 weeks of an admission
- ☐ As a certain level of medical or surgical complications increase
- ☐ Haven't seen an evaluation take place

Additional comments:

Having prompt and routine meetings with surrogates/family to define overall goals for care and develop care plans is an important aspect of care for critically ill trauma patients. Do you feel these meetings generally happen in the following time frames?

- ☐ Within the first day of admission
- ☐ Within the first week of an admission
- ☐ Within the first 2 weeks of an admission
- ☐ As a certain level of medical or surgical complications increase
- ☐ Haven't seen a family meeting take place

Additional comments:

In what proportion of cases do you feel these types of meetings occur often enough for critically ill trauma patients?

- ☐ Never (0%)
- ☐ Some of the time (≤25%)
- ☐ Half of the time (50%)
- ☐ Most of the time (≥75%)
- ☐ Always (100%)

Additional comments:

How confident would you feel leading a family meeting for a critically ill trauma patient in the SICU?

- ☐ Not at all confident
- ☐ A little confident
- ☐ Somewhat confident
- ☐ Very confident

Additional comments:

Family meetings can be quite difficult. What issues make these meetings the most difficult from your perspective? (Check all that apply and add any other issues not listed)

- ☐ Conveying a sense of prognosis when prognosis is poor or unclear
- ☐ Ascertaining a sense of patient/family wishes
- ☐ Lack of training in how to approach these meetings
- ☐ Lack of time due to competing clinical demands
- ☐ Concern about dealing with family/surrogate emotions
- ☐ Having these conversations in another language / with an interpreter
- ☐ Other