

The Service of Palliative Care

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Abstract

Millions of people require palliative care (PC), but less than 15% receive PC services. The number of PC providers is increasing, but PC referrals occur too late during the disease. PC is holistic care for anyone suffering from a severe illness and can occur at any stage of the disease process. PC is often used interchangeably with hospice, leading to the misconception that PC care is only for end-of-life patients. PC increases quality of life, provides effective symptom relief, decreases hospital visits and readmissions, and reduces hospital mortality rates.

This DNP project took place at a teaching hospital in North Carolina with over 900 beds. The project site has a palliative consult team and a palliative care unit. The DNP project aimed to educate the project site providers about PC services. A PowerPoint educational presentation and a one-page educational handout were created for the providers, including information about PC, hospice, the palliative consult team, and the palliative care unit at the project site. The PC education was emailed to 231 providers at the project site. An evaluation survey was created to determine the effectiveness of the PC education.

Based on the survey results, the Service of Palliative Care educational presentation effectively improved the participants' knowledge. PC education can impact providers, patients, nurses, and the entire healthcare system. Patients receiving PC services become active participants in their healthcare. Nurses with an increased understanding of PC services have personal healthcare literacy and provide higher-quality patient care. PC has many cost-saving benefits related to readmissions, operating costs, and emergency department visits.

Keywords: palliative care, provider education, healthcare savings

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Section I. Introduction

Background

Research shows palliative care (PC) decreases hospital visits, provides effective symptom relief, and increases the quality of life (Cardenas et al., 2022). Despite the benefits of PC, it is drastically underutilized. The World Health Organization (WHO) reports less than 15% of the 40 million patients who qualify for PC to receive it (Cardenas et al., 2022). The number of PC providers is increasing, but referrals to services occur too late in the disease trajectory. Medical providers delay PC referrals due to the misconception that the service is for the end-of-life (Flieger et al., 2020). Provider education can be the bridge to this gap in care.

Organizational Needs Statement

The project site partner is a not-for-profit teaching hospital with over 900 beds and serves 29 counties in eastern North Carolina ([REDACTED]). This hospital provides many services, including emergency and trauma, behavioral health, cancer, cardiovascular, neurological, pulmonary, surgery, women's health, pediatrics, and geriatrics. The project site's mission is to improve the health and well-being of eastern North Carolina with a vision of becoming the national model for rural health and wellness ([REDACTED]).

As a recipient of Medicare and Medicaid funds, the hospital must abide by the Centers for Medicare and Medicaid Services (CMS) rules. CMS has a 30-day risk-standardized unplanned readmission measure included in the Hospital Readmission Reduction Program, which reduces payments to hospitals with surplus readmissions (CMS [Centers for Medicare and Medicaid Services], n.d.-b). If a patient with Medicare or Medicaid is readmitted to the hospital within 30 days, the hospital's reimbursement drastically decreases for the stay. CMS also has a 30-day risk-standardized mortality measure consistent with the priorities of the Department of Health and Human Services Meaningful Measures framework (CMS, n.d.-a). A Medicare patient hospitalized related to an acute myocardial infarction, chronic obstructive

pulmonary disease, heart failure, stroke, or receiving a coronary artery bypass graft are high risk for death. CMS' 30-day risk-standardized mortality measure is essential because it encourages patient and family education, coordination, and care engagement to improve their quality of life.

The US Department of Health and Human Services and the Office of Prevention and Health Promotion analyzed national data to improve the lives of Americans by developing Healthy People 2030 (n.d.-b). Healthy People 2030 has many goals: improving hospital care, reducing avoidable hospital visits, and reducing nosocomial infections or other complications (Healthy People 2030, n.d., n.d.-a). Hospitals, communities, and outpatient providers need open and easily accessible coordination of the care system to increase education and involvement in health prevention activities. Promoting healthy behaviors in an individual's day-to-day life will decrease emergency department (ED) visits and hospital admissions.

According to Medicare (2022a), the project site hospital has an overall star rating of two out of five. The star rating is based on the hospital's performance in mortality, safety, readmission, patient experience, and timeliness of adequate care (Medicare, 2022a). The mortality rate measures are the same as the national average for patients with chronic obstructive pulmonary disease (COPD), heart attacks, heart failure, and coronary artery bypass graft. The hospital's death rate is worse than the national rate for stroke patients (Medicare, 2022b). The hospital's overall readmission rate is 16.3%, compared to the national rate of 15% (Medicare, 2022d). The hospital's readmission rate for COPD patients is 21.1%, somewhat higher than the national rate of 19.8% (Medicare, 2022d). The readmission rate for this hospital's heart attack patients is 14.8%, slightly better than the 15% national rate (Medicare, 2022d). Heart failure patients from the hospital have a 21.8% readmission rate, marginally worse than the 21.3% national rate (Medicare, 2022d). These readmissions are costly for the patients and the hospital. The estimated annual cost of readmissions in the United States is 15 to 20 billion dollars (Alper et al., 2022). Hospitals can reduce readmissions by ensuring patients

are medically stable for discharge, the discharge location is the most appropriate setting, and patients and their caregivers receive thorough discharge instructions.

The hospital's patient survey rating is three out of five stars based on the Hospital Consumer Assessment of Healthcare Providers and Systems (Medicare, 2022c). Patients rated their hospital stay below the national average in the areas of communication from nurses and physicians, assistance from staff when requested, information about their medications, cleanliness, the quietness of their surroundings, and understanding of care. These star ratings are important because they are readily available for public viewing, meaning patients may choose another hospital with higher ratings. Also, the rating system is how Medicare determines a hospital's reimbursement rate.

The project site has a strong community presence but also depends on the community's support. Most patients live in rural areas despite the hospital being in a city. The hospital desires to improve the quality of life for all. However, there is a financial benefit to providing excellent care with the hopes of fewer readmissions. The CMS Hospital Readmission Reduction Program aims to decrease the length of hospital stays and readmissions (Muchiri et al., 2022). The Hospital Readmission Reduction Program withholds hospital payments based on readmission rates. If a hospital does not receive compensation for services, there is a risk that services may be cut. Hospitals must wisely, effectively, and efficiently care for patients. Studies show that patients with complex medical conditions who receive PC services have reduced hospital readmissions (May et al., 2020).

Early referrals and acceptance of PC services improve patients' and families' quality of life and decrease healthcare expenses. Studies show that patients who receive PC visit the ED less frequently, have lower readmission rates, and experience higher healthcare satisfaction (Brickey et al., 2022). In a systematic literature review of heart failure patients and patients with cancer who received PC services, 30-day hospital readmission rates decreased from 35% to 18% (Fadol et al., 2021). A randomized crossover trial shows that post-discharge ED visits or hospital

readmissions for patients who received inpatient PC consultations reduced from 39% to 17% (Ma et al., 2019).

There is a limited understanding of PC among laypeople and healthcare providers (Flieger et al., 2020). Around 25% of American adults report having some PC knowledge. There is a common misconception that PC and hospice are the same types of service. PC is for individuals with a significant illness that impedes their comfort or daily living. Hospice is for patients with a terminal disease and a six-month prognosis. All hospice patients receive PC; however, all PC patients do not receive or require hospice. This misunderstanding leads to delayed or inappropriate PC referrals.

Problem Statement

Worldwide, over 12 million adults and children have serious illnesses which would benefit from PC services (Franjul Sánchez et al., 2020). The project site hospital has a PC consult team; however, there is a delay in referrals and a lack of utilization of this service. Ensuring patients receive quality care while the project site maintains reimbursement is positively correlated, and the lack of PC utilization is costly to the project site.

Purpose Statement

This Doctor of Nursing Practice (DNP) project aims to educate the project site providers about PC services. Since there are misinterpretations of PC among hospital staff, referrals for PC services are either delayed or inappropriate. Providing education about PC services and their benefits will result in timely and appropriate PC referrals. Increasing PC service utilization can positively impact the patient's quality of life and the project site's readmission and mortality rates.

Section II. Evidence

Literature Review

Eight articles were utilized for this literature review from five different searches. The literature search strategy has evolved throughout this project (see Appendix A). The ECU

Libraries One Search, which includes academic databases, e-books, scholarly journals, and newspaper articles, was the search engine used for the first four searches. The articles range from Level II to Level VI of evidence. The lower levels of evidence represent higher-quality studies (Melnyk & Fineout-Overholt, 2019). Higher-quality studies use evidence-based practices. They are well-designed studies like randomized controlled or systematic reviews.

Initially, a search using the terms “misconceptions of palliative care” was performed to determine if there is a common misunderstanding about the definition of PC. This search produced 165 articles. Only three were kept from the search because they directly discussed the benefits of PC and obstacles to its acceptance. One of the articles was Level II evidence since it was a descriptive sub-study from a randomized control trial. The other article is a Level VI single qualitative study, a lower evidence level. Still, the information helped provide barriers and recommendations to overcome obstacles to PC acceptance. The third article contained a Level IV cross-sectional study. Limitations for this search included full-text online, journal articles, and a five-year period. Articles with thorough information pertaining to keyword searches were kept, and articles specific to a demographic or geographic location unrelated to the topic were excluded.

The publication date was narrowed to three years for the following searches to locate the most current data. A search for reducing hospital readmissions in the United States found 1,121 articles, but only one was stored, the fourth article in the search. The saved article included the specific information needed for 2022 hospital readmission rates in the United States. The article is a Level IV retrospective study.

The following search was for “palliative care effect on hospital readmissions.” Forty-five articles were found, saving one. The other articles were about specific diseases or did not include hospital populations. The saved article is a Level IV retrospective cohort study.

A search was performed for the “cost of hospital readmissions for Medicare,” found 526 articles, and the one article kept had the most current data and was most closely related to key terms. This article is Level V, a systematic review.

Lastly, the PubMed database was searched for “hospital readmissions AND palliative” with the inclusion criteria of free full text, meta-analysis, randomized controlled trial, review, systematic review, English, and 3-year period. This search provided 13 articles, and the two articles specific to hospital readmissions and PC were kept. One of the articles is Level V evidence since it is a literature review. The second article is Level II, a single-center cluster randomized crossover trial.

Current State of Knowledge

PC is holistic care provided to individuals of any age with a severe illness affecting their quality of life to support the patients and their families (Flieger et al., 2020). Unfortunately, there is a lack of knowledge about the benefits of PC. Many people, including medical providers, inaccurately believe PC is the same as hospice. PC is a multifaceted service available in various locations to decrease suffering throughout an illness. Even for critically ill patients, early implementation of PC services improves symptom burden, quality of life, and readmission rates (Ma et al., 2019).

PC positively affects the care of critically ill patients, reducing operating costs, ED visits, ventilator days, and tracheostomies. The American College of Cardiology, the American Heart Association, the Heart Failure Society of America, the International Society for Heart and Lung Transplantation, the American Society of Clinical Oncology, the National Comprehensive Cancer Network, and the National Academy of Medicine have guidelines recommending increased access and timely referral to PC services (Fadol et al., 2021). Evidenced-based data shows that PC referrals should occur after the early diagnosis of chronic diseases to provide opportunities for informed decisions by all parties involved and allow patients active participation in advance care planning. Unfortunately, misconceptions about PC delay can prevent referrals to the

beneficial service (Franjul Sánchez et al., 2020). PC misconceptions by physicians, patients, and caregivers led to unrealistic treatment expectations, lack of communication, and delayed referrals to PC services.

Current Approaches to Solving Population Problem(s)

The project site is a hospital that services patients with cancer, cardiovascular, neurological, pulmonary, renal, and hepatic conditions of all ages (██████████). There is a PC team and inpatient unit located within the project site. Getting the PC team involved in the care of patients appropriately has been linked to improved patient outcomes and decreased readmissions (May et al., 2020).

In most of the articles, barriers are a common theme. Barriers include a lack of knowledge and an ill-conceived understanding of PC. Despite PC's presence in healthcare for the last few decades, most adults in the United States still are unaware of the service (Flieger et al., 2020). Many individuals, including providers, consider PC and hospice to be interchangeable services (Cardenas et al., 2022). This incorrect correlation between PC and hospice reduces PC's acceptance and referral to individuals not in the end-of-life stage of their disease trajectory.

Increasing knowledge of PC services can facilitate early and appropriate referrals (Franjul Sánchez et al., 2020). Options recommended for improving provider understanding of PC include residency rotations and fellowships with the PC team. The supervising physician of the PC team at the project site has medical students and residents regularly to provide PC training. Another possibility to improve understanding of PC is creating educational multimedia content for providers, patients, and caregivers and uploading it to a central and easily accessible platform. One study showed that one-third of adults in the United States utilize the internet and social media for PC information. These excellent platforms provide patients and caregivers with reliable information and sources.

There are also system approaches to implementing PC services. Utilizing an algorithm to assess a patient's need for PC services, including ten criteria, was mentioned in a literature

review (Franjul Sánchez et al., 2020). The algorithm includes functional status, complications, comorbidities, financial issues, lack of support, uncontrolled symptoms, disease or treatment distress, decision-making concerns, family requests, extended hospital stays, and readmissions. If the score were higher than five, a PC consult would occur. Mandatory PC consultations at the time of diagnosis for a severe or chronic illness, despite prognosis, might be considered a possibility. Increasing the accessibility of PC services in cancer, cardiovascular, pulmonary, and renal locations could enhance the referral and acceptance process. One study shows that when PC services are available near outpatient clinics, their time is spent more efficiently, and disease is managed more appropriately.

The big issue at the project site is the lack of understanding by hospital providers about PC services. Similarly, as many articles discuss, many providers consider PC the same as hospice (Flieger et al., 2020). Unfortunately, at the project site location, the confusion could be caused by the criteria of patients admitted to PC services in the Palliative Care Unit (PCU). For patients to be admitted or transferred to PC services, they must be end-of-life and experiencing unmanaged symptoms. There needs to be clear education developed and shared with providers about PC services and how it pertains to the project site.

Evidence to Support the Intervention

Physicians have misconceptions about PC services (Franjul Sánchez et al., 2020). Improving providers' understanding of PC at the project site can be done by developing and sharing transparent, concise PC education materials. Educating providers on how PC positively affects communication about the patient's care plan will encourage referrals. Studies show patients who receive PC services report improvement in symptom management, have fewer hospital readmissions, communicate their goals of care, and experience increased success with hospital transition (May et al., 2020). PC services provide the project site cost savings by reducing avoidable readmissions and enhancing patients' quality of life by ensuring their

healthcare wishes are honored. If project site providers understand PC, they can facilitate referrals appropriately.

Evidence-Based Practice Framework

The PDSA (Plan-Do-Study-Act) model is the framework being used to execute this project (Melnik & Fineout-Overholt, 2019). Using the PDSA cycle, the change is planned and then implemented. After the plan's implementation, the results of the change are studied so they can be refined and retested. PDSA is a helpful model for quality improvement as it can occur on a small scale and is open to adaptation throughout the process. The project includes PC education materials and an evaluation. The education and assessment will require at least one individual PDSA cycle. The site champions and I will collaborate before each project section to determine what will be included in each evaluation and the educational materials. The planning portion of the project consists of discussing the issue with the site champion and creating educational materials for distribution about PC services. The do portion of the model will be distributing the educational materials to the project site providers. The study will occur when providers complete the evaluation survey. The survey results will assist in determining what actions are needed to improve PC understanding at the project site.

Ethical Consideration & Protection of Human Subjects

There are no ethical considerations or inequalities for the project. The target population is the providers of the project site. The project will consist of an educational program for the providers at the project site and an evaluation survey. All project materials will be delivered electronically via email to allow flexibility in participation. Initially, participants will receive an invitation to complete a survey to evaluate their knowledge of PC services. PC education materials will be shared with all the providers in the selected groups. The provider groups include hospitalists and intensivist adult care providers at the project site. These groups include a variety of specialties, including oncology, cardiology, neurology, and surgery. Finally, a survey will be sent to the providers for completion to evaluate the effectiveness of the educational

materials they received. There will be no identifiers collected. Qualtrics is the tool that will be used to collect and analyze the survey results. Data will be stored securely in an ECU OneDrive file. After implementing the DNP project and analyzing data, a presentation will be shared with the ECU College of Nursing. The implementation period for this project will be January 2023 through May 2023.

The Collaborative Institutional Training Initiative (CITI) program human research curriculum was completed as required by the ECU College of Nursing (ECU, 2023). The CITI modules included information about appropriate and safe research practices. The project site needed completion and approval of the Quality Assurance/Quality Improvement Project vs. Human Research Study Determination Form. The Center for Research & Grants (CRG) and University and Medical Center Institutional Review Board (IRB) approved the form and deemed it not human subject research; therefore, formal IRB approval was unnecessary. This is a quality improvement project since it was educational and did not directly involve patient subjects.

Section III. Project Design

Project Site and Population

The project site is the primary medical center for its health system (██████████). There are 974 licensed beds offering inpatient and outpatient services to over a million people in eastern North Carolina. It is also a teaching hospital for the local university medical school. A vast number of services are available at the project site to patients of all ages, from acute care to management of chronic diseases. The mission of the project site is to improve the health and well-being of eastern North Carolina (██████████). Their values include integrity, compassion, education, accountability, safety, and teamwork.

The project site does supply a few facilitators for this PC project. There is a strong push to improve the mortality rate of the project site. The CMS 30-day risk-standardized mortality measure shows that patients are at high risk of dying from all measurable conditions or procedures at the project site (Medicare, 2022b). This is a significant facilitator for the project.

The project site champions are physicians in the project site's PC and hospice programs, so they are interested in educating other providers about PC services. As a teaching hospital, the staff is accustomed to continuing education and adapting to change.

Despite the organization and site champions being open and eager about the project, there were barriers to implementation. The project site is a large organization with 24-hour providers, so distributing the information might prove difficult. Also, since this is a teaching hospital, staff can feel overwhelmed by the continuous information flow. Even if providers view the educational materials, this does not guarantee completion of the survey.

Description of the Setting

The project site is a large teaching medical center in eastern North Carolina. It serves adults of various ages, ethnic backgrounds, and socio-economic statuses across 29 counties. Medical services include acute and chronic management of various disorders, including cancer, cardiac, neurological, gastrointestinal, liver, and renal. The educational materials will be distributed via email to over 200 hospital providers.

Description of the Population

The providers receiving the education materials include hospitalists, nurse practitioners, and physician assistants who only provide care to adults. They work in diverse departments, including internal medicine, neurology, gastroenterology, oncology, urology, family medicine, cardiology, surgery, and orthopedics. Since this is a teaching hospital, providers range from new graduates to having over 20 years of experience.

Project Team

The project team consists of four members. The DNP student serves as the leader of the project. The project leader collaborates with the team members, researches the project topic, creates project deliverables, educates stakeholders on implementation, gathers and analyzes data, and disseminates the results. The project has two site champions. The primary site champion is the medical director of hospice services. The site champion reviews project

deliverables, provides guidance, and makes recommendations to promote the successful implementation of the project. The fourth team member is faculty from the College of Nursing. The faculty member also reviews deliverables and guidance to ensure project completion.

Project Goals and Outcome Measures

The project aimed to educate the providers at the project site about PC services. After discussing the project with the project champions and gaining their approval, the project leader took the necessary steps to determine if IRB approval would be required from the project site IRB. The project leader submitted the Quality Assurance/Quality Improvement Project vs. Human Research Study Determination Form to the project site's CRG (Center for Research and Grants). The CRG deemed the project was not human subject research, so IRB approval was unnecessary. Educational materials were distributed to the providers, and a survey for their completion to give feedback about their understanding. The survey collected demographic information about the providers. Most of the survey questions asked the providers to rate their level of knowledge before and after reviewing the PC education to determine the effectiveness of it. The PDSA model will be utilized to execute the DNP project.

Description of the Methods and Measurement

A PowerPoint educational presentation (see Appendix B) and a one-page handout (see Appendix C) were emailed to 231 providers at the project site. The PowerPoint had a voice-over option so the providers could view the slides or listen to narration if desired. At the end of the presentation, there was a quick response (QR) code. The QR code linked the providers to a survey (see Appendix D) from Qualtrics. Providers entered demographic information on the survey about their titles, specialty, and years of practice. The survey asked if they had ordered PC services at the project site. Providers shared if they received previous PC education. The remaining questions were Likert scale type asking the providers to rate their knowledge before and after the education. The survey also collected feedback about their knowledge of PC and if they felt the educational materials increased their understanding of PC services.

Discussion of the Data Collection Process

Data was collected from the surveys completed by the providers. Qualtrics can store answers to the survey questions. All the data was entered into an Excel spreadsheet to build comparison graphs of before and after education ratings. The Excel spreadsheet was developed by the project leader and password protected. The project leader was the only individual with access to edit the spreadsheet. Within the survey were before and after questions to compare the knowledge gained from the educational materials. There was a section for providers to enter comments. The surveys could be completed anonymously, but there was an option to add contact information if the provider had questions they wanted answered.

Implementation Plan

The project was implemented via email over 12 weeks. Initially, the providers were sent an introductory email to inform them about the upcoming PC services education materials they would receive. Providers were sent an email with the PC education PowerPoint presentation and a one-page handout attached for download. The email message informed the providers about the attached PC education attachments and requested they review the education and complete the survey. The email included the survey QR code to link providers directly to the survey. The QR code was also at the end of the PC education PowerPoint presentation. Providers could save the education presentation and one-page handout to their electronic devices. A follow-up email was sent a month after the first one to remind the providers about access to the PC education PowerPoint and one-page handout, along with the survey link to encourage completion. Since the educational materials and survey were delivered electronically, there were no printing costs.

Timeline

The entire DNP project took several months. The implementation period occurred from January to May (see Appendix E). The first email introducing the project and distribution plan was sent in January. The introductory email also included the option for an in-person presentation and contact information for the project leader. The educational materials with the

survey QR code were emailed in February. A reminder email with the same educational materials was sent in March. The project concluded in May, and the project leader ensured all questions were answered from the surveys and in-person presentations completed. The survey data were entered into an Excel spreadsheet. This data was reviewed to determine the effectiveness of the education.

Section IV. Results and Findings

The Service of Palliative Care project was implemented over 12 weeks at the site. Educational materials were shared via email with the project site providers. A link to an evaluation survey was included in the email to collect data. The results and findings of the survey results are included in the following section.

Results

The Service of Palliative Care educational presentation and link to the evaluation survey were emailed to 231 providers at the project site on February 6, 2023. Initially, 20 providers completed the evaluation survey. As a reminder, the educational presentation and survey link were emailed to the same 231 providers again on March 6, 2023. Forty-six or 20% of providers completed the evaluation survey by the close of the project implementation period on May 1, 2023.

The evaluation survey consisted of 16 questions. The survey is included in Appendix D. The last three questions were for optional comments, questions, and contact information. Five of the survey questions collected quantitative data. Three of the quantitative survey questions collected demographic information about the participants, including their provider role at the project site, the type of service they work with, and the years they have been practicing. There is a breakdown of the demographic results in Table 1. the demographic characteristics. Thirty-nine of the 46 participants reported ordering a PC consultation at the project site before the survey. Thirty-six reported receiving PC education previously.

Eight of the survey questions collected qualitative data. The qualitative questions asked the participants to rate their knowledge before and after reviewing the Service of Palliative Care educational presentation. Before the presentation, 52% reported having moderate knowledge about PC, and 46% reported extensive knowledge. After viewing the educational presentation, 37% reported moderate improvement in their knowledge, and 48% reported extensive improvement. Forty-one percent of the participants reported having moderate knowledge about hospice services before viewing the presentation, and 57% reported extensive knowledge about hospice. Thirty percent rated moderate improvement in their knowledge about hospice services after reviewing the presentation, while 57% reported extensive improvement in their knowledge about hospice. Before the presentation, 48% of the participants rated their knowledge about the Palliative Consult Team's role as minimal, and 46% reported moderate knowledge. After the presentation, 30% rated a moderate improvement in their knowledge about the role of the Palliative Consult Team, and 57% reported an extensive improvement in their knowledge. Before reviewing the educational presentation, 50% rated their knowledge about the care provided in the PCU as moderate and 48% rated their knowledge as extensive, and 2% did not rate their knowledge. After reviewing the presentation, 30% rated a moderate improvement in their knowledge of the care provided in the PCU. However, 54% reported an extensive improvement in their knowledge about the patient care provided in the PCU.

Table 1*Survey Participant Demographic Information*

Role	<i>n</i>	%	Service Type	<i>n</i>	%
Attending Physician	12	26%	Cardiac Surgery	2	4%
Medical Student	1	2%	Cardiology	2	4%
Nurse Practitioner	20	43%	Critical Care	3	7%
Other	1	2%	Emergency Medicine	1	2%
Physician Assistant	12	26%	General Surgery	1	2%
			Hematology Oncology	1	2%
			Internal Medicine	14	30%
			Neurology	3	7%
Years in Practice	<i>n</i>	%	Neurosurgery	4	9%
Less than 5	11	24%	Oncology	2	4%
5 to 10	13	28%	Orthopedics	2	4%
10 to 15	4	9%	Palliative Care	6	13%
15 to 20	6	13%	Trauma	4	9%
Over 20	12	26%	Urology	1	2%

Discussion of Major Findings

The response rate of the survey was 20%. A majority, 69%, of the survey participants were advanced practice providers. The highest-represented service line was Internal Medicine, with 30% of respondents. PC providers represented the second highest service type of the survey participants, with 13%. Overall, the Service of Palliative Care educational presentation effectively improved the participants' knowledge based on the results. Eighty-five percent of the providers reported moderate to extensive knowledge improvement in PC after the presentation. After viewing the educational presentation, 87% rated moderate to extensive knowledge improvement about hospice services and the Palliative Consult Team's role. Eighty-four percent of providers reported moderate to extensive improvement in their knowledge about the care provided in the PCU after the presentation.

There is a lack of understanding of PC for providers, leading to delayed referrals (Flieger et al., 2020). Educational palliative programs will enhance provider understanding. After reviewing the Service of Palliative Care educational presentation, the survey results indicate the providers' improved knowledge about PC, hospice, the role of the Palliative Consult Team, and the care provided in PCU. Increasing knowledge of PC services can facilitate early and appropriate referrals (Franjul Sánchez et al., 2020).

Section V. Interpretation and Implications

Costs and Resource Management

Researching, developing, and distributing the project took approximately 80 hours, with the project leader doing most of the project independently. The project leader is a Nurse Practitioner and an Advanced Certified Hospice and Palliative Nurse who works as a member of the Palliative Consult Team. The information and way this project is disseminated do not require the project leader to be an advanced practice provider. A project leader with a clinical background, such as a registered nurse or social worker with palliative or hospice experience, is beneficial. According to Indeed, the average base hourly salary for a nurse in North Carolina is \$40.91 (2023a), and for a social worker is \$27.05 (2023b). Since some of the information in the project is specific to the project site's consult team and the PCU, a member of the Palliative Consult Team should periodically review the data to ensure its accuracy.

The project site is a large teaching hospital with several departments that could benefit from the project. The Service of Palliative Care project is a PowerPoint presentation, and PowerPoint alone costs approximately \$159.99 (Microsoft 365, 2023). Since it is a PowerPoint presentation, there are various options for dissemination. The presentation can be performed in person, made available to participants via email, or added to the project site's web-based education system. Printing the PowerPoint slides will cost approximately \$0.20 per page (Staples, 2023).

There is a dedicated education department with staff members assigned to different units throughout the hospital. The education team members can assist with reviewing and disseminating the project during onboarding or educational activities. The project site has a SurveyMonkey account if they want to continue using the evaluation survey. SurveyMonkey (2023) costs at least \$119 a month. The total cost of the project is \$4862.99. The itemized project budget can be found in Appendix F.

Implications of the Findings

The literature supports palliative education programs for providers (Flieger et al., 2020). The Service of Palliative Care educational presentation enhanced the provider's knowledge about PC, hospice, the Palliative Consult Team, and the PCU within the project site. Increasing the provider's understanding of PC services will reduce misconceptions and promotes early referrals.

Implications for Patients

Patients receiving PC services become active participants in their healthcare. PC providers ensure patients understand their healthcare status and options (Fadol et al., 2021). PC encourages and assists patients with advance care planning. Completing advance directive paperwork opens conversations about patients' preferences in unforeseen circumstances and helps ensure their wishes are honored. Allowing patients to have the opportunity to contribute to their care plan leads to improved healthcare satisfaction (Brickey et al., 2022). Patients receiving PC services visit the ED less frequently, experience decreased readmission rates, and shorter hospital stays.

Implications for Nursing Practice

Nurses with an increased understanding of PC services improve patients' quality of care and have personal healthcare literacy (Franjul Sánchez et al., 2020). PC education programs for nurses are proven to positively influence the care of patients and themselves (Flieger et al., 2020). The Service of Palliative Care project can be provided to nurses at the project site. Nurses

with knowledge about PC are more likely to participate in their advance care planning. PC education should be a routine part of their onboarding and annual education to facilitate early referrals.

Impact for Healthcare System(s)

PC has many cost-saving benefits for healthcare systems. According to Medicare (2022a), this hospital has an overall star rating of two out of five based on its patient care performance. The project site's patient satisfaction star rating is three out of five stars. These star ratings are posted online for the public, and patients may choose another hospital with higher ratings. Medicare determines a hospital's reimbursement rate based on its star rating. PC reduces readmission rates, an over 15 billion-dollar cost in the United States (Alper et al., 2022). PC also decreases patient care operating costs and ED visits (Ma et al., 2019).

Sustainability

There are no plans to continue the Service of Palliative Care project at the site. However, it can easily be sustained. The project is a PowerPoint presentation and a one-page pdf document that can be disseminated electronically. The PowerPoint presentation has a voice-over and transcribed transcript to give the project site options with the distribution. The project site can perform the presentation in person or share it electronically via email or their web-based educational platform with little to no additional costs.

Dissemination Plan

The Service of Palliative Care project poster will be presented at ECU's College of Nursing on July 11, 2023. The Service of Palliative Care project paper will be submitted to the ECU ScholarShip repository before July 25, 2023. [REDACTED] Center for Research & Grants (CRG) and the [REDACTED] Center for Learning and Performance will receive the project abstract and educational PowerPoint presentation before July 27, 2023.

Section VI. Conclusion

Limitations and Facilitators

A limitation of the project site is that providers are overwhelmed with educational content and lack time to review and complete everything they receive. Since no continuing education credits were available for reviewing the educational presentation, the providers had little motivation to complete the evaluation survey. The project site is a large teaching hospital with over 900 beds and hundreds of providers, including medical residents. It is difficult to reach all individuals who might benefit from PC education in an organization of this size.

A significant facilitator to the project is its electronic availability. All the project site providers have an organization email and access to a computer while on site. The evaluation survey was easily accessible by mobile device via a weblink or QR code. The project site champion was a tremendous facilitator in planning, developing, and implementing processes. The project site champion and other Palliative Consult Team members encouraged participation from different providers within the project site. A reminder email was sent encouraging the completion of the evaluation survey. The final date of survey availability was included in the reminder email. The Qualtrics survey program tracks the time it takes for individuals to complete the survey, which averages around two minutes. This was shared with providers in the reminder email to encourage participation.

Recommendations for Others

Despite easy access to the presentation electronically, providing in-person or live presentations may prove more effective. Since PC is relevant for all individuals at the project site, sharing relatability with everyone can promote participation in educational activities. Incorporating PC education during onboarding sessions, annual training, and staff meetings should be considered to benefit project site personnel. The one-page educational handout can be posted throughout the project site, including the physician lounge, staff dining rooms, and staff

break rooms. The organization has an intranet site, so information about and links to PC education can be added.

Recommendations Further Study

The benefits of PC education are vast because the project site is a medical center within a hospital system. PC education can be generalized for distribution throughout the entire hospital system. Ideally, the PC education can be adapted to different service lines at the project site, including nurses, administration, and clinical support, not only the providers. Patients and caregivers will also benefit from PC, so developing educational information for them should be considered. Encouraging input from different individuals at the project site about their experiences with PC and including them in developing PC education can be an effective practice in increasing participation.

Final Thoughts

Utilized effectively, PC can improve quality of life (Cardenas et al., 2022). PC increases hospital reimbursement by decreasing the length of stay and readmission rates. The misconceptions about PC lead to unrealistic treatment expectations, lack of communication, and delayed referrals to PC services (Franjul Sánchez et al., 2020). Educating clinicians about PC services can positively influence the care of patients and themselves (Flieger et al., 2020). The Service of Palliative Care project comprised an educational PowerPoint presentation and a one-page handout delivered to over 200 providers at the project site by email. The educational materials provided information about PC, hospice, the Palliative Consult Team, and the PCU. Over 80% of the providers reported moderate to extensive knowledge improvement in PC services, hospice services, the Palliative Consult Team's role, and the care provided in the PCU after the presentation. A thorough but concise PC education program can increase PC utilization and enhance clinicians' practice.

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Appendix A

Literature Review Spread Sheet

Authors	Year Pub	Article Title	Theory	Journal	Purpose and take home message	Design/Analysis/Level of Evidence	IV DV or Themes concepts and categories	Instr. Used	Sample Size	Sample method	Subject Charac.	Comments/critique of the article/methods GAPS
Bickey, J., Flannery, M., Cuthel, A., Cho, J., Grudzen, C. R., & EMPallA Investigators	2020	Barriers to recruitment into emergency department-initiated palliative care: a sub-study of a multi-site, randomized controlled trial	NA	<i>BMC Palliative Care</i>	Explore the barriers to enrolling seriously ill patients scheduled for discharge from the ED into PC research.	Level II - Descriptive sub-study from a RCT	NA	Survey	504	Eligible patients who declined participation in EMPallA at 11 sites were visited and asked to provide a reason for refusal.	NA	<p>Patients with advanced illnesses presenting to the ED often refuse to participate in PC research due to the severity of their illness, the mode of care delivery, and misconceptions about PC. In contrast with other studies, our study found minimal physician gatekeeping, which may be the result of both changing attitudes toward PC and the nature of the ED setting. Robust training programs are crucial to overcome these misconceptions and to educate patients and providers about the role of PC. Future PC programs and study designs should recognize the burden this vulnerable population endures and consider alternative modes of care delivery in an effort to increase participation and enrollment.</p> <p>Limitations: Data collection was limited due to hospital admission. Unclear if families or caregivers were a barrier to program enrollment since specific refusal reason was not included.</p> <p>Usefulness: Results were from 11 different ED across the country with multiple disease etiologies.</p> <p>Synthesis: PC program recruitment challenges. Misconceptions were a reason for decreased PC enrollment. PC seen as same as hospice. Engagement of PC providers and communication is necessary for PC success. PC can reduce ED visits.</p>
Cardenas, V., Rahman, A., Zhu, Y., & Enguidanos, S.	2022	Reluctance to Accept Palliative Care and Recommendations for Improvement: Findings From Semi-Structured Interviews With Patients and Caregivers	Grounded theory	<i>American Journal of Hospice & Palliative Medicine</i>	To identify patients' and caregivers' perceived barriers to home-based palliative care (PC) and their recommendations for overcoming these barriers.	Level VI - Single Qualitative Study	NA	Survey	25	Interviewed 17 patients and 8 proxies/ caregivers who were eligible for a RCT of home-based PC	Age mean 61.44; Female 64%; Male 36%; African American 8%; Latino 8%; Asian 8%; Caucasian 72%; Other 4%; Cancer 20%; COPD 16%; Heart Disease 32%	<p>The authors found HBPC referral barriers included reluctance to have home visits, enrollment timing, lack of PC knowledge, misconceptions about PC, and patients' self-perceived health condition.</p> <p>Limitations: There are minimal studies in the area of HBPC perspectives and responses may have been influenced by HBPC and RCT.</p> <p>Usefulness: Themes related to recommendations for overcoming these obstacles included ensuring that PC referrals come from healthcare providers or insurance companies and presenting PC services more clearly.</p> <p>Synthesis: Need for additional PC education among patients.</p>
Fleger, S. P., Chui, K., & Koch-Weser, S.	2020	Lack of Awareness and Common Misconceptions About Palliative Care Among Adults: Insights from a National Survey	NA	<i>Journal of General Internal Medicine</i>	To characterize self-reported PC knowledge and misconceptions about PC among US adults and demographic, health, and social role factors associated with knowledge and misconceptions.	Level IV - Cross-sectional study	NA	Survey	3445	Conducted secondary data analysis of data from the 2018 Health Information National Trends Survey (HINTS) 5, Cycle 2.	Female 51.2%; White 64.8%; Black 10.8%; Hispanic 16%; Asian 5.2%; Other 3.3%; High school or some college 62.3%; College or above 28.8%	<p>US adults who have some knowledge of PC are most likely to confuse it with hospice but are less likely to see it as requiring foregoing treatment or as giving up. Primary care clinicians should be encouraged to communicate about PC with patients.</p> <p>Limitations: This cross-sectional study only captures one point in time. Can only assess the level of misconceptions among the population who report at least knowing a little bit about PC. The caregiving measure is imperfect to serious illness, as not all caregiving roles would indicate a need for PC. No way to capture how individuals have learned about PC, and whether primary care providers are the source of this information.</p> <p>Usefulness: Nationally representative sample provides insight into the public's knowledge of PC. Evidence of PC Provider shortages.</p> <p>Synthesis: Most US adults report they are not aware of PC. Misconception of PC being same as hospice. Providers also have misconception of PC affecting referrals.</p>
Franjil Sánchez, A., Fuentes Armesto, A. M., Birones Chávez, C., & Ruiz, M.	2020	Revisiting early palliative care for patients with hematologic malignancies and bone marrow transplant: Why the delay?	NA	<i>Cureus</i>	To analyze and discuss the possible barriers to care and delayed referrals for hematologic malignancies and bone marrow transplant patients.	Literature review	NA	NA	NA	NA	NA	<p>The knowledge and perceptions about PC entails is misconceived by patients and physicians. Education for physicians about PC services can lead to more patients receiving it and increasing not only their quality of life but the caregivers also.</p>
Muchiri, S., Azadeh-Fard, N., & Pakdil, F.	2022	The analysis of hospital readmission rates after the implementation of hospital readmissions reduction program	NA	<i>Journal of Patient Safety</i>	To analyze the impact of Hospital Readmissions Reduction Program (HRRP) on the nationwide optimization efforts of length of stay and readmissions in the US.	Level IV - Retrospective Study	IV-HRRP DV-LOS & Readmissions	Database review	13,619,765	2010-2016 NRD provided in the Healthcare Cost and Utilization Project by the Agency for Healthcare Research and Quality	Age mean 63.5, LOS 5.6 days, 52.4% Female, 62% Medicare, 88.4% Urban hospitals, 14% Government hospitals, 52% Teaching hospitals	<p>The readmissions vary by conditions, LOS, and insurance types. Congestive heart failure has the highest readmissions among the 6 analyzed conditions at approximately 25%. The readmission rate of CHF rises to 30% for the Medicaid patients and varies between 30% and 35% by LOS. Patients with CHF with higher Charlson Comorbidity Index demonstrates the highest readmissions among 6 conditions. The patients with longer LOSs had higher readmissions, and Medicare patients have a higher reduction in readmissions in acute myocardial infarction and mood disorders compared with the other forms of payments.</p> <p>Limitations: The results may not be consistent among different patient populations (such as age groups) or across different types of hospitals. On the basis of these mixed results, it is not clear whether HRRP has an impact on other nontargeted conditions.</p> <p>Usefulness: Figures show that targeted programs, such as HRRP, may have a positive impact on readmission rates. We, however, observe some graphical evidence that nontargeted conditions could exhibit similar trends. Because of heterogeneity in hospital and patient characteristics, it is pivotal for researcher to consider them in formal analyses.</p> <p>Synthesis: High patient turnovers with shorter hospital stays may affect the quality of care and readmission rates. With optimal hospital care and planning of aftercare, it is possible to prevent some new admissions or prolong the time period from discharge to a readmission. Early discharges are supported, considering that it may be cost-effective for patients without a complicated health status and who can be safely discharged earlier than expected LOS.</p>

Appendix B

Educational Presentation

The Service of Palliative Care

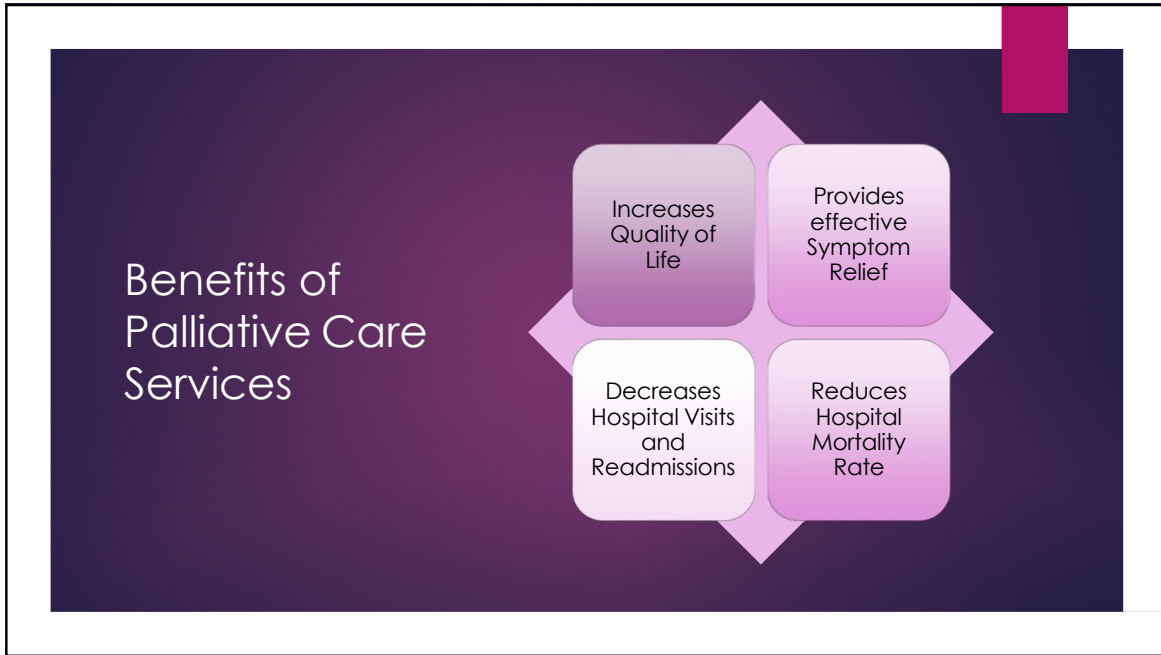
Heather Hill, FNP, ACHPN
 Doctor of Nursing Practice Student
 East Carolina University
 College of Nursing

1

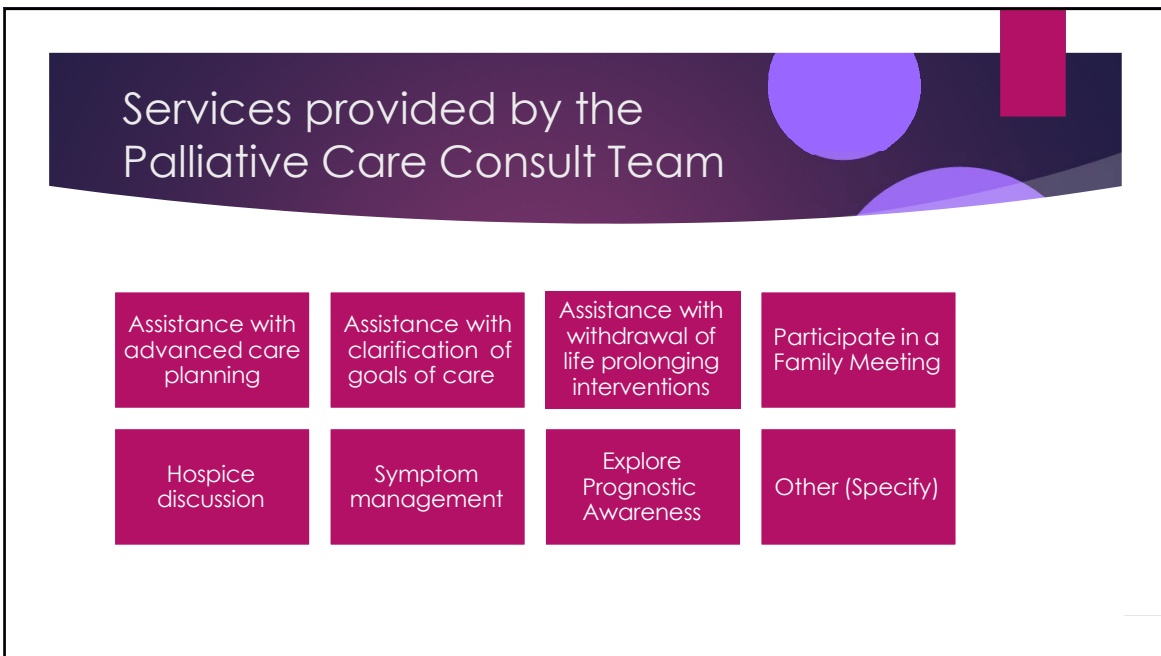
Palliative Care v. Hospice

<p>Palliative Care</p> <ul style="list-style-type: none"> ▶ Holistic care of any individual suffering from a severe illness with the aim to improve quality of life of not only the patients, but their caregivers ▶ Can occur at any stage of the disease process and provided along with curative medical treatments 	<p>Hospice</p> <ul style="list-style-type: none"> ▶ Palliative care for patients with a six-month prognosis and no longer seeking curative medical treatments ▶ Levels of hospice care: <ul style="list-style-type: none"> ▶ Routine home care <ul style="list-style-type: none"> ▶ Hospice team members visiting patient's residence routinely to support caregivers ▶ General inpatient care (GIP) <ul style="list-style-type: none"> ▶ Patients with unmanaged or complicated symptoms requiring care in a hospice inpatient facility or the Palliative Care Unit (PCU)
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2



3



4



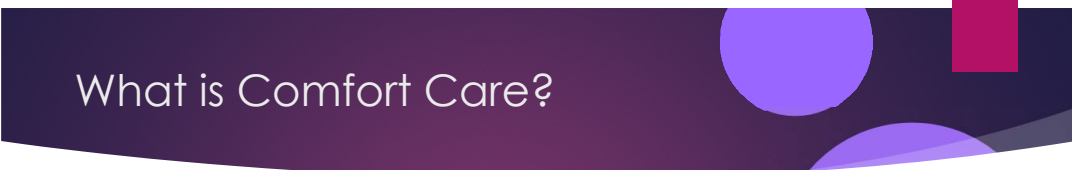
Patients eligible for transfer to PCU

- ▶ DNR
- ▶ Comfort Care

Patients eligible for Palliative Attending Services

- ▶ In the PCU
- ▶ DNR
- ▶ Comfort Care
- ▶ Requiring high intensity/complex end-of-life symptom management

5



What is Comfort Care?

No life prolonging measures:

- ▶ IV fluids
- ▶ Tube feedings
- ▶ Dialysis
- ▶ IV antibiotics/cardiac medications


Focus on comfort measures:

- ▶ Medications administered for symptom management
- ▶ Patient allowed comfort feeds

Patient specific examples:

- ▶ Ventilated patients planning extubation for comfort within 48-hours of arrival to PCU allowing patients family time to visit
- ▶ Patients on cardiac infusions, like milrinone and Levophed (norepinephrine), planning discontinuation of infusion within 48-hours without titration allowing patients family time to visit
- ▶ Patients discontinuing CRRT (Continuous renal replacement therapy)

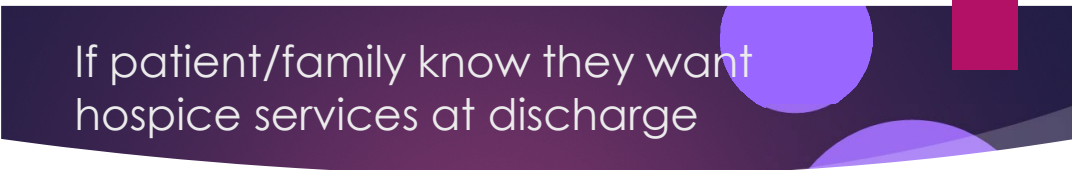
6



Outpatient Palliative Care Services

- ▶ **ECU Health Outpatient Services**
 - ▶ Heart Failure Clinic Tuesday mornings
 - ▶ Oncology Clinic Friday mornings
 - ▶ Other specialty patients can be scheduled Friday mornings at the Oncology Clinic
 - ▶ Telemedicine visits are available
- ▶ **Homebased patients' option**
 - ▶ [Redacted]

7



If patient/family know they want hospice services at discharge

- ▶ Order Inpatient Case Management Consult in *Epic*
 - ▶ Arrange for Home Care
 - ▶ Complete all the fields with red octagons and exclamation point
 - ▶ Scroll down and click +Add next to Home Health – Other option and choose Hospice Evaluation


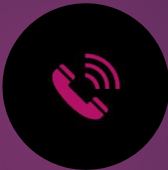
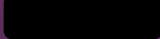

8

If patient needs a Health Care Power of Attorney (HCPOA) or Living Will

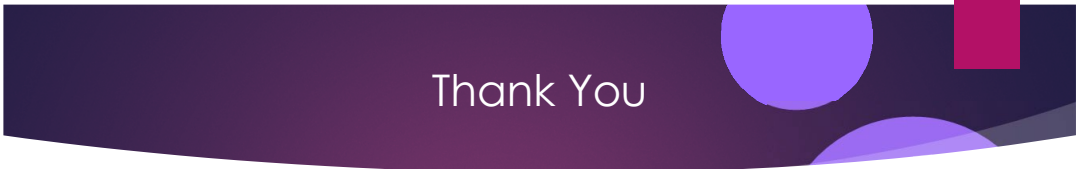
- ▶ Order Advance Directive Care Consult in *Epic*
 - ▶ A Staff member will assist the patient in completing the Advance Care Planning Toolkit
 - ▶ The patient must be alert and oriented
 - ▶ Monday through Friday pending availability of hospital volunteers to be witnesses

9

How do you reach the Palliative Care Consult Team?

- 
Place order in *Epic* for Palliative Care Consult
- 
Call Palliative Care Consult phone

- 
Available daily 8a to 5p


10



Thank You

▶ Please click on the link or QR code below to complete a quick survey related to this presentation:

https://ecu.az1.qualtrics.com/jfe/form/SV_cD7Bs7UdgU29aUC



Appendix C

Educational Handout

Palliative Care Services

- ▶ Assistance with advanced care planning
- ▶ Assistance with clarification of goals of care
- ▶ Assistance with withdrawal of life prolonging interventions
- ▶ Participate in a Family Meeting
- ▶ Hospice discussion
- ▶ Symptom management
- ▶ Explore Prognostic Awareness
- ▶ Other (Specify)

Patients eligible for transfer to PCU:

- ▶ DNR
- ▶ Comfort Care

Patients eligible for Palliative Attending Services:

- ▶ In the PCU
- ▶ DNR
- ▶ Comfort Care
- ▶ Requiring high intensity/complex end-of-life symptom management

What is Comfort Care?

No longer receiving life-prolonging measures:

- ▷ IV fluids
- ▷ Tube feedings
- ▷ Dialysis
- ▷ IV antibiotics/cardiac medications

Focus on comfort measures:

- ▷ Medications administered for symptom management
- ▷ Patient allowed comfort feeds (foods they request) if alert and assuming risk of aspiration

Patient specific examples:

- ▷ Ventilated patients planning extubation for comfort within 48-hours of arrival to PCU allowing patients family time to visit
- ▷ Patients on cardiac infusions, like milrinone and Levophed (norepinephrine), planning discontinuation of infusion within 48-hours without titration allowing patients family time to visit
- ▷ Patients discontinuing CRRT (Continuous renal replacement therapy)

Outpatient Palliative Care Services

ECU Health Outpatient Services:

- ▷ Heart Failure Clinic Tuesday mornings
- ▷ Oncology Clinic Friday mornings
- ▷ Other specialty patients can be scheduled Friday mornings at the Heart Failure Clinic
- ▷ Virtual visits are available

Homebased patients' option:

- ▷ [Redacted]

Benefits of Palliative Care Services

- ▶ Increases quality of life
- ▶ Provides effective symptom relief
- ▶ Decreases hospital visits and readmissions
- ▶ Reduces hospital mortality rate

If patient/family know they want Hospice services at discharge:

- ▶ Order **Inpatient Case Management Consult** in Epic

If patient needs a Health Care Power of Attorney (HCPOA) or Living Will:

- ▶ Order **Advance Directive Care Consult** in Epic

How do you reach the Palliative Care Consult Team?

- ▶ Place order in Epic for **Palliative Care Consult**
- ▶ Call Palliative Care Consult phone [Redacted]
- ▶ Available daily 8a to 5p

Appendix D

Survey



Default Question Block

1. Which best describes your Provider role?

- Attending Physician
- Certified Registered Nurse Anesthetist
- Fellow
- Medical Student
- Nurse Practitioner
- Physician Assistant
- Resident
- Other (Please type your role in box below)

2. Which of the following best describes your Service type?

3. How many years have you been in practice?

- Less than 5 years
- 5 to 10 years
- 10 to 15 years
- 15 to 20 years
- Over 20 years

4. Have you ever placed an order for a Palliative Care consult at ECUH Medical Center?

- Yes
- No

5. Have you previously received Palliative Care education?

- Yes
- No

6. Before this presentation, how would you rate your knowledge of what palliative care is?

0 for Minimal 2 for Extensive

0 1 2

Move slider to make selection.

7. After viewing this presentation, how would you rate the improvement in your knowledge of what palliative care is?

0 for None 3 for Extensive

0 1 2 3

Move slider to make selection.

8. Before this presentation, how would you rate your knowledge of what hospice is?

0 for Minimal 2 for Extensive

0 1 2

Move slider to make selection.

9. After viewing this presentation, how would you rate the improvement in your knowledge of what hospice is?

0 for None 3 for Extensive

0 1 2 3

Move slider to make selection.

10. Before this presentation, how would you rate your knowledge of the Palliative Consult Team's role?

0 for Minimal 2 for Extensive


0 1 2

Move slider to make selection.

11. After viewing this presentation, how would you rate the improvement in your knowledge of the Palliative Consult Team's role?

0 for None 3 for Extensive

0 1 2 3

Move slider to make selection. 

12. Before this presentation, how would you rate your knowledge of care provided in the Palliative Care Unit (PCU)?

0 for Minimal 2 for Extensive

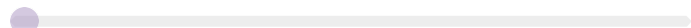
0 1 2

Move slider to make selection. 

13. After viewing this presentation, how would you rate the improvement in your knowledge of care provided in the PCU?

0 for None 3 for Extensive

0 1 2 3

Move slider to make selection. 

14. Please share any comments you have below:

15. Please share any questions you have below:

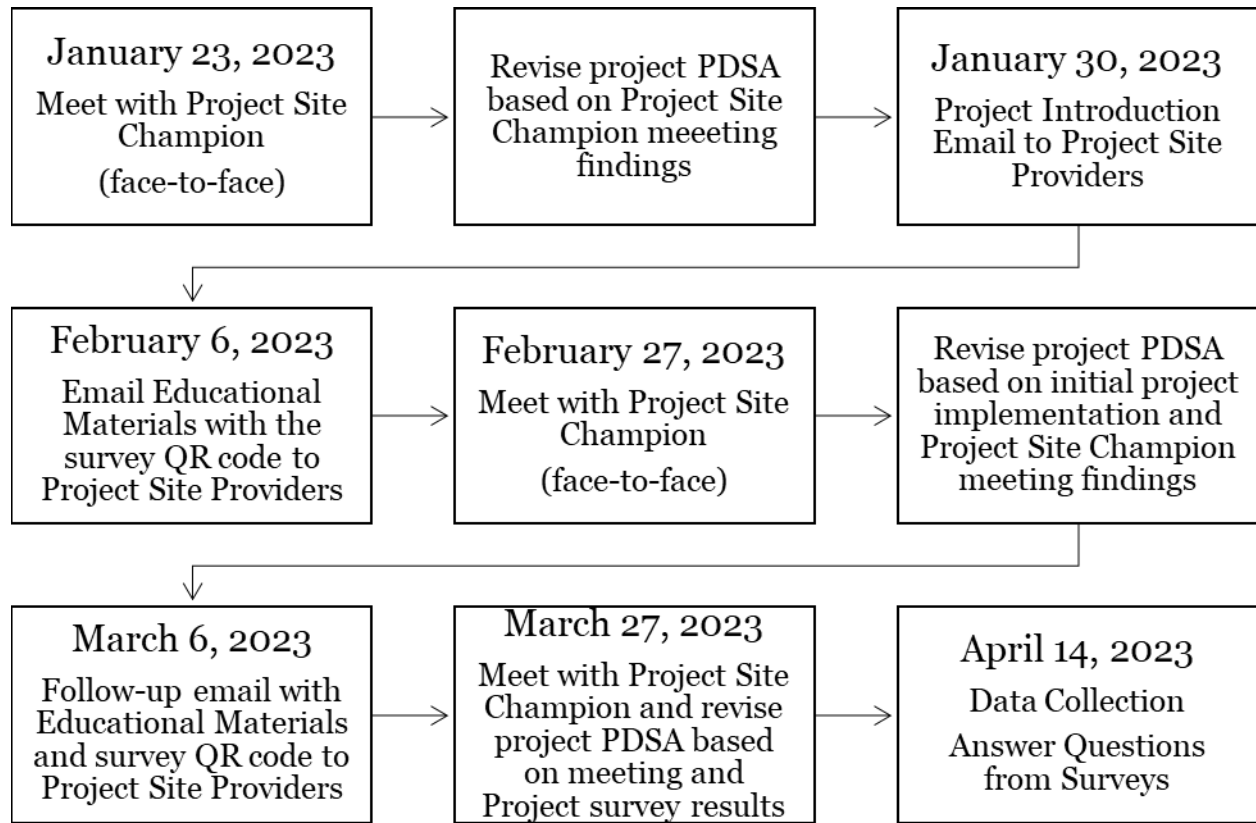
16. Please provide contact information below IF you have questions and would like to receive a response:

Name	<input type="text"/>
Email	<input type="text"/>
Phone	<input type="text"/>

Powered by Qualtrics

Appendix E

Timeline



Appendix F**The Service of Palliative Care Project Budget**

			Totals
Personnel Expenses			
	Hours	Wages	
Project Leader	80	\$40.91* (per hour)	\$3,272.80
Operating Expenses			
PowerPoint			\$159.99 (one-time cost)
Staples Printing		\$0.20 (per page)	\$2.20 (11-page presentation)
SurveyMonkey		\$119 (per month)	\$1,428.00 (annually)
Project Total			\$4862.99
*Hourly wages based on Indeed average base salary for a nurse in North Carolina			