

PALLIATIVE CARE EDUCATION TO INCREASE OUTPATIENT PROVIDER  
KNOWLEDGE AND PALLIATIVE CARE REFERRAL INTENT WITHIN  
VETERANS HEALTHCARE SYSTEM OF THE OZARKS

by

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As members of the DNP Project Committee, we certify that we have read the DNP Project prepared by Tiffany Nicole Stewart entitled “Palliative Care Education to Increase Outpatient Provider Knowledge and Palliative Care Referral Intent Within Veterans Healthcare System of the Ozarks” and recommend that it be accepted as fulfilling the DNP Project requirement for the Degree of Doctor of Nursing Practice.

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There are so many people to thank that made this project possible. First and foremost, I must thank my Father in Heaven for guiding me through this experience. I could not have made it through without his love, grace, and forgiveness.

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To my Mom, thank you for never giving up on me. Thank you for always talking me through the hard times and jumping for joy with me through the triumphs. Thank you for raising me to work hard for everything that I want and to never give up on my dreams. You are the strongest woman I know and I am so blessed to call you my mom.

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## DEDICATION

This project is dedicated to my father, Charles William Stroud. He always encouraged me to pursue my dreams, no matter the obstacles. He has been my guardian angel. I strive to make him proud of the woman I have become every day, and I believe this project would do just that.

My father was a private in the Arkansas National Guard and was proud to be a Veteran. He was diagnosed with stage four cancer and went through extensive treatment, but to no avail, and he lost his battle. He was terribly sick from the treatment and his symptoms were never truly controlled. He was not offered palliative care, as his physicians felt that curative therapies were his best option. Had I known then what I know now, I would have advocated for palliative measures, along with curative therapy if this is truly what he wanted.

Throughout my career, I have learned that the most important thing that I can do as a provider is help make my patients' lives the best they can be. Palliative care is always an option for patients suffering from serious illnesses and I will advocate for this throughout my practice to prevent suffering.

I hope and pray that by providing palliative care education to providers, patients will be able to continue to live their lives to the fullest for as long as possible, and have high quality healthcare that incorporates the patient and family as a whole. Perhaps then, patients will not suffer by undergoing unnecessary and futile care, but rather find peace and closure throughout their illness.

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## ABSTRACT

**Purpose:** Examine outpatient providers' perceptions of palliative care education in increasing their understanding, knowledge of resources, and intent to refer.

**Research questions/goals:** 1) Increase provider understanding about palliative care and the benefits that patients can receive as a result of early referral; 2) Increase provider knowledge of palliative care facilities and resources within VHSO; 3) Increase provider intent to use the referral process for patients in need of palliative care.

**Setting:** Veterans Healthcare System of the Ozarks, Fayetteville, Arkansas.

**Participants:** 14 outpatient providers within VHSO; 8 MDs, 4 NPs, and 2 PAs.

**Methods:** Descriptive research study consisting of an education session, discussion, and completion of a demographics form and evaluation questionnaire.

**Results:** Questionnaire scores: Goal 1) 4.9 (SD=1.27)/6; Goal 2) 5.07 (SD=1.1)/6; Goal 3) 5.1 (SD=1.1)/6. **Open ended question themes:** 1) 21.4%: palliative care was an "umbrella"; 35.7%: early referral improves outcomes; 21.4%: treatment plan can include curative therapies; 2) 28.6%: open group discussion; 14.3%: training opportunities; 21.4%: multidisciplinary team approach. 3) 35.7%: screenshots of the referral process; 14.3%: individual comments for the care plan; 21.4%: open discussion regarding referrals. 4) 14.3%: more about how to accommodate homebound Veterans; 28.6%: more about telehealth opportunities; 21.4%: more information on communication tactics.

**Conclusions:** There is a knowledge deficit among outpatient care providers in regards to palliative care. The providers found this education session informative, beneficial, and increased their intent to initiate palliative care referrals.

## **CHAPTER I: STATEMENT OF THE PROBLEM**

Palliative care is a patient and family-centered service that concentrates on comprehensive health care for patients with serious illnesses and their support systems that optimizes quality of life by preventing suffering and addressing physical, intellectual, emotional, social, and spiritual needs throughout the disease process (Walsh, Aktas, Hullahen, & Induru, 2011; Friebert & Williams, 2015). Palliative supports the patient's autonomy, access to information, and advocacy throughout the continuum of a severe illness (Friebert & Williams, 2015). The palliative care philosophy incorporates care being provided by an interdisciplinary team while collaborating with the patients, family members, and staff to provide high quality healthcare (Friebert & Williams, 2015). Palliative care services are available concurrently with, or independent of, curative care, and the patient and families' desires for peace and dignity are supported throughout the illness, dying process, and after death (Friebert & Williams, 2015).

The significant lack of palliative care education in the United States for healthcare providers is contributing to the delay in care for patients suffering from severe and life-threatening illnesses. If providers are not appropriately discussing the benefits that palliative care can provide, the patient is also not adequately educated regarding their medical care options. If palliative care education was implemented for more providers within outpatient services, they would have the proper tools to integrate palliative care earlier in the disease process (Patel & Masi, 2015). When palliative care is implemented early on in a disease process by an educated interdisciplinary team, quality of life has shown to improve, overall survival rates are increased, and higher satisfaction is gained from patients and family members (Sharma, Sharma, Wojtowczyk, Want, & Gajra, 2016; Patel & Masi, 2015). Thus, the purpose of this DNP project is

to examine outpatient providers' perceptions of the effectiveness of an education session in increasing their understanding of palliative care, knowledge of palliative care resources available within the Veterans Healthcare System of the Ozarks VHSO, and intent to refer patients for VHSO outpatient palliative care and resources.

### **Background and Significance**

As the aging population grows and more of the population is diagnosed with serious illnesses, there is an increased need for specialty trained providers in both community hospice settings and hospital-based palliative care programs (Case, Orrange, & Weissman, 2013). With providers needing to be able to understand multiple aspects of care including symptom management, comfort measures, cultural competencies, advocating for the patients' wishes, mental health, religious and spiritual health, and multiple communication factors between patients, families, and other healthcare professionals, it is vital that they receive appropriate education to be able to handle every task and situation (Bhat, Wehbe-Alamah, McFarland, Filter, & Keiser, 2015; Balon et al., 2015; Gramling, Sanders, Ladwig, Norton, Epstein, & Alexander, 2015).

The use of palliative care in patients suffering from disease processes including cancer, congenital injuries, acute life-threatening illnesses, progressive chronic conditions, life-limiting injuries from accidents and trauma, and terminally ill patients has not only offered a higher quality of life but also decreased overall healthcare costs (Ferrell, Connor, Cordes, Dahlin, Fine, Hutton, Leenay, Lentz, Person, & Meier, 2007). By utilizing palliative care services, health care costs have been shown to decrease by lowering the provision of unnecessary services, hospital admissions, emergency department visits, and inpatient unit care (Patel & Masi, 2015). The life

expectancy in the United States is increasing, allowing more people to live longer, but also increasing the incidence of serious chronic conditions (Sawatzky, Porterfield, Lee, Dixon, Loundsbury, Pesut, Roberts, Tayler, Voth, & Stajduhar, 2016).

There are many aspects of palliative care that remain misunderstood by both the general public and healthcare professionals (Balon, Motlova, Beresin, Coverdale, Louie, & Roberts, 2015). Most do not understand that palliative care is available to patients at any point in a serious illness rather than specifically during the end of life (Balon et al., 2015). Palliative care may be part of a curative treatment plan, specifically for illnesses such as cancer, AIDS, Chronic Obstructive Pulmonary Disease, dementia, and congestive heart failure, and it combines a multidisciplinary approach for patients as well as their families and caregivers (Balon et al., 2015; Brickner et al., 2004). In fact, the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care recommends that patients be referred to palliative care at the initial diagnosis of a life-threatening diagnosis (Bakitas, Lyons, Hegel, Balan, Brokaw, Seville, . . . & Ahles, 2009).

Major barriers to palliative care is lack of education – which is the focus of this project, inadequate size of palliative medicine-trained workforce, and lack of funding for research, reimbursement, and regulation (Aldridge, Hasselaar, Garralda, van der Eerden, Stevenson, McKendrick, Centeno, & Meier, 2015). The current healthcare system in the United States is fragmented, leaving patients unable to get appropriate coverage for palliative care services. There is an increased need for funding as there is a lack of adequate reimbursement for palliative care providers, further research is unable to be performed, and regulatory barriers increase the difficulty of receiving funding when available (Aldridge et al., 2015). These deficiencies can

generate additional barriers to palliative care referrals in the primary care setting including patients' feelings of hopelessness and giving up , patients and families not wanting to discuss this care, providers lacking time, knowledge, and communication skills to discuss palliative care options, difficulty with prognosis (Torres, Lindstrom, Hannah, & Webb, 2016).

Palliative care education is often not a requirement in medical training programs, leaving disparities in the workforce. Specific knowledge that is lacking includes patient eligibility requirements for entering palliative care services, appropriate discussion tactics to discuss terminal diagnoses and end of life wishes, knowledge regarding appropriate diagnoses that would warrant a palliative care referral, and appropriate referral processes (Brickner, Scannell, Marquet, & Ackerson, 2004). Without appropriately trained healthcare providers, there is an increased challenge to identify patients who are appropriate for palliative care referrals which can lead to a delay in care and decreased quality of life for patients (Aldridge et al., 2015).

### **Local Problem**

The state of Arkansas currently has only 33 hospitals that offer palliative care or hospice services (Center to Advance Palliative Care [CAPC], 2012). The majority of programs are specific to inpatient units with palliative care teams present only in acute care hospitals. Problems occur for patients who are designated to the palliative care team during an inpatient stay but once they are discharged, they no longer have the support that they need. This is also a national problem with only 59% of National Cancer Institute-designated cancer centers and 22% of non-National Cancer Institute centers offering outpatient palliative care services (Barton, 2014). VHSO is unique in that it offers palliative care services both through inpatient and outpatient services. Specific services that are provided for outpatient palliative care are

administered through an interdisciplinary team approach. Services include symptom management, social services, psychological and behavioral interventions, religion and spiritual services, diet and nutrition, physical therapy, and coordination and collaboration with the patient's specialty providers and primary care provider (U.S. Department of Veterans Affairs [USDVA], 2016).

According to data obtained from VHSO, there is a greater number of referrals that come from inpatient providers while patients are admitted with exacerbations of illnesses rather than outpatient providers at the time when a patient is diagnosed with a severe illness (Veteran's Healthcare System of the Ozarks [VHSO], 2016). Through an education intervention for outpatient providers, this project plans to create an outcome of increased referrals to outpatient palliative care services earlier in the disease process. This will allow patients to have ongoing care from the outpatient palliative care team to gain a higher quality of life.

There is anecdotal evidence that suggests the majority of providers within VHSO do not value the benefits that palliative care can provide for any patient other than those who are at the end of life. The majority of providers at VHSO are older in age and have many years in practice, which correlates with decreased knowledge regarding palliative care (Snyder, Hazelett, Allen, & Radwany, 2015). This is a trend nationally with 20% of primary care providers believing that palliative care is only appropriate for patients who have less than six months to live (Snyder et al., 2015). Another problem is that 29% of primary care providers believe that palliative care and hospice care are virtually the same (Snyder et al., 2015). Based on an interview with Leslie Landrum, MD, who is a palliative care provider at VHSO, providers are not educated on the services that palliative care can provide, leading to delays in care and inappropriate referral times

(L. Landrum, personal communication, July 14, 2016). Many providers within VHSO have been practicing for decades and have not had appropriate education for palliative care throughout their careers (L. Landrum, personal communication, July 14, 2016).

Upon discussing the care that this team provides with their nurse practitioner, the investigator learned that even with having the outpatient services, the majority of palliative care referrals and consultations are from inpatient providers when patients present with end stage symptoms from an illness (B. Sutulovich, personal communication, June 27, 2016). The palliative care nurse practitioner also discussed that currently, there is no form of education for palliative care for any providers within VHSO (B. Sutulovich, personal communication, June 27, 2016). The outpatient palliative care services are being underutilized within VHSO. This creates another barrier locally because providers are not referring early in the disease process, leading to decreased symptom management and decreased quality of life until they are entering the dying phase (Aldridge et al., 2015). This is where an education intervention would be most beneficial, that is, in terms of both improving knowledge and influencing values and beliefs about palliative care such that they at least increase their intentions to refer to palliative care services. Subsequent projects could explore actual application of the knowledge by actual numbers of referrals. Most immediately, it is vital to increase the knowledge and positively influence beliefs about palliative care among providers who have the power to refer patients early in a disease process to ensure patients have symptom management and appropriate care throughout the continuum of illness.

### **Purpose of the Project**

The purpose of this DNP project is to examine outpatient providers' perceptions of the effectiveness of an education session in increasing their understanding of palliative care,



knowledge of palliative care resources available within VHSO, and intent to refer patients for outpatient palliative care. The project is designed to address the general question as to whether outpatient providers perceive that a palliative care education session is effective.

Key stakeholders for this palliative care education intervention will include outpatient service providers, management, palliative care services, and research coordinators within VHSO. The palliative care education intervention will benefit providers including MDs, DOs, PAs, and NPs.

### **Conceptual Framework**

The conceptual framework proposes that education of healthcare providers in the Eight Domains of the NCP for Quality Palliative Care (Ferrell, 2005) will increase provider perceptions of their understanding of palliative care, their knowledge of palliative care resources in their clinical setting, and their intent to refer patient in need of palliative care to these services. The framework presents the Eight Domains of the NCP for Quality Palliative Care, which were used to design and evaluate the education session. The framework also presents the key assumptions and expectations underlying the reasons for implementing the educational session.

### **Assumptions**

The current subjective norm for outpatient providers within VHSO is that palliative care services should only be offered to patients who are near the end of life. This DNP project would attempt to change this subjective norm by informing providers that palliative care offers symptom management for and benefits patients suffering from all types of illness. This project is based upon several assumptions. The overall assumption is that increasing provider knowledge of palliative care will ultimately increase their confidence in and referrals to outpatient palliative

care for patients in need of this service. The education intervention will help providers develop a favorable attitude towards palliative care rather than judging that it insinuates hopelessness. Providers also may feel more in control of the situation when patients are suffering by having the confidence to address palliative care services with patients and their families. It is anticipated that the implementation of the education intervention would contribute to establishing a subjective norm for providers focused on overall better health and-higher quality of life for their patients.

### **Eight Domains of the NCP for Quality Palliative Care**

The framework incorporates the eight domains the National Consensus Project (NCP) for Quality Palliative Care, which provided the appropriate information and structure to design the education session and the evaluation of goals questionnaire for this project. The domains focus on comprehensive and multidimensional care in regard to physical, psychological, social, spiritual, and religious capacities. This framework is particularly beneficial for this DNP project because the purpose is to create an educational intervention that represents all aspects of palliative care as well as create uniformity in the education for outpatient healthcare providers.

These guidelines were introduced in 2004 and have given specific direction for palliative care services. The NCP Guidelines were developed for many reasons including to facilitate the development and continuing improvement of clinical palliative care programs providing care to patients and families with life threatening or debilitating illness, to establish uniformly accepted definitions of the essential elements in palliative care that promote quality, consistency and reliability of these services, to establish national goals for access to quality palliative care, and to foster performance measurement and quality improvement initiatives in palliative care services

(Ferrell, 2005). The eight domains have been used in developing palliative care programs, and also as an assessment framework to assess strengths and weaknesses of current palliative care programs (Ferrell, 2005; Ferrell et al., 2007). The domains have been used to provide the clinically appropriate structure and processes of new programs and increase the uniformity of palliative care education.

*Domain One* refers to the *structure and processes of care*. The recommendations for this domain are to include comprehensive interdisciplinary assessment of the patient, family, and caregivers and to ensure their expressed needs are being addressed and the environment meets those needs (Ferrell et al., 2007). The interdisciplinary team must also be consistent with their plans of care to ensure the patients and families are the focus at all times. Education and training must be administered to all outpatient healthcare providers to ensure providers understand the need and impact that palliative care can have on patients and families (Ferrell et al., 2007). Transition from outpatient services to palliative care will be more fluent if all providers are aware of the same information.

*Domain Two* addresses the *physical aspects of care*. Patients are enduring many physical changes, pain, dyspnea, constipation, and other side effects of illness or treatment and must be managed with best practice to relieve suffering. The guidelines ensure that these aspects are being addressed in a timely, safe, and effective manner that is acceptable for the patient and family (Ferrell et al., 2007). Other recommendations for this domain include having the team document and communicate standard care and alternative care to allow the patient and family to make informed choices and to educate and support the family to provide safe and appropriate comfort measures for the patient (Ferrell et al., 2007).

*Domain Three* represents *psychological and psychiatric aspects of care*.

Recommendations include assessing and managing all psychological and psychiatric issues including anxiety, depression, delirium, behavioral disturbances, and other ailments that may present in a timely and effective manner (Ferrell et al., 2007). Ensuring the interdisciplinary team will incorporate pharmacologic, non-pharmacologic, and complementary therapies when appropriate is also important in this domain (Ferrell et al., 2007). It also recommends to express the availability of grief and bereavement programs to patients and families which can assist in managing emotional and functional impairments of loss such as stress, anticipatory grief, and coping (Ferrell et al., 2007).

*Domain Four* emphasizes *social aspects of care*. A complete interdisciplinary social assessment should be performed to provide information, discuss goals of care, prognosis of illness, advanced care planning, and to offer support to the patient and family. A social care plan should be developed to include social, practical, and legal needs of patients which should include relationships, communication, social and cultural networks, decision making, finance, sexuality and intimacy, caregiver stress, and ensure access to medications and equipment necessary for treatment (Ferrell et al., 2007). Referral to other services outside of the interdisciplinary team may be needed for this domain.

*Domain Five* addresses *spiritual, religious, and existential aspects of care*. The recommendations include assessing concerns in any of these areas, recognizing and respecting religious beliefs, offering support, and making connections with groups within the community when necessary for the patient and family (Ferrell et al., 2007). A plan should be developed based on these findings and information and availability of religious and spiritual services should

be presented to the patient and family. When available, specialized religious professionals who are trained in palliative care should be involved to provide education and counseling for patients and families (Ferrell et al., 2007).

*Domain Six* focuses on *cultural aspects of care*. Recommendations include meeting culture-specific needs of patients and families, respecting all needs in the way of language, diet, habits, or rituals that may present while caring for the patient and family (Ferrell et al., 2007). The team should have access to interpreters when needed. A cultural assessment should be incorporated within comprehensive palliative care and include dietary preferences, language, family communication, alternative medicine, perspectives on death and dying, and funeral and burial habits (Ferrell et al., 2007). Cultures will be different depending on the service area and providers must be able to adapt to appropriately care for patients and families.

*Domain Seven* refers to *caring for the imminently dying*. This is important because hospice is a part of palliative care services and providers will need to know how to care for this population. Providers should know signs and symptoms of patients close to death in aspects relating to development, age, and culture, and be able to thoroughly communicate this to loved ones (Ferrell et al., 2007). Providers should recognize transitions to the actively dying phase, expectations of imminent death, ensure they are following patient and family wishes throughout the dying process, and provide adequate symptoms control when dosing analgesics and sedatives (Ferrell et al., 2007). Post mortem, the body should be treated with respect and incorporate any cultural or religious practices that the family may desire. Bereavement care should be implemented right away for loved ones and ensure the family remains the focus of care.

*Domain Eight* addresses the *ethical and legal aspects of care*. The focus of providing palliative care should always be on the patient's goals, preferences, and choices. Ethical and legal issues can present at any time and the team must be knowledgeable about how to deal with this including federal and state statutes and regulations (Ferrell et al., 2007). The team must document the designated decision maker in accordance to state law as well as document goals of care, treatment options, and evaluate as conditions change (Ferrell et al., 2007). The goals should be transferred to medical orders and ensure that the orders are transferrable across care settings including long-term care, emergency services, and hospitals. Advanced directives and surrogacy designations should also be available across care settings. The interdisciplinary teams should have access to ethics committees and ethics consultation to address any ethical concerns throughout the course of care and at the end of life. Some providers will also have to address the goals of care for minors and in this case, the child's views should be addressed and documented regarding preferences for medical care, assent for treatment and give appropriate weight in decision making (Ferrell et al., 2007). When the child's views and adult decision maker's views differ, appropriate professional staff should be available for consultation and intervention (Ferrell et al., 2007).

All domains represented in the NCP practice guidelines will be briefly addressed in the education intervention created for this DNP project. The domains were developed to educate providers on caring for patients with a wide range of illnesses including cancer, congenital injuries, acute serious life-threatening illnesses, progressive chronic conditions, life-limiting injuries from accidents and trauma, and terminally ill patients (Ferrell et al., 2007). The providers

will gain awareness of the fundamentals of palliative care to create a better understanding of the services that palliative care provides.

### **Proposed Effects and Benefits of Education**

Two intended effects of the palliative care education intervention are improvement of provider understanding of palliative care overall, and to improve knowledge of the palliative care resources available where they practice. It is important for providers in the outpatient care setting to understand the benefits and services of palliative care and patients who benefit from palliative care services because they are often the main contact for the patient, even after being diagnosed with a serious illness. A third intended effect of incorporating palliative care education is to increase intention to refer appropriate patients to palliative care and to do so earlier in the course of illness (Wong, Reddy, Williams, Wu, Liu, & Bruera, 2016).

By incorporating training to providers from a wide range of services within the outpatient clinics may better serve patients across all specialties, including primary care (Wong et al., 2016). Providers can gain an understanding about when to refer to palliative care including when patients have uncontrolled symptoms related to their medical diagnosis, when patients are no longer receiving curative therapies and need to prepare for end of life care, and when overall symptom burden needs to be decreased (Wong et al., 2016). Other benefits of incorporating palliative care services include decreasing healthcare utilization including health care costs related to stays in the ICU and ED visits (Wong et al., 2016).

General practitioners who have had training in palliative care are able to identify patients who would benefit from palliative care and more often provide multidisciplinary care including symptom management, spiritual health, and psychological health (Thoonsen, Gerritzen, Vissers,

Verhagen, van Weel, Groot, & Engels, 2016). Trained general practitioners are also better able to communicate with seriously ill patients about treatment options and assist them with decision-making, including advantages and disadvantages of treatment options, better than untrained practitioners (Thoonsen et al., 2016).

### **Research Goals**

Three research goals were derived from the conceptual framework. Achievement of these three short-term goals will be evaluated based upon the providers' self-report of their perceptions following the education session:

1. To increase provider understanding about palliative care and the benefits that patients can receive as a result of early referral.
2. To increase provider knowledge of palliative care facilities and resources within VHSO so that they have a better understanding of what occurs when a referral is sent.
3. To increase provider intent to use the referral process for patients in need of palliative care.

While the *content* of these goals was derived from the Eight Domains described above, the *behaviors* underlying these goals were identified based upon cognitive and affective learning objectives that are used in evaluating higher education learning behaviors (Kibler, Cegala, Barker, & Miles, 1974). Knowledge and understanding are first and second level objectives in the cognitive domain, respectively, that can be expected of the healthcare providers following an educational session. Providers' expression of intent to use knowledge in an indicator within the affective domain of their value for and motivation to use knowledge (Kibler, et al., 1974).



Achieving these goals may help boost providers' confidence in presenting the option of palliative care to patients who would potentially benefit from palliative care services. Long-term learning goals are for providers to develop a preference for this treatment approach and apply this knowledge in their practice as evidenced by increased referrals to benefit patients. As a result, patients would receive better symptom management for a longer period of time and improved quality of life throughout their disease process or treatment programs.

## **CHAPTER II: LITERATURE REVIEW**

### **Synthesis of Evidence**

There has been a substantial increase in palliative care education for providers, particularly physicians, over the last two decades including clinical rotations with board certified palliative medicine physicians and didactic and small group curriculums (Case, Orange, & Weissman, 2013). There are now several schools working together with medical, nursing, and social work students to provide a thorough education process, reinforcing teamwork skills and the overall idea of the interdisciplinary team (Case, Orange, & Weissman, 2013). While newly graduated providers may have a more thorough understanding, providers who have been in the field, like the majority of outpatient providers within VHSO, will need this intervention to improve their understanding of palliative care and the importance of the interdisciplinary team.

Results reported in the literature indicate positive outcomes of palliative care education. To investigate the effects of implementing palliative care education interventions for providers, several literature searches were performed using PubMed, Google Scholar, and Cochrane. The following key words were utilized for the searches: palliative care, education, providers, quality improvement, and interventions. Other related terms that were used include: education programs, students, medical, and communication. The inclusion criteria for the search included human studies, full-text availability, published within the last ten years, and published in the English language. The search yielded 380 articles. Articles were excluded if they did not closely correlate with the subjects of healthcare providers, education, interventions, quality improvement, or palliative care. A total of fourteen articles were utilized for this project and the results can be obtained in Appendix 1.

Education programs for providers, even short courses, have been shown to improve provider perceptions of palliative care, increase teamwork and collaboration abilities, improve symptom management knowledge, and support patients and family members during the palliative phase (Friedrichsen, Heedman, Astradsson, Jakobsson, & Milberg, 2013). By completing a comprehensive online module for palliative care, knowledge of the primary care provider has been shown to increase 14%-20% as well as increase perception of confidence in symptom management and communication about palliative care with patients and their families (Pelayo, Cebrian, Areosa, Agra, Izquierdo, Buendia, 2011).

One major training program that has been implemented is the ELNEC-Graduate (End of Life Nursing Education Consortium) program for advanced practice nurses. (Malloy et al., 2008). The ELNEC-graduate curriculum provides education in the areas of palliative care in advanced practice, pain management, symptom management, ethical issues, communication, loss, grief and bereavement, final hours of life, and achieving quality palliative care (Malloy et al., 2008). With the implementation of this program, there has been a substantial curriculum change in graduate nursing programs which now provide an average of 34.22 hours of palliative care education compared to the 11.89 prior to implementation (Malloy et al., 2008). Each area of the ELNEC training has shown a statistically significant improvement, including adequacy of palliative care, pain management, symptom management, ethical/legal, communication, grief/loss, preparation for time of death, and quality of life (Malloy et al., 2008).

Another important component to palliative care is the ability to communicate with patients and families about their situation and options, which can be particularly difficult where family dynamics are dysfunctional. One study based on a communication skills training module

found that providers are often unable to effectively discuss palliative care and end of life care with families (Gueguen, Bylund, Brown, Levin, & Kissane, 2009). The strengths of creating a module on communication include participants having a significantly increased (93%) view in self-efficacy on their ability to conduct a family meeting discussing palliative care (Gueguen et al., 2009). Another aspect during these conversations is the overall goal of the patient. Providers must understand how to effectively communicate with the patient to identify, clarify, and prioritize what the patient wishes to achieve during the remainder of their life, regardless of how much time they have (Gramling, Sanders, Ladwig, Norton, Epstein, & Alexander, 2015). Providers often struggle with communication about goals when suffering, fear, and confusion are substantial and dedicating a portion of this intervention to communication could ease fears of providers by giving directions on leading such discussions (Gramling et al., 2015).

Education on appropriate communication strategies is also lacking for healthcare professionals. One way this may be evident is that currently 90% of Americans would prefer to die in their homes where in reality, 53% of patients actually do (Grant, Elk, Ferrell, Morrison, & von Gunten, 2009). More than 13% die in a hospital and 24% die in a nursing home (Grant et al., 2009). By implementing a course on communication for providers with palliative care patients, it has been found improve the delivery of bad news and increased the ability to respond to emotional cues of the patient (Alexander, Keitz, Sloane, Tulsky, 2006). Communication courses have also been found to improve the provider's ability to discuss patient preferences in regards to life sustaining care and other wishes (Alexander et al., 2006). Providers have the ability to discuss and educate patients and families about their options and if more providers went through proper education, there would be less of a discrepancy about patient wishes, providers would be

able to deliver news more effectively and in a more caring fashion, and increase the provider's ability to respond appropriately to emotional situations.

Another area that remains poorly addressed by providers is cultural preferences within palliative care. Cultural competence in health care can improve care delivery, patient outcomes, and patient and family satisfaction, particularly when faced with serious or life-threatening illnesses (Bhat, Wehbe-Alamah, McFarland, Filter, & Keiser, 2015). The created intervention would need to include specific cultural considerations for palliative care so that providers are able to understand the needs of the patient and family from a cultural standpoint (Bhat et al., 2015). This is also the sixth domain from the NCP guidelines, which will be incorporated into the education intervention.

In summary, the literature review indicates that education continues to be a significant barrier to the implementation of palliative care. Even though there have been several modules and education programs on palliative care in the hospital setting, it is still not required in medical school curricula or nurse practitioner programs in the United States (Case, Orrange, & Weissman, 2013). It is encouraging that European countries are implementing such programs throughout colleges but the United States has improvements to make. With the elderly population only growing and chronic and life-threatening illnesses being diagnosed more frequently, education during medical school and nurse practitioner programs will be vital in the coming years.

### **CHAPTER III: METHODS**

As part of the process of developing a project for improvement in practice, several questions were answered regarding the methods of this DNP Project. These questions, along with other components, are addressed in the Methods section of this project. The components of the method of this DNP project included descriptions of the design, sample and setting, the palliative care education intervention, procedure for disseminating the educational session to providers within VHSO, and evaluation questionnaire for the education intervention.

#### **Design**

This study was a quantitative descriptive research study for quality improvement to address the research questions, analysis of results, and implications for practice and research. This study elicited pertinent information for future quality improvement projects to increase referral rates.

#### **Sample**

The participants included providers such as doctors of medicine (MD), doctors of osteopathic medicine (DO), nurse practitioners (NP), and physician assistants (PA). There were fifty-five outpatient care providers within VHSO. The outpatient care providers met on a monthly basis to discuss various topics and have guest speakers throughout the year. The participants had a variety of experiences and diversity of specialties, which created a well-rounded group for this DNP project. The participants worked in a variety of service areas within the outpatient clinics at VHSO, as listed above. The target number of participants was a maximum of 55 and a minimum of 40.

### **Setting**

This project was performed at VHSO within the outpatient clinics in Fayetteville, Arkansas. The outpatient clinics presented a variety of services including primary care, home based primary care, outpatient palliative care, mental health, health coaching, nutrition counseling, community care, medical foster homes, and specialty outpatient services (USDVA, 2016). The specialty outpatient services included audiology, dental, oncology/hematology, physical therapies, speech pathology, and surgical specialties (USDVA, 2016). By including all outpatient services rather than focusing on primary care alone gave the opportunity to reach out to all providers who care for patients at risk for developing severe and life-threatening illnesses. All services within the outpatient clinics had MDs, NPs, DOs, and Pas, which created a wide range of providers to reach with the palliative care education intervention from this project.

VHSO was also a unique setting as it provided outpatient services for palliative care. This was significant because after educating other outpatient providers on palliative care, they understood where to refer patients when palliative care is needed. This was also a valuable resource for outpatient providers when questions arise regarding patients who may benefit from palliative care. The palliative care team within VHSO contained an interdisciplinary team, which was a mainstay of palliative care services. This interdisciplinary team included a physician, nurse practitioner, social worker, chaplain, dietician, psychologist, and physical therapist.

### **Palliative Care Education Session**

The education session was twofold and consisted of providing a packet of printed materials with an *in-person presentation* and *discussion* to last approximately one-hour total during the outpatient provider monthly meeting. The discussion segment helped reinforce the

education materials and reach more of the providers, as well as answer any questions that arose in person. The presentation was conducted by the DNP student who conducted the project, the VHSO palliative care nurse practitioner, and the outpatient provider coordinator.

The lecture and printed packet of materials were created by the investigator and the VHSO palliative care nurse practitioner to ensure that the content was easily utilized by outpatient care providers. Both the lecture presentation followed by discussion and the printed materials presented the NCP practice guidelines and eight domains including: structure and process of care, physical aspects of care, psychological and psychiatric aspects of care, social aspects of care, spiritual, religious, and existential aspects of care, cultural aspects of care, care of the patient at the end of life, and ethical and legal aspects of care to further indicate the makeup of palliative care (National Consensus Project for Quality Palliative Care, 2013).

The printed packet of written materials specifically addressed the NCP guidelines, when referral is appropriate, and the process that providers must perform to send a palliative care referral. The printed materials also addressed specific resources that are available within VHSO including websites and seminars, as well as the options that are available for further education on palliative care, such as the ELNEC (End-of-Life Nursing Education Consortium) course that is offered yearly on the VHSO campus.

The lecture presentation gave the participants an opportunity to ask questions regarding the information in the printed materials, participate in a discussion with their colleagues, and have an opportunity to discuss specific scenarios that the investigator will present. There were two outlined scenarios, including a patient who just found out they have stage IV lung cancer without curative therapy options as well as a patient who has been diagnosed with congestive



heart failure and is having severe symptoms. These scenarios gave the providers the idea of a patient who may undergo curative therapy but would also benefit from a palliative care referral, as well as a scenario where curative therapy is not an option and end-of-life care planning is warranted. There was also a PowerPoint up during the in-person presentation to outline the presentation which had the scenarios, specific questions for each scenario, slides representing the eight domains, slides with the pictures of the referral process within the EMR, and names and contact information for the palliative care team.

The VHSO palliative care nurse practitioner was also present during the presentation to answer questions. The in-person discussion portion of this project was voice recorded specifically for purposes of assisting the investigator in reviewing the teaching content, responses to the class, and the class questions.

The palliative care interdisciplinary team within VHSO was also introduced during the lecture, including their title and role within the palliative care team. Their contact information was made available within the printed materials for further discussion or questions if desired.

### **Palliative Care Education Session Evaluation Form**

The data for this DNP project was obtained from the participant responses on the Palliative Care Education Session Evaluation Form (see Appendix B), which was developed by the investigator. The evaluation questionnaire consisted of 12 items that addressed the three goals of this project (each corresponding to a subscale of the overall scale), which are to determine if the education session gave them a better understanding of palliative care, knowledge of the resources and team members available and the process for sending in a referral, and if they intend to refer patients to palliative care in the future, and to do so earlier when it is most

effective. The questionnaire was constructed using a 6-point Likert-type scaling technique. No items were reverse-scored since it would be obvious as well as confusing to the participants on this brief questionnaire.

Content validity of the questionnaire was estimated using Lynn's (1986) two-stage process. In the first stage, the 12 items were generated based upon the theoretical framework and identifying the domain of relevant content. In the second stage, three content experts who are clinical practice scholars evaluated the questionnaire's content validity. Content validity was calculated using the item-based Content Validity Index (I-CVI) based on analysis of all items (not just the overall instrument) (Lynn, 1986; Polit & Beck, 2006). Respondents rated each of the 12 items on a 4-point Likert-type scale of relevance ranging from *Not Relevant, Somewhat Relevant, Mostly Relevant, to Very Relevant*. Response ratings were dichotomized where 1 or 2 indicate not relevant, and 3 or 4 indicate a relevant item. The CVI is the proportion of items attaining a rating of 3 or 4. The criterion for content validity was met, with a minimum of three raters indicating 100% agreement on relevance across all items (I-CVI=1.0). One item was slightly modified to address an expert's suggestion to clarify the wording.

The questionnaire was evaluated for internal consistency (estimated by Cronbach's alpha) on the overall questionnaire and the three subscales based upon the study's sample (Chapter 4). However, the questionnaire is regarded as a preliminary method of evaluation for this project, and is recognized for its possible limitations in reliability and validity.

**Scoring.** The items were rated on a 6-point Likert-type scale. Responses were summed across items within each of the three subscales representing each of the three goals, for subtotals ranging from 4 to 24. Items 1 to 4 evaluate Goal 1. Items 5 to 8 evaluate Goal 2. Items 9 to 12

evaluate Goal 3. Responses were also summed across all 12 items to obtain a general evaluation rating that ranges from 12 to 72. An open-ended question was provided at the end for provider written feedback and comments if desired.

**Procedure.** The education session was carried out at the February, 2017 outpatient provider meeting. The implementation was conducted through coordination with the outpatient provider coordinator, Office of Nursing Research coordinator, the palliative care team, and the DNP student to disseminate the palliative care education intervention to all outpatient service providers within VHSO. The investigator conducting this project, along with the palliative care nurse practitioner at VHSO, carried out the in-person presentation of the content within the education intervention to maximize education and to reach the goals set forth for this project. The investigator conducting this project ran the implementation and ensured outpatient providers receive the education with the assistance of the DNP project committee within the University of Arizona. As mentioned previously, the in-person portion of this project was voice recorded for assistance of evaluation and assistance with changes to the project in the future.

The palliative care education session intervention created for this DNP project was scheduled with the assistance of the outpatient care provider coordinator. The education intervention was announced through the monthly news email to allow providers to be aware of the topics of the upcoming monthly meeting. Because the monthly meeting is not mandatory, the providers had the option not to attend the education intervention. If providers did not wish to participate in the intervention, they did not have to attend the monthly meeting. The in-person presentation of this project was conducted during the scheduled February 2017 monthly staff

meeting. Following the completion of the presentation, the providers evaluated the presentation and printed materials.

**Resources.** The resources that were needed included a conference room for the in-person presentation, materials for printing the printed material packet, and coordination with the palliative care nurse practitioner and outpatient care provider coordinator to carry out the presentation. The palliative care nurse practitioner assisted with creating the printed education packet as well as assist with the in-person presentation to the providers. The outpatient care provider coordinators assisted with dispersing the packets to the providers at the meeting as well as dispersing the packets to any providers who desire to have the information but were unable to attend the in-person presentation.

**Budget.** The budget included the cost for paper and ink for the printed portion of the education material packets. The conference room for the in-person presentation was necessary but did not have any cost associated, as this is where the providers meet on a monthly basis. The cost to carry out this DNP project was \$100 for paper, ink, and any other supplies that were needed for the printed materials packet.

### **Ethical Considerations for Human Subjects**

Each project comes with risks and benefits for participants. Informed consent was obtained of all participants in this project (Appendix A).

### **Informed Consent**

The participants of this project gave informed consent by authorizing the use of their data for the project (Baily et al., 2006). Informed consent involves the participant status, goals, type of data, procedures, nature of the commitment, sponsorship, potential risks, potential benefits,

confidentiality, voluntary consent, right to withdraw and withhold information, and have contact information (Polit & Beck, 2012). Participants were informed of the education intervention and the goals of the project and were given a disclosure handout to ensure that they understood what they are asked to do. The providers could determine if they wished to participate in the intervention and had the ability to leave the meeting if they were not interested in this topic or had already attended education sessions on palliative care.

Benefits included access to a beneficial intervention that the participants may not have had access too previously, increased knowledge about opportunities available to the participant, escape from the normal routine, satisfaction that the participant may be able to help themselves and others from the knowledge gained, and material gains offered through the study (Polit & Beck, 2012; Baily, Bottrell, Lynn, & Jennings, 2006). In the case of this DNP project, providers gained benefits through the education intervention with important information available when they have a patient that may be in need of palliative care services. The providers gained knowledge related to palliative care and gained confidence when approaching patients, families, and other healthcare professionals about palliative care.

Potential risks for participants being a part of a study included physical discomfort, fatigue, boredom, psychological or emotional stress, social risks such as being stigmatized, loss of privacy, loss of time, or monetary costs relating to time lost from work (Polit & Beck, 2012). The risks for participants of this project mostly included fatigue or boredom if palliative care is not something they are interested, risk of loss of privacy, loss of time as they must attend the provider meeting to take part in the education intervention, and monetary loss from potentially losing productivity at work.

**Beneficence**

It is the duty of the researcher to ensure that harm is minimized and benefits are maximized while performing a research study (Polit & Beck, 2012; U.S. Department of Health and Human Services [USDHHS], 1979). The researcher must decide when it is ethical to seek benefits despite risks and when the benefits should be foregone due to the risks (USDHHS, 1979). The risks and benefits listed above have been compared and the knowledge gained for the participants of the project certainly outweigh the risks. There is no immediate or detrimental harm to the participants partaking in this DNP project.

**Justice**

Participants hold the right to fair treatment and their right to privacy regardless of their experience, age, deprivation, competence, merit, and position (USDHHS, 1979). Participants in this project will experience the same learning scenarios from the education intervention regardless of their previous experiences with palliative care, merit, or position. The information that the participant provides on the written evaluation will be will remain anonymous, which allows all data to be analyzed without judgement or bias.

**IRB**

This project went through the Institutional Review Board (IRB) through the University of Arizona as well as the IRB for VHSO to ensure that the project was following the requirements for ethical research. IRB approval ensured that risks to participants are minimized, risks are reasonable compared to benefits, the knowledge that was gained was important, selection of participants was equitable, informed consent was gathered and appropriately documented, participants' privacy and confidentiality of the data were adequately protected, and any

safeguards were in place that were necessary (Polit & Beck, 2012). See Appendix A for IRB approval forms.

The consent procedure was that participants indicated consent to being involved in this DNP project by attending the meeting and participating in the education intervention. A signed consent was not necessary. They were informed of all rights of human subjects in a written and verbal statement prior to their participation through the disclosure handout.

## **CHAPTER IV: RESULTS**

This section presents the findings for each goal of the study along with a description of the sample and reliability estimate of the questionnaire based upon the current sample. The data obtained from items on the use of the official name throughout the chapters were analyzed using descriptive statistics, including measures of central tendency (mean, median, mode) and dispersion (range and standard deviation) on each item in the questionnaire (Polit & Beck, 2012) to evaluate the education session. Qualitative data were analyzed by content analysis methods to identify key themes across responses.

### **Description of Sample**

A sample of 14 participants completed all questions on the palliative care education session evaluation questionnaire. While the meeting generally has a healthy attendance population, the medical director was out on leave during this meeting, so attendance was diminished. Generally, there are between 40-55 attendants, however, there were only 14 providers present during this meeting. All 14 attendees participated in the education session and completed the education session evaluation and demographics forms. Although there was an unexpectedly small sample size, the data collection study was concluded because the research questions within the scope of this study could be addressed with the existing data and because additional participants were not available within the investigator's required timeline.

Out of the sample size, eight (57.1%) were MDs, four (28.6%) were NPs, two (14.3%) were PAs, and none were DOs. The participants stated that they had been providers anywhere from two years – 40 years, with a mean of 17.6 (S.D = 11.6).



The areas that the provider was practicing in were two in Home Based Primary Care (HBPC), nine (64.3%) were in Primary Care, two (14.3%) were in Internal Medicine, and one (7.1%) was in Occupational Health. Length of time in practice ranged from 2 to 40 years, with a mean of 12.5 (SD=13.0). Only two of the 14 (14.3%) stated that they had any previous palliative care education. This leaves 12 of the 14 participants (85.7%) without any previous education on the subject.

This is important to address, as this creates a baseline of knowledge for the participants. In looking back at the literature review, this sample size, even though unexpectedly small, correlates with the findings. The majority of healthcare professional training programs do not require education in palliative care (Friedrichsen et al., 2013).

### **Reliability of the Palliative Care Education Evaluation Questionnaire**

Cronbach's alpha was calculated for the questionnaire as a whole, as well as for each subscale. Cronbach's alpha coefficient is used to examine internal consistency of multi-item scales such as Likert, which was used for this project (Grove, 2007). Multi-item scales generally include subscales, such as this project using subscales for each goal. Cronbach's alpha must be determined for each subscales, as well as the total scale, to calculate the internal consistency of the scale (Grove, 2007). A Cronbach's alpha score of 1.00 equals perfect reliability and 0.00 indicates no scale reliability (Grove, 2007). The lowest suitable coefficient is 0.80 and the reliability of a scale generally improves over time as the scale is used in studies and refined (Grove, 2007).

All subscales and the overall scale obtained high estimates of internal consistency, indicating very adequate reliability. Cronbach's alpha for Subscale 1 was 0.97, Subscale 2 was .98, and Subscale 3 was 0.99. The Cronbach alpha of the total scale was 0.99.

### **Results for Each Goal**

**Goal 1. To increase provider understanding about palliative care and the benefits that patients can receive as a result of early referral.**

The score on Subscale 1, measuring provider perception on the increase in understanding about palliative care and the benefits that patients can receive as a result of early referral, was 4.9 (SD=1.27) out of a possible 6.0. See Table 1 for the descriptive statistics for each question within the subscale.

**Goal 2. To increase providers' knowledge of palliative care facilities and resources within VHSO so that they have a better understanding of what occurs when a referral is sent.**

The score on Subscale 2, measuring the provider perception on the increase in understanding about the palliative care facilities and resources, was 5.07 (SD=1.1) out of a possible 6.0. See Table 1 for the descriptive statistics for each question within the subscale.

**Goal 3. To increase provider intent to use the referral process for patients in need of palliative care.**

The score on Subscale 3, measuring the provider perception on the increase in intent to use the referral process, was 5.1 (1.1) out of a possible 6.0. See Table 1 for the descriptive statistics for each question within the subscale.

TABLE 1. *Scoring for Each Goal*

<b>Question/Subscale</b>	<b>Mean (Standard Deviation)</b>	<b>Median</b>	<b>Mode</b>
Question 1	4.9 (1.3)	5	6
Question 2	4.9 (1.2)	5	5
Question 3	4.86 (1.2)	5	6
Question 4	5.07 (1.1)	5	6
Question 5	5.14 (1.1)	5	6
Question 6	4.92 (1.1)	5	6
Question 7	5.21 (1.1)	5.5	6
Question 8	5 (1.1)	5	5
Question 9	5.07 (1.1)	5	6
Question 10	5.14 (1.1)	5	6
Question 11	5.07 (1.1)	5	6
Question 12	5.15 (1.1)	5	6
Subscale 1	4.93 (1.2)	5	5.75
Subscale 2	5.07 (1.1)	5.13	5.75
Subscale 3	5.1 (1.1)	5	6
<b>Total Score</b>	<b>5.03 (1.1)</b>	<b>5.04</b>	<b>5.83</b>

### Open Ended Questions

The open-ended questions were analyzed for common themes.

#### **Question 1: What content was most valuable in what you learned from this educational session about palliative care?**

This question resulted in *three themes* based on participant feedback. Three out of 14 participants (21.4%) stated that learning that “*palliative care was an “umbrella” and that this encompasses hospice care was helpful for them to learn.*” Another theme that was recognized was that five out of 14 participants (35.7%) felt it was “*helpful to learn that an early referral to palliative care can improve outcomes.*” The third theme that was noted was that “*chemotherapy, along with other curative therapies, could be part of the treatment plan with patients who are referred to palliative care.*” Three out of 14 participants (21.4%) found this information most valuable.

**Question Two: What content was most valuable in what you learned from this education session about the palliative care facilities and resources within VHSO?**

This question generated *three themes*. Four out of the 14 participants (28.6%) stated that “*having an open discussion with the group and with the palliative care nurse practitioner was most beneficial.*” The second theme that two of the 14 (14.3%) participants brought up was “*learning about the training opportunities within VHSO.*” Three out of the 14 participants (21.4%) stated that the most valuable learning point was that “*palliative care utilizes a multidisciplinary team approach.*”

**Question Three: What content was most valuable in what you learned from this educational session about the referral process within VHSO?**

This question also generated *three themes*. Five of the 14 participants (35.7%) stated that the “*screenshots of the referral process were most beneficial, as they could determine the exact process.*” The second theme was that two of the 14 (14.3%) stated that they learned that they could “*make specific comments within the referral so that specific needs of the patient could be addressed.*” The final theme for this question was that three of the 14 providers (21.4%) felt that the “*open discussion about the referral process was most beneficial.*”

**Question Four: What, if anything else, would be beneficial to you regarding palliative care education?**

This question resulted in *three themes* among the participants. The first theme, reported by two of the 14 providers (14.3%), was that they would like to “*learn how to accommodate patients who are home bound and do not need hospice, but rather need palliative care.*” The second theme was reported by four of the 14 providers (28.6%) and they wanted to know about

the “*telehealth possibilities in the future.*” The final theme was reported by three of the 14 providers (21.4%). They wanted to know about “*specific communication tactics to discuss palliative care with patients who associate palliative care with death and dying.*”

### **Discussion of the Results**

Overall, the findings indicated that the participants perceived an increase in knowledge for each goal set forth by this DNP project. The discussion of the results for each Research Goal is organized in reference to the findings from the Questionnaire, the open-ended questions, and sample characteristics from the Demographic Questionnaire.

#### **Goal 1: To increase provider understanding about palliative care and the benefits that patients can receive as a result of an early referral.**

The first goal of this project was to increase provider understanding about palliative care, and the benefits that the patients can receive as a result of an early referral. The majority of participants found this education session informative in regards to knowing that an early referral is best for patients experiencing a severe or life-limiting illness. It is important for providers to understand that an early referral is most beneficial to their patients because this will improve the support that the patient receives throughout the illness as well as improve the patient’s quality of life in the time they have remaining (Bakitas et al., 2009). Also, as a result of the literature review, it is known that this can also increase the amount of time a patient has left (Barton, 2014).

**Evaluation questionnaire.** One area of significance that was gained through this project was learning that many providers did not understand the basic definition and aspects of palliative care. As mentioned above, some of the providers did not understand that there was a difference

between palliative care and hospice care. Most also did not know that palliative care can be implemented at any stage throughout a life threatening illness. This is consistent with the literature review, as providers were unable to differentiate palliative care and hospice care, as well as experienced difficulty with understanding when palliative care can be implemented as part of the care plan (Wong et al., 2016; Walsh et al., 2011). For the best outcome, a palliative care referral is recommended as soon as possible after a severe or life-limiting illness (Sawatzky et al., 2016).

By the providers gaining a basic understanding of palliative care, they are now able to differentiate the types of care and determine what the most appropriate referral to make would be, depending on the patient's condition, care needs, and goals of care. The providers also had brief education on teamwork and collaboration abilities, symptom management knowledge, and how to support patients and families before, during, and after a palliative care referral is made (Alexander et al., 2006). Even though this was a brief education session on palliative care, the providers were able to improve their perceptions of palliative care, teamwork and collaboration abilities, symptom management tactics, and ways to support the patient and family during this phase of care (Friedrichsen et al., 2013). The providers learned that working in a collaborative environment, such as in the multidisciplinary team within palliative care, that coordination of care and outcomes are greatly improved.

Another important consideration throughout this education session is that the Veteran population has a specific culture that is all its own. Providers who work with Veterans understand that they have a special set of beliefs and attitudes toward medical care, and this is also true with palliative care. It is important for providers to have an understanding of the culture

of the population for which they care for, which can improve healthcare delivery, patient outcomes, and satisfaction from all involved (Bhat et al., 2015). This was an important topic that came up in the discussion during the education session. Veterans are generally hesitant to discuss options that are not curative in nature, as many have the idea that they will do whatever it takes to survive, in this case, conquer an illness. Many providers believe that Veterans do not wish to talk about options that are not curative. It was discussed that this is when the providers must be able to introduce palliative care as a support system for symptom management to go alongside curative therapies, and inform the patients that it can be concurrent treatment. Veterans are able to have the support of the palliative care team for symptom management despite having other teams for curative therapies.

**Open-ended questions.** Regarding the themes analyzed from the open-ended questions from the Evaluation Questionnaire, there were multiple discussion topics related to this goal. The majority of the participants believed that palliative care and hospice care were interchangeable, and many did not know the difference between the criteria for each type of care. Most did not understand that palliative care can be initiated early on in a disease process, rather than when the patient was near the end of life (Sawatzky et al., 2016). This was an important learning point for the participants of the study and will help them understand the benefits of a palliative care referral.

Providers gained the knowledge that by implementing palliative care early on in the disease process, patients can experience improved quality of life with decreased severity of symptoms (Grant et al., 2009). This is important for the providers to understand because the

earlier that palliative care is discussed with the patient, and the earlier that the referral is sent in, the better the quality of life for the patient.

Most of the participants believed that palliative care was not an option when the patient wanted to pursue curative therapies. This is important to understand because providers are able to refer patients for symptom management of a serious illness, even when curative therapies are still being pursued in the treatment plan (Grant et al., 2009). This is also beneficial because patients Veterans often wish to pursue curative therapies, and may need the extra support that palliative care can provide.

Providers wanted to delve deeper into communication tactics for discussing palliative care with patients. There were some tactics discussed during the education session, but there is a definite need for a more in-depth session for communication tactics specific to patients who are experiencing a severe illness. This was discussed with the palliative care team in order to set up a course that could assist with this need and could definitely take place in the near future and participants were appreciative of this. Communication is a vital component of palliative care and providers need to have a solid education on communication tactics (Gueguen et al., 2009; Alexander et al., 2006).

**Sample characteristics.** Each of the providers within the sample size serves in the outpatient setting, which is important to note as they generally see patients more frequently than other providers, be this in specialty clinics or in the inpatient setting. This project was tailored to the needs of the outpatient care provider, as they are generally able to initiate conversations regarding goals of care, leading in to the opportunity for the discussion of palliative care and possible referral. With this being said, it is imperative that providers in the outpatient setting



have a solid understanding of the services that palliative care provides as well as the goals of care.

It was also significant to learn about the amount of time that each provider had been in practice in their current area, as well as the total time they have been in practice. This relates back to the amount of training they have had previously in regards to palliative care, and how many of them feel comfortable with this subject. Being that the majority of the providers had been in practice over a decade, it can be concluded that most had not had formal palliative care education, as this is not a requirement for many medical and graduate level schools (Friederichsen et al., 2013).

**Goal 2: To increase provider knowledge of palliative care facilities and resources within VHSO so that they have a better understanding of what occurs when a referral is sent.**

The second goal of this project was to increase provider knowledge of palliative care facilities and resources within VHSO so that they have a better understanding of what occurs when a referral is sent. The findings indicated that participants enjoyed having an open discussion with the palliative care nurse practitioner, as well as knowing whom to contact when they have questions regarding any aspect of the referral. The participants gained an understanding of how a palliative care referral is sent within VHSO's electronic medical record, how to individualize the referral to include specific aspects of care that the patient will need, and general guidelines that would warrant a palliative care referral if there was any question as to whether the referral should be initiated or not. The participants also gained the knowledge of who to contact for any assistance when they are not sure of the next steps for a patient's care.

**Evaluation questionnaire.** Another significant aspect of this education session is that many providers found it helpful to learn about the education opportunities within VHSO. Only one participant had previously taken an ELNEC course. From the literature review, it was determined that the ELNEC program gives providers an in depth education on pain management, symptom management, ethical issues, communication, loss, grief and bereavement, final hours of life, and achieving quality palliative care (Malloy et al., 2008). This is a course that is offered on the VHSO campus yearly and gives the providers an opportunity to have more exposure in order to provide better care. There are also other training opportunities through VHSO including a course within their TMS training that they have access to. This gives the providers the opportunity to learn on their own time whenever they are able. Many of the providers did not know these were available and now they know that they do have access to these training opportunities.

**Open-ended questions.** In regards to the themes analyzed from the open-ended questions from the Evaluation Questionnaire, there were multiple discussion topics related to this goal. It was valuable to have the palliative care nurse practitioner present during the education session to be able to answer questions that were presented, as well as being able to go into further details if needed. The providers believed that they benefited from having direct access to the palliative care nurse practitioner to assist in answering their questions and relating her to the palliative care team.

Many of the providers were not aware of training opportunities held on the VHSO campus, as well as opportunities that are available for them to learn on their own time. This was an important component of the presentation as providers were unaware that they had access to

these courses and training opportunities. By the providers knowing these programs are available to them, they have the opportunity to further their knowledge on palliative care.

Many felt that they would be left out of the patient's care if they were referred to palliative care, so in turn, they felt that they needed to manage them on their own. This is a common theme among primary care providers nationally, as they do not want to give up their patients, so they feel they must manage them on their own (Aldridge et al., 2015). There was an open discussion about this point with the palliative care nurse practitioner and reassurance was given that the primary care provider remains a piece of the care team and have regular updates with the palliative care team. The primary care provider will still coordinate care for the patient and have access to all of their treatment plans, but they will not have to go about this by themselves. There is a whole team to assist in caring for the patient as a whole, and this needed to be explained.

Most of the participants stated that they had previously initiated a referral for patients at the end of life, but were not familiar with the process so the pictures were most helpful. By showing the providers the step-by-step process of initiating and sending a referral, they are able to complete this with ease and have peace of mind that the referral is being taken care of.

The providers felt that it would be beneficial if they could individualize the care plan if the patient. They learned during this presentation that this was possible, and indeed, preferred when sending a referral to add specific comments of the needs of the patient. This helps create an individualized care plan while incorporating the medical team, patient, and support system (Brickner et al., 2004). The providers felt that discussing the process of the referral and consultation process, along with discussing follow up and coordination of care between the

palliative care team and primary care, helped clarify any concern they had about not being involved in care.

**Sample characteristics.** One of the most clinically significant characteristics of the sample that the majority of the providers had not previously had any type of palliative care education, both in their education training and in the workforce. This is important because it relates back to what was found in the literature review. While palliative care education has become of greater importance during medical school or graduate school within the last two decades, providers who entered practice prior to this time had little to no formal training (Friedrichsen et al., 2013). This was shown with this sample size as well with many of the provider being in the field for multiple decades. By having the providers exposed to the basics of palliative care and the importance of this specialty, along with exposing them to further education opportunities, the providers are able to grasp this information and use it to benefit the patients that they care for.

**Goal 3: To increase provider intent to use the referral process for patients in need of palliative care.**

The third goal of this project was to increase provider intent to use the referral process for patients in need of palliative care. Results indicated that the providers learned many new aspects of palliative care that they were not aware of prior to this education session. After learning about the benefits that a palliative care referral can present a patient with, many of the providers now feel that serious illnesses warrant a palliative care referral, leading to an increase in referral intent within VHSO. After listening to the comments made during the presentation and discussion, and analyzing the themes from the provider feedback, it can be determined that the providers do

intend to utilize the resources within VHSO, including the palliative care team, which increases their referral intent within their practice. As providers are educated on palliative care and begin to acknowledge the benefits that a referral to palliative care can provide to patients, their intent to utilize palliative care for qualifying patients will increase (Snyder et al., 2015; Thoonsen et al., 2015).

**Evaluation questionnaire.** One area of significance was the feedback and themes from the open-ended questions on the evaluation questionnaire. In looking back at the literature review, it is well known that providers need training in communication, particularly with explaining bad news to patients (Alexander et al., 2006). Providers must know how to effectively communicate with patients to determine the specific and individualized goals of care, as well as to be able to better educate the patient on the expectations for their health going forward (Gramling et al., 2015). While the education session did explain brief tactics for communication regarding palliative care, an improvement in the future would be to expand on the communication tactics, or perhaps, have a training session specific to communication for patients who have a serious or life threatening illness. Many providers stated that they wanted to have more education on communication tactics to discuss palliative care with patients and their families. It is important to know the current knowledge of the participants to gain a better understanding of their specific needs within the setting (Pelayo et al., 2011). By increasing the participants' knowledge of communication tactics for palliative care, they will gain confidence in having these difficult discussions (Pelayo et al., 2011). This theme can be utilized in future palliative care education sessions for providers within VHSO, as well as give the participants

information so that they are able to look up different tactics that may benefit them personally in practice.

**Open-ended questions.** In regards to the themes analyzed from the open-ended questions from the Evaluation Questionnaire, there were multiple discussion topics related to this goal. The Home Based Primary Care team brought up the point that currently, the palliative care team at VHSO is not able to travel outside of the facility due to limited resources. This is a current limitation that is being explored in order to care for Veterans who need care within their home. The patient remains under the care of the HBPC team with coordination of care between the palliative care team and community hospice organizations. If the palliative care team were able to have access to travel, the HBPC team states that they would be more likely to initiate a referral.

Currently within VHSO, there are a few specialties that are able to utilize telehealth services for patients who are unable to make it to the facility for a visit. The palliative care team is working on utilizing this technology in order to provide care to a wider region. This would also encourage more providers to refer to palliative care due to having access to patients who would not have access to these services otherwise.

**Sample characteristics.** Each of the providers within the sample size serve in the outpatient setting, which is important to note as they generally see patients more frequently than other providers, be this in specialty clinics or in the inpatient setting. This project was tailored to the needs of the outpatient care provider, as they are generally able to initiate conversations regarding goals of care, leading in to the opportunity for the discussion of palliative care and possible referral. With this being said, it is imperative that providers in the outpatient setting

have a solid understanding of the services that palliative care provides as well as the goals of care.

Also by learning about the area of medicine that the providers have experience in, it can be determined the topics that they are discussing with their patients. When a provider has taken care of a patient for an extended amount of time, they develop a rapport with the patient and their family, leaving an opportunity for the provider to open up a discussion about the goals of care, even initiating this when a patient is healthy and without a serious diagnosis. Providers are able to discuss patient wishes, which is helpful to know because if the time comes and a patient is diagnosed with a serious illness, the provider will be able to discuss important topics, such as goals of care, advanced directives, and surrogacy designations to ensure that the patient's wishes are carried out (Ferrell et al., 2007).

### **Conceptual Framework**

The conceptual framework, the NCP Guidelines, was useful throughout this project, particularly with this the first goal. The providers were taught about the definition of palliative care, which creates uniformity of understanding for providers. This also creates consistency of care for patients experiencing severe illnesses, as providers understand when to refer patients (Ferrell, 2005).

The NCP Guidelines also address culture as a domain, creating a connection for the first goal of this project. This is important because the providers who participated in this education session provide care for a very unique population: Veterans. It is important for the providers to understand that when they understand the culture, they are better equipped to care for the patient population for which they serve (Ferrell, 2005). Veterans are often resistant to discussing death

and dying, so providers must understand this an approach the topic appropriately with this population.

The conceptual framework is incorporated into the learning opportunities for the providers, including the ELNEC course and TMS course through VHSO. These guidelines offer a structured set of information for the providers in order for them to learn how to systematically approach palliative care. The NCP guidelines also assist with knowing when to initiate a referral. If the patient needs any of the services that palliative care provides, then a referral would be warranted.

The conceptual framework was also useful in guiding inclusion of the component of communication for providers, including the interdisciplinary team, patients, and families. Each of the eight domains requires communication between the healthcare team, patient, and support system, leaving this an important component for providers to be able to initiate (Ferrell, 2005).

### **Limitations and Strengths**

The small sample size limits the conclusions that can be drawn from these results, and generalized to any other samples. Even though the sample size was quite diminished compared to the initial target, important information was obtained throughout this project and the findings provide initial insights about the goals of the study. Another limitation was that there was a limited time frame to complete the in-person education session, as there was a full agenda for the February 2017 meeting. The providers were still able to engage in discussion and review the printed materials, giving them the opportunity to further review the information on their own time.



Strengths of the study include the strong reliability of the questionnaire, and the completeness of the data provided by all participants. Another strength of this project was that it brought everyone together to for an open discussion amongst peers in regards to palliative care. The providers were able to learn and discuss components of palliative care to better care for their patients and collaborate with each other.

### **Implications for Future Research**

In the future, when this education session is presented, some changes will be implemented to improve the outcomes from this project. These changes include, but are not limited to, adding more detail regarding communication tactics, obtaining a larger sample size, a longer presentation time will be obtained to go into further details, and more members of the palliative care team will be present for open discussion. There will also be more case studies in order to engage more of the audience members and get their feedback on how they think through specific cases.

Another option for the future of this project would be to collect data in regards to the amount of referrals that are obtained from outpatient care providers before and after this education session. This would allow the investigator to determine if the education was beneficial for the long term and have hard data to determine if it was beneficial or made a difference in the outcomes. By monitoring the number of palliative care referrals, the investigator could determine changes that needed to be made and other needs that the outpatient care providers may have.

As a result of the educational session, the providers at VHSO realized that there was much to learn in regards to palliative care that was not known prior to this education session. Many now understand the benefit that palliative care can offer patients and their families, as well

as the provider, as they now have a team beside them to collaborate with in the care of their patients. The majority of provider's state that they now understand the education opportunities within VHSO and intend to take advantage of these offerings in the near future, leading to an even greater knowledge of palliative care. This DNP project incorporates many aspects of multidisciplinary team approaches, definitions and scientific foundations of palliative care, the referral process, and communication tactics, which are needed for this group of providers.

The providers now understand the referral process and what to expect when a referral is initiated. Providers have contact information for the palliative care team when questions arise, whether this be on a consultative basis to see their patients, or for general questions in regards to palliative care. Education opportunities are available to them and they are now aware of different options that fit their schedule, knowledge base, and how specialized they want their education to be.

Overall, this project informed the providers, investigator, and palliative care team, that there is a deficit in knowledge from outpatient care providers in regards to palliative care. The providers did find this education session informative and beneficial, as well as improved their intent to initiate referrals to palliative care for those who would benefit.

APPENDIX A:  
HUMAN SUBJECTS FORMS



DEPARTMENT OF VETERANS AFFAIRS  
 INSTITUTIONAL REVIEW BOARD  
 Central Arkansas Veterans Healthcare System  
 4300 West 7th Street  
 Little Rock, AR 72205



DATE: December 13, 2016

TO: Britny Sutulovich, APRN  
 Principal Investigator

FROM: Ellen Fischer, PhD  
 CAVHS Institutional Review Board Chair

PROTOCOL TITLE: [930692-2] PALLIATIVE CARE EDUCATION TO INCREASE OUTPATIENT  
 PROVIDER KNOWLEDGE AND PALLIATIVE CARE REFERRAL INTENT  
 WITHIN VETERANS HEALTHCARE SYSTEM OF THE OZARKS: A  
 QUALITY IMPROVEMENT PROJECT

SUBMISSION TYPE: Response/Follow-Up

REVIEW TYPE: Expedited Review

ACTION: DETERMINATION OF NOT RESEARCH

EFFECTIVE DATE: December 12, 2016

Thank you for submitting the **New Project** materials for the above activity. The CAVHS Institutional Review Board's designated reviewer has determined this activity does not meet the Common Rule or FDA definition of research. As such, neither IRB approval nor oversight of this project is required.

This determination will be reported to the IRB committee during the next convened IRB meeting. Neither you nor any of the identified collaborators participated in the review or decision making. No further action on submission 930692-2 is required at this time.

The following items are acknowledged in this submission:

- Letter - Response to Contingencies Letter.doc (UPDATED: 12/3/2016)
- Other - VHSO R&D Committee Request to Review Research Proposal. 12/3/16 (UPDATED: 12/3/2016)
- VA - R&D Request to Review Research Proposal - VA - R&D Request to Review Research Proposal (UPDATED: 12/3/2016)

The following documents which support this determination were reviewed November 30, 2016:

- Abstract/Summary - IRB Abstract and Procedures.docx (UPDATED: 11/22/2016)
- Other - Project Data Information.docx (UPDATED: 11/21/2016)
- Other - Non-Human Non-Research Worksheet Fillable FINAL V1.2 06242015-StewartFINAL-2.pdf (UPDATED: 11/18/2016)
- Other - VHSO R&D Committee Request to Review Research Proposal.pdf (UPDATED: 11/7/2016)
- Questionnaire/Survey - Demographics Form.docx (UPDATED: 11/21/2016)
- Questionnaire/Survey - Palliative Care Education Session Evaluation Form.docx (UPDATED: 11/21/2016)

- VA - R&D Request to Review Research Proposal - VA - R&D Request to Review Research Proposal  
(UPDATED: 11/22/2016)

***By copy of this letter, R&D will be notified of this Non-Research determination.***

Ellen Fischer, PhD

FWA00002261  
IRB00006264

This electronically generated document serves as official notice to sponsors and others of approval, disapproval or other IRB decisions. Only those individuals who have been granted authority by the institution to create letters on behalf of the IRB are able to do so. A copy of this document has been retained within CAVHS IRBNet records. The IRBNet System is fully compliant with the technology requirements for Electronic Records per CFR 21, Part 11, Section 11.10 - Controls for Closed Systems, and the technology requirements for Electronic Signatures per CFR 21, Part 11 Subpart C - Electronic Signatures.



DEPARTMENT OF VETERANS AFFAIRS  
Medical Center  
1100 North College Avenue  
Fayetteville, AR 72703-6995

In Reply Refer To:

DATE: December 21, 2016

TITLE: # 930692-2

Palliative Care Education to Increase Outpatient Provider Knowledge and Palliative Care Referral Intent within VHSO, a Quality Improvement Project

PRINCIPAL INVESTIGATOR: Britny Sutulovich, APRN

Your proposal as listed above was reviewed and deemed NON-RESEARCH by the IRB sub-committee. The VHSO R&D Committee reviewed this and approved as non-research. This implies to the PI that this activity is NOT designed to develop or contribute to generalizable knowledge outside of VHSO. Therefore this project is not to be undertaken with the intent to be published or generalized beyond the VA healthcare system.

  
Janet Tekell, MD  
Research Coordinator



**Research**  
Office for Research & Discovery

Human Subjects  
Protection Program

1618 E. Helen St.  
P.O.Box 245137  
Tucson, AZ 85724-5137  
Tel: (520) 626-6721  
<http://rgw.arizona.edu/compliance/home>

<b>Date:</b>	January 13, 2017
<b>Principal Investigator:</b>	Tiffany Nicole Stewart
<b>Protocol Number:</b>	1701124463
<b>Protocol Title:</b>	Palliative Care Education to Increase Outpatient Provider Knowledge and Palliative Care Referral Intent Within Veterans Healthcare System of the Ozarks: A Quality Improvement Project.
<b>Determination:</b>	Human Subjects Review not Required

The project listed above does not require oversight by the University of Arizona because the project does not meet the definition of 'research' and/or 'human subject'.

- **Not Research as defined by 45 CFR 46.102(d):** As presented, the activities described above do not meet the definition of research as cited in the regulations issued by the U.S. Department of Health and Human Services which state that "research means a systematic investigation, including research development, testing and evaluation, designed to contribute to generalizable knowledge".
- **Not Human Subjects Research as defined by 45 CFR 46.102(f):** As presented, the activities described above do not meet the definition of research involving human subjects as cited in the regulations issued by the U.S. Department of Health and Human Services which state that "human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention *or* interaction with the individual, or identifiable private information".

Note: Modifications to projects not requiring human subjects review that change the nature of the project should be submitted to the Human Subjects Protection Program (HSPP) for a new determination (e.g. addition of research with children, specimen collection, participant observation, prospective collection of data when the study was previously retrospective in nature, and broadening the scope or nature of the research question). Please contact the HSPP to consult on whether the proposed changes need further review.

The University of Arizona maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #00004218).

APPENDIX B:  
PALLIATIVE CARE EDUCATION SESSION EVALUATION FORM



**Palliative Care Education Session Evaluation Form**

**Instructions:** Please evaluate the *Palliative Care Education Session Evaluation* by placing an 'X' in the box to indicate your level of agreement (on the 6-point scale) with each item below.

<b>The palliative care education session and materials increased:</b>	<b>Strongly Disagree 1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>Strongly Agree 6</b>
1. The palliative care education session and materials increased my understanding of the 8 Domains of National Consensus Project (NCP) guidelines for palliative care.	○					○
2. The palliative care education session and materials increased my understanding of the benefits that patients can receive as a result of early referral.	○					○
3. The palliative care education session and materials increased my understanding of the difference between palliative care and hospice.	○					○
4. The palliative care education session and materials increased my understanding of the interdisciplinary nature of palliative care.	○					○
5. The palliative care education session and materials increased my knowledge of conditions that warrant a palliative care referral.	○					○
6. The palliative care education session and materials increased my knowledge of the VHSO palliative care referral process.	○					○
7. The palliative care education session and materials increased my knowledge of palliative care resources and services available at VHSO.	○					○
8. The palliative care education session and materials increased my knowledge of how to communicate with patients and families regarding palliative care.	○					○

### **Palliative Care Education Session Evaluation Form**

**Instructions:** Please evaluate the *Palliative Care Education Session Evaluation* by placing an 'X' in the box to indicate your level of agreement (on the 6-point scale) with each item below.

<b>The palliative care education session and materials increased:</b>	<b>Strongly Disagree 1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>Strongly Agree 6</b>
9. The palliative care education session and materials increased my intention to discuss palliative care as an option for patients and families facing serious illness or end of life.	<input type="radio"/>					<input type="radio"/>
10. The palliative care education session and materials increased my intention to make referrals to palliative care for patients who would benefit from it.	<input type="radio"/>					<input type="radio"/>
11. The palliative care education session and materials increased my value for palliative care for patients and families who are suffering from serious illnesses.	<input type="radio"/>					<input type="radio"/>
12. The palliative care education session and materials increased my intention to recommend palliative care education to other outpatient providers.	<input type="radio"/>					<input type="radio"/>

1. What content was most valuable in what you learned from this educational session about palliative care?

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2. What content was most valuable in what you learned from this education session about the palliative care facilities and resources within VHSO?

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3. What content was most valuable in what you learned from this educational session about the referral process within VHSO?

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4. What, if anything else, would be beneficial to you regarding palliative care education?

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APPENDIX C:  
DEMOGRAPHICS FORM



APPENDIX D:  
LITERATURE REVIEW

Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Bhat, A.M., Wehbe-Alamah, M., McFarland, M., Filter, M., Keiser, M. (2015). Advancing cultural assessments in palliative care using web-based education. <i>Journal of Hospice and Palliative Nursing</i>, 17:4, 348-355. DOI: 10.1097/NJH.0000000000000175</p>	<p>Quasi-Experimental Design</p>	<p>To determine if, after completing cultural competence education, registered nurses working in a combined palliative care and hospice unit increased their cultural awareness, sensitivity, and cultural assessment documentation.</p>	<p><b>Sample:</b> 15 volunteer Registered Nurses.</p> <p><b>Setting:</b> PCH unit of a 1070-bed Midwestern teaching hospital. PCH unit has 22 private rooms with an average monthly admission of 150 patients.</p>	<p><b>Data Collection:</b> Electronic chart review with 40 patients per stage of intervention with initial pre-intervention sample. Nurse participants took a pre-intervention and post-intervention Cultural Competence Assessment (CCA) for accurate module effectiveness. Nurses also completed 3 modules on cultural competence created by the researchers and cultural competence as assessed again. Scored from the CCAs were compared.</p> <p><b>Data Analysis:</b> Statistical analysis software (SPSS) was used to analyze pre and post intervention CCA scored of participating nurses using paired a t test with a 95% confidence interval. A Mann-Whitney U test was performed to evaluate effectiveness of educational degree, diversity training, and self-rated cultural competency value on all scores.</p>	<p>The paired t test indicated a statistically significant change in the total CCA after the intervention, with both the cultural competence behavior (P&lt;.001) and cultural awareness and sensitivity subscales (P&lt;.05) showing significance. The independent t test and Mann-Whitney U test confirmed that there was no correlation between the score changes and the variables of age, prior cultural diversity training, or education degree.</p> <p>Each section was analyzed separately. The culture section did not have a significant change (n = 2 [4.9%]). The spirituality section had an increase in post-intervention selected choices (n = 6 [14.6%]) as compared with the pre-intervention charts (n = 1 [2.5%]). The significance was (P</p>

					<p>&lt;.052). The cultural/end-of-life/spirituality section had the greatest change with negligible need identification (n = 1 [2.5%]), whereas the post-intervention charts had a significant increase in identified needs (n = 12[29.3%]) with the significance being (P&lt;.001).</p>
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Case, A.A., Orrange, S.M., Weissman, D.E. (2013). Palliative medicine physician education in the United States: A historical review. <i>Journal of Palliative Medicine</i>, 16:3, 230-236. DOI: 10.1089/jpm.2012.0436</p>	<p>Systematic Review</p>	<p>This review sought information about palliative care education milestones, instrumental projects, and barriers to further development of palliative medicine education.</p>	<p><b>Sample:</b> 18 Hospice and Palliative Medicine Educators</p> <p><b>Setting:</b> United States</p>	<p><b>Data Collection:</b> A survey tool was designed and was emailed to 18 leaders in the field of HPM education regarding their experiences in promoting palliative care education over the past 20 years. Follow-up phone calls were made to further explore specific questions.</p> <p><b>Data Analysis:</b> A history was developed based on the literature review and the feedback from the HPM educators. The survey were placed into categories based on education in various areas, national projects, what has happened in the past, and what is expected to happen in the future regarding HPM education.</p>	<p>Clinical HPM training experiences for medical students, residents, fellows, and midcareer trainees, the most important component of meaningful HPM education, are growing in scope but are straining the resources of hospice and palliative medicine specialist teams. Improving the knowledge of primary care providers with palliative care knowledge and skills will help ease the strain on the specialists. This will not substitute for specialist-level interactions. Training with specialists is still needed with didactic teaching methods as the primary method of palliative medicine education. Improving education through policy work is needed now more than ever. A policy agenda around expanded palliative medicine</p>



					physician manpower is essential, as the aging U.S. population will require more and more specialist palliative resources.
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Grant, M., Elk, R., Ferrell, B., Morrison, S., von Gunten C.F. (2009). Current status of palliative care—Clinical implementation, education, and research. <i>CA: A Cancer Journal for Clinicians</i>, 59:5, 327-335. DOI: 10.3322/caac.20032</p>	<p>Descriptive Research Design</p>	<p>To identify the current status of palliative care, the challenges to implementing palliative care, the methods to improve application of palliative care principles, and the clinical implications for clinicians involved in caring for patients with serious and advanced cancer.</p>	<p><b>Sample:</b> Health care professionals caring for cancer patients</p> <p><b>Setting:</b> United States</p>	<p><b>Data Collection:</b> Information was obtained from agencies that are utilizing national guidelines for quality care, multidisciplinary educational offerings, research endeavors, and resources made available to clinicians who are seeing patients with life-limiting illnesses.</p> <p><b>Data Analysis:</b> The information that was obtained was analyzed to determine the current use of the NCP guidelines and other forms of palliative care and end-of-life care educational opportunities. Each state was evaluated to determine how effectively they are managing palliative care education. Challenges with utilizing palliative care resources were also determined.</p>	<p>To date, approximately 2,300 hospitals and hospices and more than 5,000 individuals have participated in CAPC seminars or PCLC training. Two years after training, 76% of teams that did not have a program in place at the time of training succeeded in establishing a palliative care program. CAPC seminars and PCLC training are attended by a diverse population of health care professionals: 33% physicians, 21% nurses, 17% advanced practice nurses, 5% social workers, and 3% clergy.</p> <p>Multidisciplinary educational initiatives, in clinical applications, and research studies have begun to move palliative and end-of-life care toward the recommendations</p>

					identified in the National Consensus Guidelines. Continued efforts on all fronts will be needed to identify compassionate and appropriate care and to disseminate this care to all clinicians caring for cancer patients.
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Malloy, P., Virani, R., Ferrell, B.R., Bednash, G.P. (2008). End-of-life nursing education consortium: 5 years of educating graduate nursing faculty in excellent palliative care. <i>Journal of Professional Nursing</i>, 24:6, 352-357. DOI: 10.1016/j.profnurs.2008.06.001</p>	<p>Descriptive Quantitative</p>	<p>To describe the history of the ELNEC-Graduate project and to demonstrate its impact in empowering graduate nursing faculty members to improve their teaching methods and strategies regarding end-of-life and palliative care education.</p>	<p><b>Sample:</b> 286 graduate nursing faculty  <b>Setting:</b> ELNEC-Graduate courses</p>	<p><b>Data Collection:</b> Participants were competitively chosen to attend one of the four courses based on competitive selection from an application that included their goals for the dissemination and implementation of the curriculum. An aggressive 6- and 12-month post-course evaluation was conducted to document the experiences of the trainers.  <b>Data Analysis:</b> The strengths of the educators was determined by the post-course evaluations and their students' evaluations of education. Evaluations took place 12 months post ELNEC training and evaluated to initial and posttests.</p>	<p>With the implementation of this program, there has been a substantial curriculum change in graduate nursing programs which now provide an average of 34.22 hours of palliative care education compared to the 11.89 prior to implementation. Each area of the ELNEC training has shown a significant improvement of P&lt;.001 including adequacy of palliative care, pain management, symptom management, ethical/legal, communication, grief/loss, prep for time of death, and quality of life.</p>

Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Gramling, R., Sanders, M., Ladwig, S., Norton, S.A., Epstein, R., Alexander, S.C. (2015). Goal communication in palliative care decision-making consultations. <i>Journal of Pain and Symptom Management</i>, 50:5, 701-706. DOI: 10.1016/j.jpainsymman.2015.05.007</p>	<p>Cross-Sectional Design</p>	<p>To describe the frequency, types, and determinants of goal expression in PC consultations.</p>	<p><b>Sample:</b> 71 inpatient palliative care consultations</p> <p><b>Setting:</b> 750-bed academic medical center in the northeast U.S. with a mature inpatient PC consultation service completing more than 1000 consultations annually.</p>	<p><b>Data Collection:</b> The consultations were video recorded with participant consent. The consultation forms allowed data collection including the areas of patient age, gender, primary diagnoses, referral reason, Palliative Performance Scale (PPS) score, Edmonton Symptom Assessment System score, current mechanical ventilation, bi-level positive airway pressure (BIPAP), artificial nutrition or hemodialysis, and, if present, any advance directives. A communication evaluation tool based on theoretical and empirical understanding of goals communication in advanced illness was created for coding purposes for this study.</p> <p><b>Data Analysis:</b> The frequency and distribution of all study variables, including goal expression,</p>	<p>During the four-month enrollment period, 15 PC clinicians (11 attending physicians, two nurse practitioners, and two physician fellows) actively participated in at least one observed consultation. 100 patients were approached and 75 completed both consent and audio recording. Three recorded consultations contained insufficient conversation for analyses. Thus, the final sample includes 72 conversations. Characteristics of the study sample did not differ substantively from a historical sample of 2043 PC consultations preceding this study. Approximately 7/10 conversations included at least one goal expression, and one-third contained expressions of more than one type of goal. The frequency of goal expressions followed a count distribution,</p>

				<p>topics of goal expression, and number of goal expression topics addressed per conversation were described. For stratification variables with many potential thresholds, low/middle/high categories based on the observed distributions of our data to explore potential dose-response relationships were created. For categorical variables, proportions and Chi-squared tests were used. Based on the observed count distribution of goal expressions, bivariate and multivariate Poisson regression modeling for statistical significance testing and assessment of confounding was used. Both forward and backward model-building procedures to assess potential confounding, using change in magnitude of association as an indicator of confounding were utilized.</p>	<p>having a mean of 1.5 and an SE of 0.2.</p>
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Gueguen, J.A., Bylund, C.L., Brown, R.F., Levin, T.T., Kissane, D.W. (2009). Conducting family meetings in palliative care: Themes, techniques, and preliminary evaluation of a communication skills module. <i>Palliative and Supportive Care</i>, 7:1, 171-179. DOI: 10.1017/S1478951509000224</p>	<p>Quasi-Experimental Design</p>	<p>To develop a communication skills training module for health care professionals about how to conduct a family meeting in palliative care and to evaluate the module in terms of participant self-efficacy and satisfaction.</p>	<p><b>Sample:</b> 40 multi-specialty healthcare professionals working in oncology</p> <p><b>Setting:</b> New York City Metropolitan-area hospitals</p>	<p><b>Data Collection:</b> At the conclusion of each module, participants completed an anonymous course evaluation form that contains eight statements about the workshop to be rated on level of agreement disagreement using a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree).</p> <p><b>Data Analysis:</b> The pre and post tests were compared using a paired t-test using the data created by the evaluations at the end of each module.</p>	<p>The use of a paired t-test shows that learners' confidence in conducting a family meeting increased significantly as a result of participation in the workshop as measured by the retrospective pre and post questions (<math>t=-5.551</math>, <math>df=39</math>, <math>p &lt; .001</math>). 92% of participants found each of the four elements of the curriculum process (booklet, didactic teaching, exemplary video, role play observation) aided their learning somewhat or a lot, with 100% of learners reporting this to be the case for the exemplary video and role play observation. Three of the 40 participants answered the open-ended question, with two suggesting more time for role play practice.</p>

Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
Balon, R., Motlova, L.B., Beresin, E.V., Coverdale, JH. Louie, A.K., Roberts, L.W. (2015). A case for increased medical student and psychiatric resident education in palliative care. <i>Academic Psychiatry</i> , 40:2, 203-206. DOI: 10.1007/s40596-015-0479-6	Systematic Review	To determine if United States medical students in the specialty of psychiatry and neurology are prepared to have difficult conversations relating to symptomatic care and end of life care.	<p><b>Sample:</b> Medical students in psychiatry and neurology</p> <p><b>Setting:</b> United States and European Countries</p>	<p><b>Data Collection:</b> Literature was reviewed on previous studies to determine if medical students were prepared to have these conversations and if the education was relevant to the intended interaction.</p> <p><b>Data Analysis:</b> Literature was analyzed based on which education programs best helped medical students prepare for palliative care patients and their families.</p>	The general recommendations for curriculum development in palliative care would address six areas: basics of palliative care, pain and symptom management, psychosocial and spiritual aspects, ethical and legal issues, communication, and teamwork and self-reflection. It is proposed that the curriculum be a minimum of 40 hours throughout the program. Residency training programs should be encouraged and perhaps mandated to introduce rotations in palliative care. It is the hope that actual knowledge and essential core information is taught, using small groups for problem-based learning and multidisciplinary teaching.



Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Phillips, J.L., Heneka, N., Hickman, L., Lam, L., Shaw, T. (2014). Impact of a novel online learning module on specialist palliative care nurses' pain assessment competencies and patients' reports of pain: Results from a quasi-experimental pilot study. <i>Palliative Medicine</i>, 28:6, 521-529. DOI: 10.1177/0269216314527780</p>	<p>Quasi-Experimental Design</p>	<p>To test the impact of an online pain assessment learning module on specialist palliative care nurses' pain assessment competencies, and to determine whether this education impacted positively on palliative care patients' reported pain ratings.</p>	<p><b>Sample:</b> 34 nurses <b>Setting:</b> Two Australian inpatient specialist palliative care services</p>	<p><b>Data Collection:</b> Participants took the Self-Perceived 'Pain Assessment Competencies' survey (Self-PAC Survey). The 17 survey questions reflected the essential elements of a comprehensive pain assessment. The survey sought demographic information related to clinical experience, postgraduate education and insights into pain assessment capabilities through a series of pain assessment knowledge and confidence questions.</p> <p>There was also a chart audit of 60 consecutive palliative care inpatients admitted with pain. A standardized pain assessment audit tool designed to capture pain assessment practices at admission, and throughout the admission and up to the a priori audit date for patients who had not been</p>	<p>The results reported conform to the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Guidelines. Participants who completed the education intervention (n= 34) increased their pain assessment knowledge, assessment tool knowledge and confidence to undertake a pain assessment (p&lt; 0.001). Participants were more likely to document pain intensity scores in patients' medical records than non-participants (95% confidence interval = 7.3%–22.7%, p= 0.021). There was also a significant reduction in the mean patient-reported pain ratings between the admission and audit date at post-test of 1.5 (95% confidence interval = 0.7–2.3) units in pain score.</p>

				<p>discharged, was utilized.</p> <p><b>Data Analysis:</b> Statistical analyses were performed using SPSS software. Independent sample t-test was used to compare the 'responders' (participants who completed the T1 and T2 surveys and the intervention) and 'non-responders' (participants who only completed the T1 survey). A paired sample t-test was used to determine whether there was a difference between nurses' pain assessment: knowledge, tool awareness and confidence scores at T1 and T2.</p>	
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Alexander, S.C., Keitz, S.A., Sloane, R., Tulsky, J.A. (2006). A controlled trial of a short course to improve residents' communication with patients at the end of life. <i>Academic Medicine</i>, 81(11), 1008-1012. DOI: 10.1097/01.ACM.0000242580.83851.ad</p>	<p>Prospective trial</p>	<p>The goal was to evaluate the effect of a short course to improve residents' communication skills delivering bad news and eliciting patients' preferences for end-of-life care.</p>	<p><b>Sample:</b> 56 internal medicine residents <b>Setting:</b> Duke University</p>	<p><b>Data Collection:</b> Residents' communication skills were evaluated using audio-recorded encounters with standardized patients and completed two tasks: delivering bad news and discussing patients' preferences for life-sustaining treatments. The intervention group interviewed four standardized patients before the intervention (two bad-news cases and two patient-preferences cases) and four standardized patients afterwards. The control physicians completed only one evaluation at one point in time (two bad-news cases and two patient-preferences cases).  Two communication evaluation tools (Bad-News Conversations And Patient Preferences) were derived from</p>	<p>Thirty-seven residents received the intervention and 19 were in the control group. Residents attending the course demonstrated statistically significant increases in their overall skill ratings in the delivery of bad news, with improvement in the specific areas of information giving and responding to emotional cues. Although cumulative scores for discussions about patient preferences for treatment did not increase, residents demonstrated enhanced specific skills including discussing probability, presenting clinical scenarios, and asking about prior experience with end-of-life decision making. A relatively short, intensive course can improve the end-of-life communication skills of U.S. medical residents.</p>

				<p>empirical literature and were based on the “standards of practice” for palliative care.</p> <p>Both evaluation tools incorporated specific content and interaction physician communication skills.</p> <p><b>Data Analysis:</b> Two research assistants (coders), who were blinded to physician treatment group, evaluated the encounters. Thirty-seven percent of the bad-news conversations and 40% of the patient-preferences conversations were coded by both raters and a kappa statistic was calculated for each code to obtain interrater reliability of the coding system.</p>	
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Bakitas, M., Lyons, K.D., Hegel, M.T., Balan, S., Brokaw, F.C., Seville, J., . . . Ahles, T.A. (2009). Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: The project ENABLE II randomized control trial. <i>JAMA</i>, 302(7), 741-749. DOI:10.1001/jama.2009.1198.</p>	<p>Randomized Control Trial</p>	<p>To determine the effect of a nursing-led intervention on quality of life, symptom intensity, mood, and resource use in patients with advanced cancer.</p>	<p><b>Sample:</b> 322 patients with advanced cancer. <b>Setting:</b> Rural National Cancer Institute–designated comprehensive cancer center in New Hampshire and affiliated outreach clinics and a VA medical center in Vermont.</p>	<p><b>Data Collection:</b> A multicomponent, psychoeducational intervention (Project ENABLE [Educate, Nurture, Advise, Before Life Ends]) conducted by advanced practice nurses consisting of 4 weekly educational sessions and monthly follow-up sessions until death or study completion vs usual care. <b>Data Analysis:</b> Quality of life was measured by the Functional Assessment of Chronic Illness Therapy for Palliative Care (score range, 0-184). Symptom intensity was measured by the Edmonton Symptom Assessment Scale (score range, 0-900). Mood was measured by the Center for Epidemiological Studies Depression Scale (range, 0-60). These measures were assessed at baseline, 1 month, and every 3 months until death or study completion. Intensity of service was</p>	<p>A total of 322 participants with cancer of the gastrointestinal tract (41%; 67 in the usual care group vs 66 in the intervention group), lung (36%; 58 vs 59), genitourinary tract (12%; 20 vs 19), and breast (10%; 16 vs 17) were randomized. The estimated treatment effects (intervention minus usual care) for all participants were a mean (SE) of 4.6 (2) for quality of life (<math>P = .02</math>), -27.8 (15) for symptom intensity (<math>P = .06</math>), and -1.8 (0.81) for depressed mood (<math>P = .02</math>). The estimated treatment effects in participants who died during the study were a mean (SE) of 8.6 (3.6) for quality of life (<math>P = .02</math>), -24.2 (20.5) for symptom intensity (<math>P = .24</math>), and -2.7 (1.2) for depressed mood (<math>P = .03</math>). Intensity of service did not differ between the 2 groups.</p>

				measured as the number of days in the hospital and in the intensive care unit (ICU) and the number of emergency department visits recorded in the electronic medical record.	
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Friedrichsen, M., Heedman, P., Astradsson, E., Jakobsson, M., Milberg, A. (2013). Does a half-day course about palliative care matter? A quantitative and qualitative evaluation among health care practitioners. <i>Journal of Palliative Medicine</i>, 16(5), 496-501. DOI: 10.1089/jpm.2012.0489</p>	<p>Evaluation Study</p>	<p>The aims of this study were to quantitatively and qualitatively explore professionals' experience of the usefulness and importance of a palliative care course.</p>	<p><b>Sample:</b> structured and open-ended questions (n=355) and in focus group discussions (n=40). <b>Setting:</b> Sweden</p>	<p><b>Data Collection:</b> Quantitative: A questionnaire explored participants' perceptions of the usefulness and importance of the course regarding the pedagogical aspects, the content, time used, and the expected benefits of the intervention in daily work. The participants were asked to fill in the questionnaire directly after the interventional course. An extended questionnaire was sent to the participants after three months without reminder, with additional questions on team cooperation, breakpoint dialogue, symptom management, and support to family members, as well as two open-ended questions. Qualitative: Staff members participated in the focus group interviews, with varied participants in regards to occupation, age, and gender. The interviewers</p>	<p>The majority of participants were allied professionals (86%). Course evaluation immediately after the intervention showed high scores. At three months, 78% of the 86 participants who had cared for a dying patient since the course claimed that the course had been useful in their work. In addition, there were improvements regarding symptom management (37%), support to family members (36%), more frequent break point conversations (31%), and improved cooperation in the teams (26%). The qualitative analysis showed that the course made participants start to compare their own working experiences with the new knowledge. When returning to work, the participants feel strengthened by the newly acquired knowledge, but the will</p>

				<p>took different roles: a facilitator and a transcriber role. The facilitator role involved guiding the discussion. The transcriber made observations and took notes, asked follow-up questions, and ended the session by giving a summary of the content of the discussion and then inviting the participants to give positive and negative feedback. The interview guide focused on perceptions of palliative care, positive/negative experiences of working with dying people, and expectations of the course intervention. In the second and third interviews the participants were asked if the course intervention had changed their everyday practice with dying patients, and if so, in what way.</p> <p><b>Data Analysis:</b>  Quantitative: analyzed statistically using X2 (Statistica 7.1).  Qualitative: The focus group interviews were transcribed verbatim and analyzed using qualitative</p>	<p>to improve the care also led to frustration, as some of the participants described that they wanted to change routines in the care of the dying, but felt hindered.</p>
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				<p>content analysis. Three of the authors first read through the interview text and analyzed it separately (identification of meaning units, coding, and preliminary categorization). This was followed by a discussion about their separate preliminary categories. Closely related categories were merged together and descriptions of the content of the final categories were developed.</p>	
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Pelayo, M., Cebrian, D., Areosa, A., Agra, Y., Izquierdo, J.V., Buendia, F. (2011). Effects of online palliative care training on knowledge, attitude, and satisfaction of primary care physicians. <i>BMC Family Practice</i>, 12(37). DOI: 10.1186/1471-2296-12-37</p>	<p>Randomized Controlled Trial</p>	<p>To measure the effectiveness of an online educational module for palliative care for primary care physicians regarding knowledge, attitude towards palliative care, and physician's satisfaction in comparison with a control group.</p>	<p><b>Sample:</b> 165 physicians (85 intervention; 84 in control) <b>Setting:</b> Primary care centers in Spain</p>	<p><b>Data Collection:</b> Multiple questionnaires for subjects including professional data, attitudes, and basic knowledge were taken by each provider in the study after taking the 4 online modules. <b>Data Analysis:</b> Frequencies and mean comparisons were analyzed with SPSS (version 18), non-parametric tests were conducted (sign test and Mann-Whitney U test for matched and independent ordinal data) with significant bilateral contrasts in level 0.05, and the Cohen's effect size was calculated between both groups.</p>	<p>There were significant differences in favor of the intervention group, in terms of knowledge (mean 4.6; CI 95%: 2.8 to 6.5 (p = 0.0001), scale range 0-33), confidence in symptom management (p = 0.02) and confidence in terms of communication (p = 0.038). Useful aspects were pointed out, as well as others to be improved in future applications. The satisfaction of the intervention group was high.</p>

Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Thoosen, B., Gerritzen, S.H.M., Vissers, K.C.P., Verhagen, S., van Weel, C., Groot, M., Engels, Y. (2016). Training general practitioners contributed to the identification of palliative patients and to multidimensional care provision: secondary outcomes of an RCT. <i>BMJ Supportive &amp; Palliative Care</i>, 0, 1-8. DOI:10.1136/bmjspcare-2015-001031</p>	<p>Randomized Controlled Trial</p>	<p>To determine if general practitioners identified more palliative patients, and provided multidimensional and multidisciplinary care more often after 1 year of training than untrained general practitioners.</p>	<p><b>Sample:</b> 134 general practitioners <b>Setting:</b> The Netherlands</p>	<p><b>Data Collection:</b> One year after GPs in the intervention group of an RCT were trained, a survey was performed. With the help of a questionnaire, all 134 GPs were asked how many palliative patients they had identified, and whether anticipatory care was provided. Researchers studied number of identified palliative patients, expected lifetime, contact frequency, whether multidimensional care was provided and which other disciplines were involved.</p> <p><b>Data Analysis:</b> Statistical analyses were performed with the use of SPSS software, V.20.0. Descriptive statistics were used to calculate frequencies, means and SDs of the study variables. Differences between trained and untrained GPs, and</p>	<p>Trained GPs identified more palliative patients than did untrained GPs (median 3 vs 2; p 0.046) and more often provided multidimensional palliative care (p 0.024). In both groups, most identified patients had cancer. RADPAC sensitizes GPs in the identification of palliative patients. Trained GPs more often provided multidimensional palliative care. Further adaptation and evaluation of the tools and training are necessary to improve early palliative care for patients with organ failure.</p>

				between patients of trained and of untrained GPs, were assessed with the use of Fisher Exact tests for categorical variables, as some cells counted less than 5 and, because of the relatively small number of patients, with the non-parametric Mann Whitney tests for continuous variables. As these data concerned secondary outcomes of an RCT, no power calculation was made.	
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Reference	Study Design	Objective	Sample and Setting	Data Collection and Data Analysis	Findings
<p>Torres, L., Lindstrom, K., Hannah, L., Webb, F.J. (2016). Exploring barriers among primary care providers in referring patients to hospice. <i>Journal of Hospice and Palliative Nursing</i>, 18(2), 167-172. DOI: 10.1097/NJH.0000000000000233</p>	<p>Cross-Sectional Quantitative Study</p>	<p>The purpose of this project is to explore attitudes, knowledge about, referral practices, and other barriers to hospice care among providers in a primary care practice setting.</p>	<p><b>Sample:</b> 49 primary care providers including MD, DO, NP, PA <b>Setting:</b> Florida primary care practice</p>	<p><b>Data Collection:</b> The survey used for this project was modeled from a previous study of primary care providers at the Mayo Clinic in Jacksonville, Florida. The survey had 11 questions examining attitudes and knowledge regarding barriers to hospice referral in primary care and addressed various topics regarding hospice, including beliefs, past experiences, patient perceptions, and referral reasons. Responses used a 5-point Likert scale, with response options of strongly agree, agree, neutral, disagree, and strongly disagree. Three questions addressed demographics: years in practice, insurance percentages of the office, and respondent sex.</p> <p><b>Data Analysis:</b> Survey results were tabulated using SPSS for Windows Version 21 (SPSS Ver.</p>	<p>Providers had a generally positive response toward hospice (70%) and none reported a bad experience with hospice. Most (90%) supported living wills, but less than half (46%) personally had one. Providers were comfortable discussing hospice with patients (70%) and discussing living wills (70%). Time was a significant barrier to initiating discussions about hospice (45%). A needs assessment revealed 0 referrals in a 6-month period before the survey implementation. The results from this survey show that there may be a discrepancy between provider attitudes toward hospice and their actual referral practices. In addition, studies have reported that when providers complete their own living will they are more apt to discuss these documents with patients'</p>

				21). Descriptive statistics for categorical variables on the survey instrument were obtained by frequency analysis.	and families.
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