2022

Enhancing Hospitalists' Knowledge In Relation To Palliative Care

Herline Raphael

Southern Adventist University

Recommended Citation

Raphael, Herline, "Enhancing Hospitalists' Knowledge In Relation To Palliative Care" (2022). *DNP Research Projects*. 53.
https://knowledge.e.southern.edu/dnp/53

ENHANCING HOSPITALISTS' KNOWLEDGE IN RELATION TO PALLIATIVE CARE

by

Herline Raphael

Dr. Frances Johnson

A Scholarly Project Presented in Partial Fulfillment

of the Requirements for the Degree

Doctor of Nursing Practice

Southern Adventist University

December 2022

Abstract

Palliative care was not the specialty of many hospitalists; thus, communication was hindered regarding ELC and advanced directives. Despite healthcare utilization in the United States, inadequate treatment of serious illnesses continues due to the lack of provider education and understanding of ELC (palliative and hospice care). Hospitalists are not formally or informally trained to care for patients that need palliative or hospice care. A quantitative, quasi-experimental and qualitative approach was utilized to determine if hospitalists who received educational training on palliative care communication and collaboration improved knowledge, skills, and collaboration when caring for end-of-life or critically ill patients. This project's findings suggested a statistically significant relationship between the education of hospitalists and increased knowledge of palliative care. COVID-19 restrictions hindered palliative care treatment, such as communication and patient isolation. The educational session enhanced the knowledge of the hospitalist and increased effective communication between the hospitalist and patients. The project findings can bring awareness to the need for palliative care education for hospitalists. The education can enhance critical aspects of end-of-life care, such as communication and optimizing care.

Dedication

To my late Father Raphael. You will forever be my Hero. I miss you even more today.

Acknowledgements

I would also like to extend a very special thank you to my family, I could not have completed this project without your support, encouragement and spiritual covering. To my Children, thank you for love, I feel blessed to have you in my life. You believed in me, you encouraged me when I felt like giving up.

I would also like to extend a very special thank you to my accademic advisor, editor, and mentor. I would like to thank Dr. Lou O'Boyle for his professional encouragement throughout this process.

I would like to extend a special thanks to Dr. Frances Johnson for her tremendous efforts in reviewing, editing, and guiding this project; without her help, this would not have been possible. Thank you Dr. Jill Buchholz for your kindness and encouragment.

This project would not have been possible without the assistance of my Medical Director and colleagues for their insight, patients and collaboration.

Table of Contents

Acknowledgements 1

List of Charts 6

List of Tables 7

List of Figures 8

Chapter 1: Introduction 9

- What is Palliative Care? 9
- Hospice Care 10
- Curative vs. Non-Curative Care 11
- Choosing Between Palliative Care and Curative Treatment 11
- Background and Significance of Proposed Topic 12
- Problem Statement or Purpose 16
- Clinical Question 19
- Definitions of Terms 20
  - *Critically Ill Patient* 20
  - *Hospice Care* 20
  - *Hospitalist* 20
  - *Hospitalist's Knowledge* 20
  - *Palliative Care* 20
- Theoretical Framework 21
- Introduction 25
- Search Strategy 25
- History of the Nurse Practitioner Hospitalist 26
- What Is Still Needed 31
- Paradigm Shifts in Palliative Care 32
- Primary Palliative Care Roles for the Nurse Practitioner Hospitalist 34
  - *Symptom Management* 34
  - *Transitioning to Hospice Care* 35
- Palliative Care and the COVID-19 Pandemic 35
- Patient's Decision to Use Palliative Care 38
- The Need for Palliative Care Education 40
- Future of Palliative Care 41
- Filling the Gap: Hospitalists and Palliative Care 43

Chapter 3: DNP Project Plan 47

Evidence-Based Project/Intervention Plan 47
Purpose, Objectives, and Design of the Project 47
Design 48
Qualitative 48
Setting and Participants 48
Palliative Care Webinar 49
Procedure 49
Measures and Interventions 50
Palliative Care Knowledge Assessment Tool 50
Reliability and Validity of PEACE-Q 50
The Palliative Care Practice Outcomes Assessment Tool 51
COVID-19 Impact on Palliative Care Tool (Qualitative) 52
Privacy and Confidentiality 52
Evaluation Plan 53
Chapter 4: Results 54
Sample Description 54
Analysis of Project Questions/Hypothesis 55
Knowledge Scores 55
Pre-Test-Post-Test Knowledge 55
Results of Qualitative Analysis 58
Theme 1: Problems During COVID-19 58
Subtheme 1.1: Burnout 59
Subtheme 1.2: Inadequate resources and Covid testing waits 60
Subtheme 1.3:Communication and face masks 60
Subtheme 1.4: Poor Caring and Less Staff/ More Patients 61
Subtheme 1.5: Waiting for COVID-19 Tests 61
Theme 2: Palliative Care Education as a Way to Improve Communication 63
Subtheme 2.1: Education was Helpful 64
Subtheme 2.3: Additional Experience Needed 65
Theme 3: Patient's Palliative Care Service Modes 66
Subtheme 3.1: Telemedicine and Outsourcing 67
Subtheme 3.2: Not offering services 68
Subtheme 3.3: Not Offering Services 68
Subtheme 3.4: Hospitalist 68

Theme 4: Key Factors in Palliative Care Giving 69

Subtheme 4.1: Timing. 70

Subtheme 4.2: Teamwork Amongst Palliative Care Workers/Social Workers Being Key to Palliative Care 71

Subtheme 4.3: Following Protocols and Due Process 71

Subtheme 4.4: Family 72

Subtheme 4.5: Communication with Patients 72

Chapter 5: Discussion 74

Practice Inquiry and Purpose Discussion 74

Observations and Limitations 74

Observations 74

Limitations 75

Implications for Future Projects/Research 76

Implications for Practice/Health Policy/Education 77

Conclusion 78

References 80

Appendices 98

Appendix A 99

Appendix B 100

Appendix C 101

Appendix D 102

Appendix E 109

Appendix F 114

Appendix G 115

Appendix H 118

Appendix I 119

Appendix J 121

List of Charts

Chart 1 Knowledge Scores In Question Category Prior Training Session 32 Participants 55

Chart 2 Knowledge Scores in Question Category Post Training Session 9 Participants 55

Chart 3 Problems of Palliative Care During COVID-19 56

Chart 4 Problems of Palliative Care During COVID-19 57

Chart 5 Improves Communication 62

Chart 6 Patient’s Palliative Care Service Modes 66

List of Tables

Table 1 Analysis Between Pre Knowledge Score and Post Knowledge Score 56

Table 2 Theme 1: Problems of Palliative Care During COVID-19 61

Table 3 Theme 2: Problems of Palliative Care During COVID-19 65

Table 4 Patient’s Palliative Care Service Modes 68

Table 5 Key Factors in Palliative Care Giving 69

Table 6 Theme 4: Key Factors in Palliative Caregiving 72

List of Figures

Figure 1 Palliative Care Enhanced Model 21

Figure 2 Adventist Nursing Practice Model 22

Figure 3 Hopsitalist Education for Pallative Care 23

Chapter 1: Introduction

What is Palliative Care?

Health care aims to improve the overall quality of patient care, while palliative care specializes in ELC for patients and their families. Illnesses and the minimization of pain are also important focuses of palliative care. Patients are offered an enjoyable life by utilizing palliative care to manage acute and chronic disease processes (Institute of Medicine [IOM], 2015; National Consensus Project for Quality Palliative Care, 2018). Serious illness affects approximately 90 million citizens of the United States (US), and due to the aging baby boomers, that number is expected to increase over the next 25 years consistently. Palliative care patients (those having four or more chronic conditions) account for approximately 68% of all Medicare costs (CAPC, 2020).

Palliative care is provided by specialists who collaborate with other professionals and with patients and families to form a palliative care team. The goal of the palliative care team is to provide additional support as needed based on the patient's needs. Palliative care intends to extend treatments or therapies to patients to resolve an issue (Meier, 2014). Patients can utilize palliative care while receiving curative treatment and have more control over their treatment options with enhanced understanding. This can assist with matching patient goals to available options while offering support for the family, caregivers and practical support (Meier, 2014). Those who benefit from palliative care suffer from chronic obstructive pulmonary disease (COPD), end-stage renal disease (ESRD), or other conditions that threaten the patient's life.

The Joint Commission oversees the quality and safety of patient care and has enacted two elements of performance (EP) and revised one EP to demonstrate the participation of palliative care in community-based programs (The Joint Commission, 2021). The goal of the changes to the EPs was to align with Clinical Practice Guidelines for Quality Palliative Care (2018). This project aims to provide palliative care education to hospitalists, enhancing their knowledge to achieve quality standards for patients suffering from chronic illness.

Hospice Care

In contrast to palliative care is the option of hospice care. Patients reaching the end of life have the option of hospice care instead of curative care. The interprofessional hospice team addresses terminally ill patients' psychological, social, physical, and spiritual needs. However, hospice is not only focused on patients. Counseling, practical support, and respite care are offered to families while the terminally ill patient is treated. The overall goal is to utilize the remainder of the patient's life to provide support and extend the highest quality of life possible (Mayo Clinic, 2019).

As long as the patient's condition is diagnosed and certified as life-limiting by a physician and care team, hospice care can be provided (Mayo Clinic, 2019). Hospice care varies from most forms of health care. Frequently, a family member is a primary caregiver, and the care setting is in the patient's home to provide additional comfort. Hospice staff is on call 24 hours to ensure high-quality care is provided during need (Mayo Clinic, 2019). Additionally, hospice staff makes routine visits to ensure continuity of care. However, hospice care may also be available in nursing homes, hospitals, dedicated hospice facilities, and assisted living facilities (Mayo Clinic, 2019).

The need for hospice services determines if services are offered rather than the patient's ability to pay for care. Hospice care is typically paid for by various services, including Medicare, Medicaid, the Department of Veterans Affairs, and private insurance (Mayo Clinic, 2019).

Curative vs. Non-Curative Care

"Curative care is designed to cure a disease, improve or eliminate a symptom, or aid in recovery from an illness or injury. Curative care involves treatments, which will extend the overall length of the patient's life." (Wheeler, 2018, para. 1). Curative care may be given in hospitals, outpatient offices, and homes. Some examples of curative measures include a liver transplant, physical therapy, chemotherapy, a cast for broken limbs, dialysis for kidney failure, or an antibiotic (Mroueh et al., 2019). With curative care, the patient and their team actively work towards the best possible way to cure the disease or heal the injury. Curative care and palliative care can be used concurrently to enhance a patient's life (Mroueh et al., 2019).

"Non-curative treatment constitutes an interprofessional treatment plan for patients whose illnesses are unresponsive to curative treatment and palliative care." (Mroueh et al., 2019). The goal of non-curative treatment is to alleviate symptoms instead of prolonging a patient's life. A non-curative plan focuses on completing tasks that help with symptom management and comfort care to facilitate home care. Hospice care accommodates those suffering from the most common forms of extended, terminal illnesses. Acute and chronic illnesses cause unbearable pain and long-term symptoms. Maintaining individualized care plans is key to delivering customized non-curative hospice care (Mroueh et al., 2019).

Choosing Between Palliative Care and Curative Treatment

When determining if a patient is a candidate for curative or palliative treatment, the healthcare team must consider many factors. Factors include but are not limited to disease progression, the age of the patient, and the patient's overall health. Curative treatment is typically the best option when diseases are diagnosed early before becoming very serious. The Center for Medicare Advocacy (2016) reported that curative care promotes recovery to assist patients with overcoming ailing disease processes, yet, providing relief of disease symptoms aligns with palliative care. There are differences between curative care and palliative care, which is important so the patient and family can choose the best care option covered by Medicare.

The palliative and curative divide are not easily discerned. For example, a person with ESRD without dialysis will most likely die within two weeks (Center for Medicare Advocacy, 2016). A person with ERSD who chooses hospice care can expect a dramatic decrease in life expectancy. Dialysis for an individual with ERSD is not curative (Center for Medicare Advocacy, 2016). Then, it must be palliative care and should be covered by Medicare under the hospice benefit. Choosing care for critically ill patients can be difficult if it is decided that palliative care is the best option.

Background and Significance of Proposed Topic

Hospitalists are referred to patients with life-threatening illnesses near the end of life who need palliative care or palliative care services (Pantilat, 2002). Although people suffering from serious illnesses account for high healthcare utilization in the U.S., routine care for patient symptoms is often under-treated (Center to Advance Palliative Care [CAPC], 2020). Inadequate routine care is exhibited by ineffective communication between the healthcare team and the patient/family related to illness, disease progression, and expectations/options leading to family and caregiver strain (CAPC, 2020). This problem exists within the hospital group used for this project since the hospitalists lack adequate training and have minimal knowledge to provide palliative care. Hospitalists must relieve distressing symptoms which patients encounter, effectively communicate with patients and families, and provide psychosocial support during EOL to provide effective care (Pantilat, 2002). Due to having an abundance of responsibility for caring for patients during EOL, hospitalists can be change agents in the improvement of care for patients that are dying.

In the 1970s, palliative care was not routinely or proactively discussed with patients presenting with the progression of the disease to the point of no return. Palliative care is routinely integrated into collaborative and interprofessional care (Hickner, 2017). Although the living will concept was first proposed in 1969, the topic was not addressed in a scholarly forum for another 16 years (Hickner, 2017; Kutner, 1969). In a small-town practice in the 60s, 70s, and 80s, the family physician would be present when their patients were dying and usually knew their family members (Hickner, 2017). Family meetings were easier to arrange, and the family quickly reached a consensus about healthcare concerns (Hickner, 2017). Today, people are less likely to have a family physician that intimately knows their dying wishes. Now, most dying hospitalized patients are cared for by hospitalists who may be meeting the patient for the first time (Hickner, 2017). As medical care and technology have advanced, patients have been able to live longer, which also means that many patients, along with many providers, actively push for aggressive care in situations in which palliative care would likely be the better choice (Hickner, 2017). During ELC, it is important to understand and document the patient's advanced directives and wishes to maintain their dignity and control during their dying days. There is value in advanced care planning; however, approximately two-thirds of Americans do not have an advanced directive that demonstrates their EOL wishes (Tierney et al., 2001; Weathers et al., 2016; Yadav et al., 2017). Rolnick et al. (2017) suggested delegalizing the process to remove barriers and make it easier for people to execute such documents and integrate them into the health care systems. These documents should be integrated into the routine office visit and hardwired into the electronic medical records (EMR) and office routines (Hickner, 2017). This has led to the focus on aggressive treatments that may provide patients and their families with hope for survival or more time for the patient. Furthermore, healthcare providers were traditionally trained to focus on providing treatments to prolong the patient's life instead of the withdrawal of active or curative treatments and their replacement with comfort care (Hickner, 2017).

However, the patient care team often discusses palliative care to inform patients with life-threatening illnesses of their options for comfort care and provide recommendations from various providers. However, many patients still equate agreeing to palliative care as essentially giving up on curative treatments and acknowledging that they are at the end of their lives (Hickner, 2017). Palliative care is positively correlated with EOL intensive and aggressive treatments provided in the emergency room or the intensive care unit setting (Daly et al., 2016). Many patients, who have opted not to take advantage of palliative care, experience health crises and exacerbations as their condition deteriorates and often seek emergency care (Mierendorf & Gidvani, 2015). However, this can create a situation where providers focus on stabilizing the patient's condition, which may involve the use of aggressive tactics, such as the admission of patients to the intensive care unit (ICU), which might contribute to the patient's needless suffering at the end of their life (Mierendorf & Gidvani, 2014).

Sixty percent (60%) of Americans die in hospitals while receiving acute care, with the remaining 40% dying either in a nursing home or in their private home setting (Stanford School of Medicine, 2020). At the same time, healthcare experts stated that about 60% of all Americans, if given a choice, would choose to die in their private home setting, as opposed to a hospital (Stanford School of Medicine, 2020). Up to 40% of patients are enrolled in palliative care when they die, but the vast majority choose to enroll in a palliative program in the last two to three weeks (Stanford School of Medicine, 2020).

This topic is clinically significant because palliative care enables many patients with chronic or serious health conditions to live longer (Hickner, 2017). Longer life with a debilitating disease has contributed to situations where patients and providers need to plan care. Patients do not always agree to receive palliative care in place of aggressive treatment when their health condition warrants the latter. This leads to many critically ill patients dying in the emergency department or being admitted following such a visit (Mierendorf & Gidvani, 2014). Despite this, hospitalists, who will likely and ultimately provide care to the critically ill patients presenting to the hospital for urgent care at the end of their lives, have the duty and responsibility to educate the family and patient about palliative care and ensure the patients' palliative needs are met. This ensures the patient and their families are sufficiently prepared for the projected outcome of the patient's health condition in a sensitive and culturally appropriate manner (McPherson, 2018).

Frontline clinicians, including hospitalists, provide core palliative care skills, while specialty palliative care consults are reserved to treat complicated EOL cases (Beresford, 2016). According to CAPC (2019), 72% of hospitals have a palliative care program with 50 or more beds, increasing five percent since 2015. In 62-94% of U.S. hospitals, palliative care teams have greater than 300 beds and 50 to 299 beds, respectively (CAPC, 2019). Palliative care services are more prevalent in nonprofit (82%) hospitals in comparison to public hospitals (60%) and for-profit hospitals (35%, up from 23% in 2015) (CAPC, 2019). However, meeting the needs of critically ill patients requires more than access. At present, at least twelve million adults (Hayes et al., 2016) and 400,000 children live with serious illnesses (IOM, 2003). By 2035, the number of people over age sixty-five, 81% of whom live with multiple chronic conditions, will approach seventy-eight million. For the first time, this number will eclipse the number of people 18 years old or younger and the number of women aged 18-55, the traditional caregiver workforce (Buttorff et al., 2017; CAPC, 2019; U.S. Census Bureau, 2018). Although numerous people are managing chronic illnesses today, access to hospitals with palliative care continues to be limited. Palliative care access is typically determined by the patient's demographics and services provided by the hospital in the local area (CAPC, 2019). CAPC (2019) stated a call to action, and palliative caregivers often experience negative psychological, behavioral, and psychological effects on their health. The demand based on patients' EOL status in the hospital setting leads to understaffing in the hospital palliative care programs.

The resources for palliative care services must be improved to ensure equitable and reliable access. Skilled communication, appropriate management of symptoms, and assessments inclusive of psychosocial factors and support are required to improve patient care. Understanding the appropriate timing for specialty palliative care referrals will improve patient care quality. Misconceptions and fears about palliative and hospice care referral may impede patient and family options (Beresford, 2016). Hence, it is important to clarify the differences between palliative and hospice care (Beresford, 2016; CAPC, 2019). The hospitalist must be trained on standards for palliative care to ensure gaps and challenges set forth by policymakers are overcome and sustained (Beresford, 2016; CAPC, 2019).

Problem Statement or Purpose

Within the palliative environment where patient care is provided in the hospital setting, hospitalists often do not have sufficient training in palliative care that would allow them to optimize the care given to members of this patient population (Beresford, 2016; CAPC, 2019; Pantilat, 2002). As a result, during the EOL, many patients not only die in hospitals but also receive care from a hospitalist that they have never met before and who is not familiar with their health history beyond what can be immediately and readily found in the patient's electronic health record (Hickner, 2017). Outside of the emergency room and intensive care unit setting, critically ill patients typically have a provider care team familiar with their condition and treatment (Hickner, 2017). However, these same providers are often not available for care when the patient deteriorates to needing urgent care, which leaves the seriously ill and suffering patients in the hands of hospitalists (Hickner, 2017).

Many providers are not knowledgeable enough about what palliative care entails or when this type of care can be offered to the patient and initiated as part of patient care (Broglio & Walsh, 2017). Providers may also not be sufficiently prepared to engage in this type of care as part of an interdisciplinary team due to the lack of knowledge regarding the provision of care role (Anderson et al., 2017). Additionally, providers may not be aware that they can work with multidisciplinary teams to deliver palliative care so that the patient can gain access to treatment modalities that are well-rounded and meant to address all of their needs in a holistic manner (Broglio & Walsh, 2017). This can present a barrier to the patient being transferred into palliative care when the patient can become comfortable with their care team based on mutual trust and respect and does not want to rebuild this therapeutic relationship with a new team of providers (Pitorak, 2003).

Other reasons for palliative care being significantly underutilized at the end of life include the cultural background of the patient not aligning with the acceptance of this type of care, the patient's healthcare goals not aligning with moving into palliative care or focusing only on the symptoms, patients and families not having access to this type of care. Palliative care cost is too expensive for the patient and caregivers, and the fact that many patients and family members are often not aware that this type of care is covered under Medicare and many types of private health insurance policies (Broglio & Walsh, 2017).

There is a significant benefit to providers having enough training and experience to approach discussions regarding palliative care promptly. Patients undergoing this type of care reported greater relief from their care and health condition symptoms and improved quality of life (Manzano et al., 2015). Additionally, existing data points to the fact that patients referred to and entering palliative care at an appropriate point of their disease progression have a smaller risk of being admitted to in-patient care that can be overly aggressive and which can limit the patient quality of life (Manzano et al., 2015). This is because acute care hospitals and in-patient treatment are rooted in rapidly treating the health condition that has caused patients to be hospitalized so that patients can be discharged as quickly as possible to prevent needless overuse of medical resources (Sung & Herbst, 2017). As aggressive treatment can stabilize patients for a short time, they face a high risk of rapidly destabilizing and needing to be hospitalized again, creating a cycle of readmissions and the patient's symptoms never being sufficiently addressed or treated (Sung & Herbst, 2017).

Evidence points to hospitalists and nurses working in the inpatient setting not being knowledgeable enough to engage the EOL patients in discussing their transition to palliative care (Broglio & Walsh, 2017). Additionally, hospitalists tend to be challenged by working together as part of a patient care team for a collaborative effort to help end of life patients establish and carry out healthcare goals at this point in their life and this particular point in the trajectory of their illness (Broglio & Walsh, 2017). The purpose of this DNP project was to evaluate whether targeted training would better prepare hospitalists for caring for patients with terminal and life-limiting illnesses.

The research gap that has been identified is that hospital facilities not only lag in terms of ensuring that their hospitalists are sufficiently trained to provide palliative care to patients but also lack a tool that can properly assess the degree to which hospitalists are prepared to engage in this type of a conversation with patients. Without a tool to support evaluating whether a knowledge gap exists and its extent, facilities have no way of approaching this problem and determining how to best solve it. As a result, this type of tool and subsequent training can alleviate this issue and its consequences and drastically improve the care of patients during the end of life.

Clinical Question

The PIO question guiding this project is:

(P) Do hospitalists working with end-of-life or critically ill patients provide with
(I) a training session on palliative care, communication, and collaboration techniques,
(O) to improve knowledge, skills, and collaborative ability in practice and improve patient care?

The goal associated with this clinical question was to determine whether targeted training sessions for hospitalists on palliative care communication and collaboration techniques improved hospitalists' level of knowledge and skills concerning palliative care. This project enhanced the quality of care provided to patients in that it trained hospitalists on how to initiate palliative care conversations with patients and their families effectively. This developed training and assessment tool would allow hospitalists to become more proactive with palliative care consultations.

Definitions of Terms

Critically Ill Patient

A patient with a serious health condition is not expected to be cured of their health condition and whose life is expected to end due to the illness. In general, the dysfunction of six organ systems: cardiovascular, respiratory, neurologic, hematologic, renal, and hepatic, is used to assess the degree of critical illness in any patient (Vincent & Creteur, 2019).

Hospice Care

Care focused on setting and achieving patient care goals focused around a critically ill patient's comfort once any curative treatments have been ceased and are not projected to be effective in treating or improving the patient's health condition (Shiel, 2020).

Hospitalist

A hospitalist can be defined as a healthcare provider or clinician who cares only for patients receiving hospital care on an in-patient basis. Hospitalists engage in performance improvement for the healthcare system through teaching, reaching, and clinical care (Society of Hospital Medicine, 2020).

Hospitalist's Knowledge

Hospitalist's knowledge is the degree and extent of experience, education, professional development, and information that hospitalists have regarding palliative care when working with critically ill patients (Nabili & Shiel, 2020).

Palliative Care

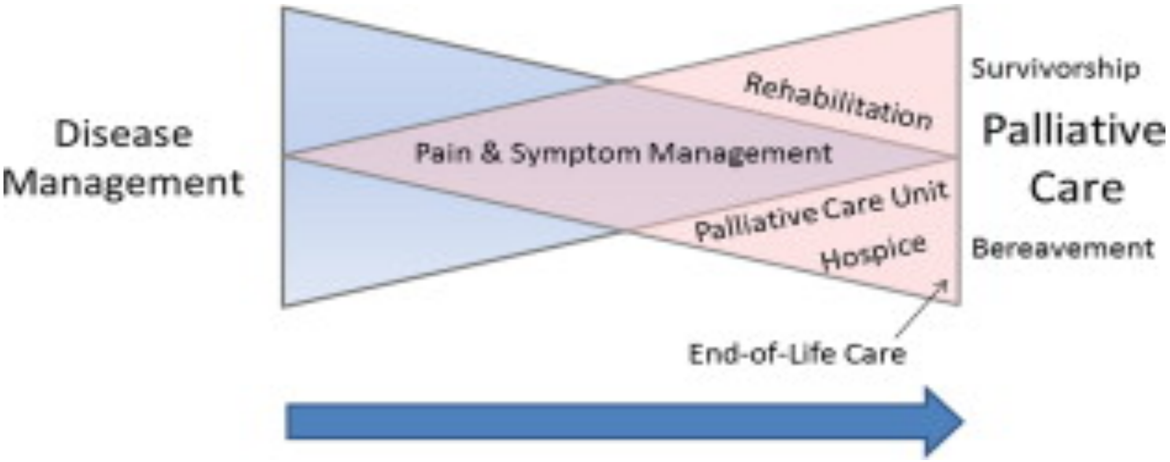
Palliative care is a specialty that focuses on relieving pain and symptoms related to serious illness, providing comfort, and improving the quality of life (WHO, 2020). Palliative care may be a part of hospice care, in that no other curative treatment is provided, or it may be part of a curative care protocol (Mayo Clinic Staff, 2017).

Theoretical Framework

The theoretical framework for this evaluation project is based on two models. First is the palliative care model, which focuses on assessing the patient's symptoms with a progressive life-threatening illness, communicating prognosis and goals of care, and providing family and caretakers support (Anderson et al., 2017). The second model is the Adventist nursing practice model, which focuses on how nurses practice, evaluate patient needs, care with compassion, connect the nurses' practices with education, and improve outcomes while empowering nurses to provide safe connective care with God (Jones et al., 2017). Nursing is focused on evaluating patient needs and determining how best to fill these needs on the premise that human beings are a cohesive system of individual parts (Ard et al., 2018). The palliative care model applies to this project to guide its development. The palliative care model focuses on nurses and providers identifying the patient’s needs related to complex illnesses and aiming to improve that care (Anderson et al., 2017). Hospitalized patients have palliative care needs that include managing psychological and emotional symptoms through communicating personal goals. Life-sustaining treatments are provided in the ICU with guidance by a hospitalist with a palliative care skill set that focuses on advanced illnesses, treatments, and services to assist with service transition to ELC. Patient-centered, quality care is essential for providers despite the patient’s diagnosis, the transition of care, and ELC (Ahtisham & Jacoline, 2015). At the core of the palliative care model is the idea and acknowledgment that each patient’s needs are individual and unique, and providers must identify what these needs are and ensure that whatever care they provide to the patient is appropriately tailored to these needs on an individual basis (Ahtisham & Jacoline, 2015). (Figure 1)

Figure 1

Palliative Care Enhanced Model

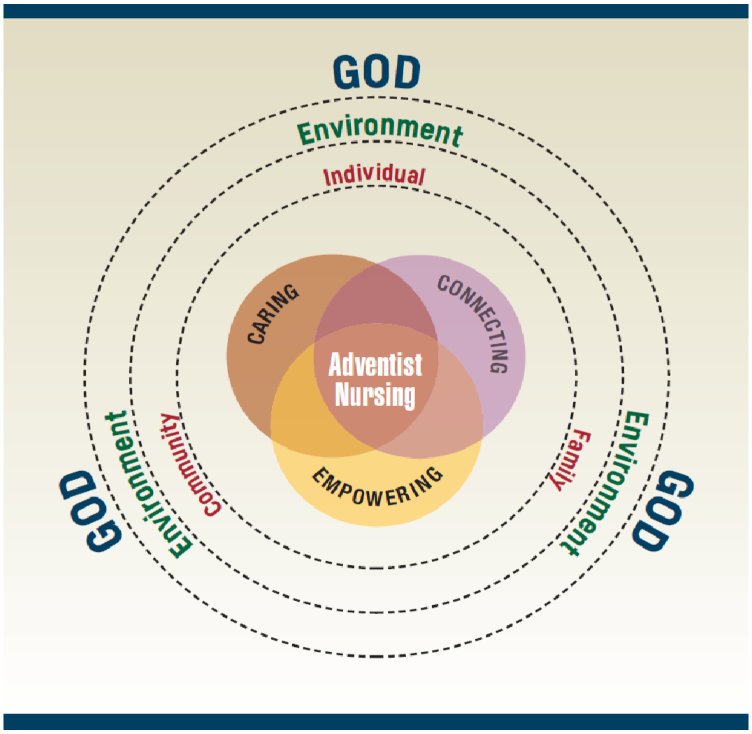


Palliative care-enhanced model. Adapted from “The Bow Tie Model of 21st Century Palliative Care,” by P. H. Hawley, 2014, *Journal of Pain And Symptom Management*, *47*(1), p. E4.

Additionally, the Adventist nursing practice model would apply to this project. The Adventist model is rooted in the biblical belief that providers need to promote the patients’ development in all aspects, whether emotional, psychological, spiritual, or physical, so that the patient’s divine purpose, as intended by God, can be realized (Adventist Health Portland, 2020; Jones et al., 2017). Based on this model, providers need to assist patients in strengthening their faith and relationships and fostering productive and positive behaviors and habits that align with the principles outlined in the Bible (Jones et al., 2017). The Adventist model’s concern for health and holism plays a prominent role in the tradition that values respect for autonomy, sees service through nursing as a form of beneficence, and values life with particular concern for justice. This model affects the practice and ethics of Adventist nurses. As such, this model can help guide the project by aligning the goal of enhancing the knowledge of hospitalists so that an improved level of patient care can be provided (Figure 2).

Figure 2

Adventist Nursing Practice Model



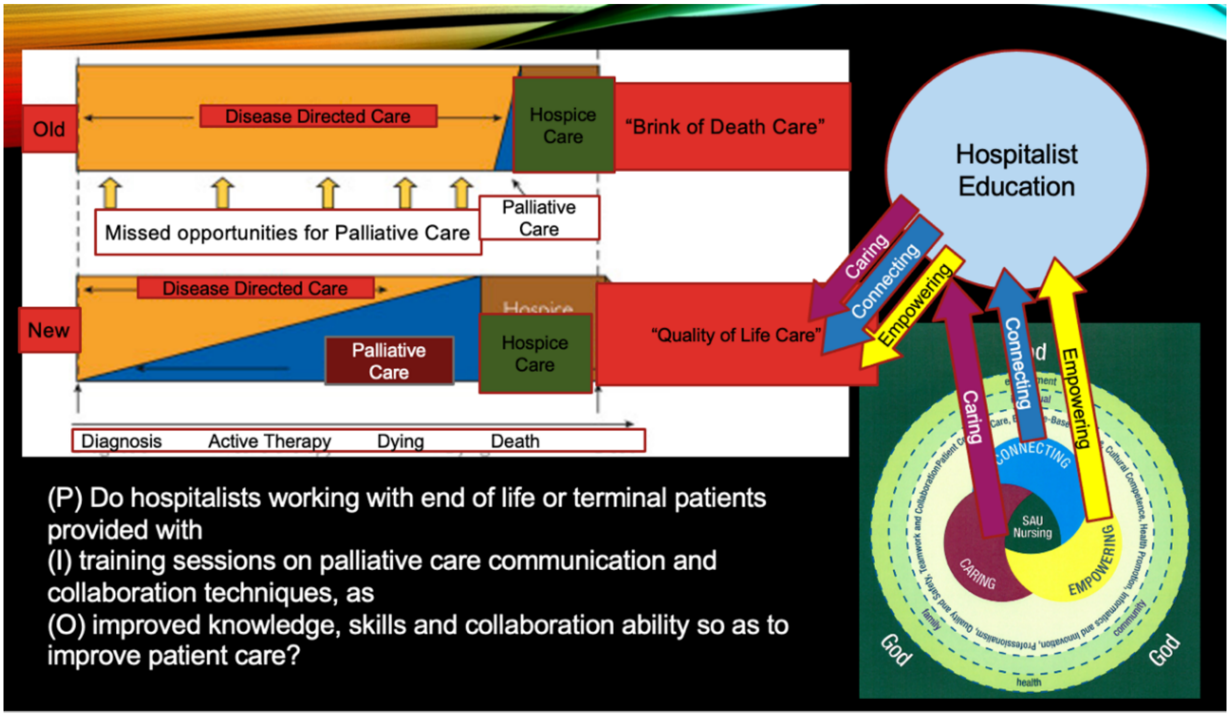
Adapted from "A Distinctive Framework for Adventist Nursing," by P. S. Jones, B. R. James, J. Owino, M. Abemyil, A. P. de Beltrán, and E. Ramal, 2017, *Journal of Adventist Education*, *79*(5), p. 11.

Palliative care is a culmination of life-limiting illness with ELC. Enhancing communication and managing patient symptoms can improve palliative care outcomes. Hospice referrals can have barriers, including the hospitalist's decreased comfort with engaging in effective EOL conversations. Hospitalists take the place of the primary physician in a healthcare system with multiple comorbidities. The hospitalist is expected to independently treat medical conditions with their knowledge and expertise. The growing need for hospitalists competent in palliative care is very important due to the requirement to communicate with the patient and family to guide them through a diagnosis dialogue and a discussion of advance care planning.

The palliative care model and the Adventist nursing practice model guided this project. The hospitalists' professional development program consisted of a webinar session and bedside coaching using the palliative care assessment tool. Furthermore, the hospitalists understood primary palliative care, therefore, taking ownership of the care of the terminally ill patients. The hospitalist increased communication with the palliative specialty team to ensure appropriate hospice referrals were completed. The webinar also enhanced effective communication with patients and their families (Figure 3).

Figure 3

Hospitalist Education for Palliative Care



(P) Do hospitalists working with end of life or terminal patients provided with
(I) training sessions on palliative care communication and collaboration techniques, as
(O) improved knowledge, skills and collaboration ability so as to improve patient care?

Chapter 2: Integrated Review of Literature

Introduction

The project provided hospitalists with a professional palliative care development program. The goal was to improve hospitalists' understanding of palliative care, effectively treat terminally ill patients, and effectively communicate with the palliative specialty team, patients, and families. This chapter discusses the evidence-based literature analyzed and is synthesized from many sources related to the project's purpose.

Search Strategy

Electronic databases were comprehensively searched to examine the utilization of a palliative care assessment tool in ICU to improve the communication process for patient referrals to hospice. Specifically, electronic databases utilized were Nursing Reference PLUS, Cumulative Index to Nursing and Allied Health Literature, SCOPUS, Medical Literature Analysis and Retrieval System Online, and the Cochrane Database of Systematic Reviews. The key search terms were palliative care, communication palliative care, non-curative, hospice care, terminal illness, end-of-life, nurse practitioner hospitalist education, history of nurse practitioner (NP) hospitalist, paradigm shifts in palliative care, palliative care and COVID-19 pandemic, patient's decision to use palliative care, palliative care models, Adventist nursing care model for palliative care, and need for NP education. Additionally, teamwork attitudes, team-building skills perceptions, and integration of the palliative care tool within the clinical practice were identified as literary themes. The Boolean operators AND and OR were utilized to optimize search results. Searches were limited to scholarly, full-text, peer-reviewed articles published within the last five years. Inclusion criteria included the English language that addressed the PICO question with a primary focus on clinical evidence utilizing the palliative care enhanced model and the Adventist nursing practice model in conjunction with hospitalist's education for palliative care. References from studies were utilized to increase the number of articles for review. Exclusion criteria included studies that did not address the PICO question.

History of the Nurse Practitioner Hospitalist

In 1996, the term hospitalist was developed and altered patient care in the hospital setting (Kutner, 1969). Initially, a hospitalist was a medical doctor (MD or doctor of osteopathic medicine (DO) who specialized in hospital medicine and had a subspecialty of internal medicine. The hospitalists coordinated the patent's hospitalized care with the other professionals of the healthcare team. Patients receiving care from one physician throughout the hospital stay established continuity of care. Today, the role of hospitalists has evolved to admit patients into inpatient care and provide them with treatment while they are hospitalized (Hillard, 2021). In many ways, this role has replaced that of primary care physicians for inpatient care (Hillard, 2021).

Between the end of the 1950s and the beginning of the 1960s, a shortage of primary care physicians occurred due to the increased number of specialists (Cushing, 2020). Due to this change, many individuals living in rural areas lose access to quality primary care (Barnes et al., 2018). As a result, primary care physicians without specific specialties collaborated and recruited expert registered nurses (RN) to treat patients in the primary care setting. This helped alleviate some detrimental effects of the primary care physician shortage, particularly in areas where predisposed shortages due to geographical constraints were common (Barnes et al., 2018).

The Social Security Amendments developed Medicare and Medicaid programs in 1965. These programs provided healthcare access for low-income children and women, the elderly, and people with disabilities (Simmons University, 2014). Access to healthcare increased primary care usage throughout the United States, and nurses naturally stepped in to educate families about health promotion and prevention.

After 1960, multiple palliative care and hospice institutions were developed. This trajectory was spurred by advances in medicine, which allowed for longer lifespans and a greater focus on patients' experience with healthcare (Abbott et al., 2020). Saunders raised attention to caring for patients with advanced malignant disease during EOL. However, there was limited research on caring for dying patients (Clark, 2007). Professional organizations lacked healthcare promotion that raised awareness of the dying patient, and palliative care was not commonly used (Baines, 2011; Clark, 2004; Clark & Seymour, 1999).

In the 1960s, Elisabeth Kübler-Ross provided respect, openness, and honest communication throughout the stages of death and dying. In 1969, Kübler-Ross wrote a book, *On Death and Dying*, which acknowledged and humanized the stages of death for patients. Patients were admitted to the hospital and remained there until they died, with very few exceptions. The few patients that went home had no follow-up care. In 1972, Kübler-Ross presented death with dignity to the U.S. Senate Special Committee on Aging.

In 1974, Dr. Balfour Mount defined the term palliative care. Patients who experienced physical, psychological, social, and spiritual distress delivered by the interprofessional team were provided holistic care. Palliative care families were also included in the holistic care model (Baines, 2011; Loscalzo, 2008).

In 1997, the Institute of Medicine report documented that the United States had insufficient standards for ELC (Field & Cassel, 1997). Palliative care was introduced to nursing and mainstream medicine with support from the Robert Wood Johnson Foundation and George Soros' Open Society Institute (Loscalzo, 2008). In 2004, the scope for palliative care expanded to include life-limiting illnesses in conjunction with dying patients. By 2006, approximately 100 physicians were trainees in one of the 57 palliative medicine fellowship programs (Loscalzo, 2008).

In 2006, the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education recognized hospice and palliative medicine as a subspeciality (Loscalzo, 2008). The first ten specialties cosponsored the ABMS certification examination was given in 2008. This certification is reflected in the foundation of the specialty fields in palliative medicine.

Palliative medicine is one's difficulty with openly and honestly accepting life on its terms. Palliative medicine is a new subspeciality introduced into academia, which enabled future physicians to learn palliative medicine skills to advance the field. This assisted physicians in fulfilling the promise to avoid abandoning patients despite the outcome of treatment and everything to be done to relieve patients' suffering.

Palliative care services are developed in multiple settings. This care is closely related to oncology due to the wide range of treatment-associated symptoms that patients affected by cancer and undergoing chemotherapy or radiotherapy often experience (Chow & Dahlin, 2018). The need for palliative care exceeds the provision (Clark, 2007). However, palliative care interest is great, especially amongst policymakers and influential bodies (Baines, 2011; Clark, 2007).

Throughout the country, nursing roles have expanded based on healthcare knowledge and expertise related to the needs of children and families. This led to the expansion of the nursing roles. Nurses now have roles parallel to the roles and responsibilities of a primary care physician. In 1965, the first nurse practitioner (NP) training program was developed by Loretta Ford and a physician named Henry Silver (University of Rochester Medical Center School of Nursing, 2020). The NP program focused on family health, disease prevention, and health promotion. This ground-breaking work led to the creation of the NP role and changed how health care was provided. One of the greatest strengths of the NP program is that they learn alongside experienced practitioners bringing a level of expertise and professionalism that creates a stronger connection with the patients and families in their care. However, the program was met with resistance from health care professionals. There were concerns that NPs could not independently practice medicine due to their lack of qualifications (Simmons University, 2014).

During the 1970s and 1980s, the profession was validated by NPs. NPs were required to demonstrate their abilities and health outcomes, despite the lack of training and credentialing (Simmons University, 2014). Patient satisfaction was documented in conjunction with care to develop standards of practice for NPs. This generated substantial shifts in patient quality of care and improved patient care outcomes. NPs also monitored evidence-based studies, which documented the primary care increase throughout the country.

As time went on, the value of NPs was evident, and it was clear that the profession was an essential component of health care. Economic and professional acknowledgments were recognized, which became the basis of NP work (Baines, 2011). Between 1973 and 1985, NP organizations in the United States increased to more than 11 (Simmons University, 2014). The organizations were important because they allowed NPs to gain credentials by passing certification examinations. This allowed reimbursement of NP services based on federal regulations.

In 1974, the American Nurses Association created the Council of Primary Care Nurse Practitioners to help solidify the role of NPs in the United States healthcare system. By 1979, there were approximately 15,000 NPs across the country (Thrive AP, 2012). The American Academy of Nurse Practitioners was established in 1985 and created educational standards for future NPs (Simmons University, 2014; Thrive AP, 2012).

In the 1980s, the government did not recognize NPs as providers, which limited their legal scope of practice and reimbursement status (Baines, 2011). This meant the services provided by NPs were not reimbursable or tied to any monetary value for the organization. The limited scope of practice and the inability to generate revenue caused NPs to be viewed differently than providers, which caused difficulty when services were utilized (Baines, 2011). During this time, NPs were provided a check from the hospital or physician (Simmons University, 2014).

Nurse leaders collaborated with Congress and lobbyists to gain provider status and obtain the ability to receive reimbursement from insurance companies. In 1989, the Omnibus Reconciliation Act was signed and provided NPs the opportunity to obtain limited reimbursement (Simmons University, 2014). This helped set the stage for NPs to become much more prominent within healthcare and attain a greater legal scope of practice, allowing them to take on more of the roles and responsibilities of physicians (Carlson et al., 2020).

In 1993, the NP community gained an identity and support of advocates through the American College of Nurse Practitioners (Burman, 2020). The Balanced Budget Act of 1997 assisted NPs with obtaining reimbursement for services rendered. This allowed NPs to meet the primary care demands throughout the country. Although an NP's scope of practice may vary, the 192,000 NPs in the United States assist with filling the gap of providers in healthcare (Simmons University, 2014).

What Is Still Needed

According to Meier (2015), hospitals do not provide access to palliative care programs within their existing programs. Palliative care should be developed and disseminated within the hospital setting, despite the prognosis of the patient's condition. Since most illnesses occur outside the hospital setting, there is a lack of quality standards for patients with complex disease processes that utilize healthcare in various settings (Meier, 2015). Standards for accreditation requirements, payment incentives for meeting quality standards, core skills used for training, a clinical pathway, and insurance benefits are still needed. As far as the workforce goes, Meier (2015) reported one palliative care physician to every 1,700 patients with a terminal illness, which leads to an abundance of palliative care patients without specialized treatment. There is a demand to change graduate medical education to include the palliative care specialty. Additionally, the palliative care specialty lacks mandatory training for various healthcare providers (Meier, 2015). The current palliative care practice was established using data from other specialties and making inferences with a limited patient population, which was not the type of care patients and families needed or expected (Meier, 2015).

Numerous misconceptions and decreased palliative care standards affect the patient's decision to choose palliative healthcare. This results in increased suffering among patients in hospitals and home care. According to Zheng (2016), research, standardization, education, and funding policies are needed to improve the United States' standards of palliative care. The CAPC (2019) recommended three education, research, and funding; however, standardization is vital to ensure equality and access. The CPAC recommended the development of specific centers to train palliative care professionals. Mandatory training should be considered for palliative care physicians and nurses; however, the training should be offered to residents, students, and NP hospitalists (Zheng, 2016).

Another important aspect is to educate the public on palliative care. Disseminating information through educational palliative care centers while correcting misperceptions is accomplishing that aspect (Baines, 2011; Meier, 2011; Zheng, 2016). In conjunction with education, the efficacy of comfort, cost efficiency, and pain management should be considered (Zheng, 2016). According to Zheng (2016), physicians, clinicians, and hospitalists need to have knowledge of diseases and when life should be prolonged or when curative treatment should be halted. However, one of the unique things about palliative care is that each patient should receive patient-centric care based on their personalized care plan (Zheng, 2016).

Paradigm Shifts in Palliative Care

As opposed to being a provider, the hospitalist will sometimes shift to becoming a patient comforter. Elderly care might cause paradigm shifts that hospitals must consider (Greysen, 2018). Kuhn developed a paradigm shift model, which explained that new problems were presented when an older model is adrift in thinking did not alight (Greysen, 2018; Kuhn, 1996). Kuhn (1996) continued to explain that the dominant power ignores revolution as insignificant. Greysen (2018) believed this was a way of viewing scientific paradigm changes and clinical practice.

Demographics play a vital role in a paradigm shift in the care of the elderly. Our world is growing older. By 2050, the number of people aged 65 years and older is expected to be about one in six people or 1.5 million. This is roughly double the 65 and older population from 2000 (United Nations, 2019a). The population of people 85 years and older is expected to reach 20 million within the next 30 years (United Nations, 2019a). Life expectancy will increase to 84 years (United Nations, 2019b). Also, from 1960 to the present, individuals living over the age of 65 increased by 25% in high-income countries (United Nations, 2019b). In 2030, the hospitalized population is expected to shift to 40% of patients below 65 years of age (United Nations, 2019a). This will result in patients that need highly complex care to treat an abundance of medical conditions.

Centers for Medicare and Medicaid Services (2013) reported that approximately 50 million people were 65 years and older, accounting for 80% of beneficiaries. Functional impairment is a common condition in the geriatric population that has not been evaluated for the effects of readmission. Greysen et al. (2015) evaluated the functional impairment of the elderly population and found that if there was functional impairment, being readmitted to the hospital within 30 days of discharge was 4.7% higher.

There was a correlation between Medicare targeted conditions and increased readmission rates. Individuals with Medicare conditions were at a 25.7% instead of 16.9% readmission rate for no impairment (Greyson et al., 2015). According to Greysen (2018), providers need to focus more on the potential harm of elderly patients' multiple comorbidities to decrease readmission rates. These findings suggest that hospitalists and specialty teams overlook a functional impairment to reduce Medicare hospital readmissions.

Part of the paradigm shift needed is to focus on post-hospital care, such as nutrition, sleep, discomfort, cognition, and adverse effects of medications (Greysen, 2018). Greysen (2018) stated that the patient should be included in the healthcare team during hospitalization and discharge planning. Also, conducting patient satisfaction surveys may be another option.

Due to insufficient healthcare protocols and frameworks, the world is not ready for this aging century. To meet the demands of this changing patient population, colleges and universities, hospitals and clinics, physicians, clinicians, and hospitalists must have the ability to adapt to the elderly population. Greysen (2019) noted that most of the care for the elderly would fall to the hospitalist due to a decrease in geriatricians in the field.

Primary Palliative Care Roles for the Nurse Practitioner Hospitalist

NPs encompass occupations in all healthcare settings and medical fields. Furthermore, NPs currently work in many healthcare fields and specializations, from primary care to more specialized positions. NPs also work with various patient populations and groups and have become closely integrated into care provision. Nurse Practitioner Associates for Continuing Education (NPACE, 2020) reported that nurse practitioners are well-positioned to manage all aspects of care, including advanced care planning.

Symptom Management

NPs can identify abnormal assessments and develop a treatment plan to address the symptoms and align with the patient's overall goals. NPACE (2020) reported that NPs are competent to explain different therapies and treatments to patients and the risks and benefits present. Palliative care patients may experience emotional and spiritual distress due to the emotional and psychological stress experienced and brought on due to their health conditions and associated changes. Therefore, NPs should include spirituality in the patient-centric care plan (Carmel & Small, 2019; NPACE, 2020; Wheeler, 2016). This may be a challenge due to the need for empathy and interpersonal communication (NPACE, 2020). NPs may also be involved in patients' advance care planning with their primary care provider, interprofessional provider team, and family. NPACE (2020) stated that NPs assist with determining the appropriate medical decision-makers for the patient and acknowledge their health care wishes. NPACE (2020) and Carmel and Small (2019) indicated that it is essential for an NP to discuss symptoms, diagnoses, and prognosis clearly and openly with patients and their families. Due to the complexity and seriousness of the terminally ill patient, it is of utmost importance to have a dialogue to address their ELC plan. NPACE (2020) stated that patients and families should have time to think about their EOL choices, so it is best to complete advanced directives in the outpatient setting. All aspects of the disease process, therapies and treatments offered, and prognosis should be discussed with the patient by the NP (Carmel & Small, 2019; Wheeler, 2016). These conversations may be challenging; however, it is a skill that can be taught. Online resources provide written and video examples to enhance the knowledge about EOL conversations (NPACE, 2020; Roberts et al., 2020).

Transitioning to Hospice Care

Hospice care is an important topic to discuss when undergoing palliative care. NPACE (2020) and Wheeler (2016) indicated that a hospice referral should be provided if NPs believe the patient's life expectancy is less than six months. NPs have the credentials to discuss hospice options and expectations; however, certification to the hospice program must be completed by the provider (NPACE, 2020). Often, NPs are not palliative care experts, so a consult with a palliative care specialist may be best to address complicated care decisions related to EOL (NPACE, 2020). NPACE (2020) also indicated that a consultative role could be reserved for the NP once admitted to hospice if the patient prefers.

Palliative Care and the COVID-19 Pandemic

Palliative care has played an essential part in a healthcare institution's reaction to the COVID-19 pandemic. The COVID-19 pandemic has caused an increased number of terminally ill and dying patients, which requires specialty management (deLima et al., 2020). The rapid spread of COVID-19 increased the workload for palliative care programs due to surges of terminally ill patients, their families, and other clinicians seeking assistance (deLima et al., 2020). Many patients infected with COVID-19 have not only been receiving critical care within hospitals but have also died in the same setting (Abbott et al., 2020). For example, between March 2020 and April 2020, New York Presbyterian Weill Cornell Medical Center and Lower Manhattan Hospital experienced an influx of more than 1,100 COVID-19 infected patients being hospitalized in its intensive care unit (Bloom-Feshbach et al., 2021). Such a high number of new patients requiring complex and high acuity care led facilities across the country to experience shifts in care that were complicated by patient and provider anxiety regarding the pandemic and its health effects, the potential of infected patients to deteriorate rapidly, and hospital administrators fear a possibility of healthcare resource shortage (Bloom-Feshbach et al., 2021). This has prompted many of the nation's healthcare institutions to generate new treatment protocols concerning patients infected with COVID-19.

Mindful of the pandemic, the Dana-Farber Cancer Institute and Brigham Women's Hospital created a collection of educational material that aligned with palliative care initiatives for non-palliative care clinicians caring for COVID-19 patients (deLima et al., 2020). An interprofessional workgroup developed a toolkit of resources. Pocket guides were created for educational reference for palliative care summaries (deLima et al., 2020). These pocket guides were distributed to professionals working closely with COVID-19 patients, such as COVID-19 ICUs, emergency departments, and COVID-19 hospital medical services. Bedside nurses adapted the information for daily use, and another subgroup added the information online to be readily available to all. This toolkit empowered care providers to focus more on complex consultations that require higher-level palliative care expertise (deLima et al., 2020).

The workgroup added coaching options to the toolkit to provide robust assistance for a patient's case. This allows for a better ability to manage available healthcare resources. The workgroup has also built new clinical programs for the emergency department, ICU, and hospital medical teams. Also, the website, which contained communication skills and support tools, was accessed more than 2,000 times between April 7, 2019, and May 4, 2019 (deLima et al., 2020).

The COVID-19 pandemic necessitated essential palliative care education for clinical staff. Limited training hindered outpatient providers' confidence in treating critically ill patients. This knowledge gap was recognized during the early stages of COVID-19 (Roberts et al., 2020). Various palliative care organizations, such as CAPC, VitalTalk, and Respecting Choices, placed online resources rapidly. The primary care setting encountered challenges when applying the tools to practice. This led to Roberts et al. (2020) developing a concise toolkit built upon the narrative approach to goals of care conversations already integrated into numerous programs at their institution. Before developing the toolkit, Roberts et al. (2020) created the Palliative Creative Operations Team (PCOT), which consisted of a physician and nurse from the clinical team, a business analyst, and an administrative coordinator. The PCOT utilized a six-step approach to change inpatient education to support outpatient providers' needs during the pandemic (Roberts et al., 2020). An interprofessional team of contributors was formed to disseminate a concise, user-friendly toolkit that guided primary care clinicians to address advanced care plan discussions with patients suffering from COVID-19 and stay home for ELC (Roberts et al., 2020). The curricular content was organized into two modules: Advanced care planning and comfort care at EOL for patients at home. The researchers grounded the content with literature-based references and online resources. They created the toolkit using Microsoft Word with hyperlinks connecting elements to the table of contents for easy viewing and navigation on the clinician's smartphone. The completed toolkit was sent via email to all clinicians in the two hospital groups and over 300+ providers at more than 30 practices in Maryland.

The initial feedback was positive, with many expressing gratitude for the modules (Roberts et al., 2020). The researchers made an effort to bridge the COVID-19 educational gap for outpatient clinicians. Webinars for comfort care and advanced care planning were led by palliative care teams (Roberts et al., 2020). Different approaches to teaching primary palliative care communication exist; however, serious illnesses do not take a prescribed path. Therefore, this teaching narrative was an adaptive global positioning system to guide the way through an increasingly complex, dynamic domain for outpatient clinicians.

Patient's Decision to Use Palliative Care

The reality of hospital care is that chronic and life-limiting diseases tend to be the main cause of death for patients seeking care in the urgent and emergency care department setting (Fine & Davis, 2017). This has largely occurred because medical care advanced to allow Americans to live longer while developing serious illnesses near the end of their lives (Fine & Davis, 2017). At the same time, many patients and providers are still uncomfortable about openly discussing EOL planning and associated comfort care (Cervantes et al., 2016). As a result, members of both groups, patients, and providers, often actively avoid engaging and sustaining these types of conversations or delay them until a point in time in which patients are suffering or in chronic pain (Cervantes et al., 2016).

Patients nearing the end of their lives due to a health condition or a terminal illness are often subconsciously ready to have such a discussion, as they may be aware that their treatment is not working, even if their families and loved ones are attempting to shield them from such knowledge (Cervantes et al., 2016). These discussions should be initiated long before the patient reaches the terminal stage. This allows the patient and their family members to openly discuss the available options before the point in the patient's health trajectory that palliative care services need to be utilized (Ecarnot et al., 2018). This is because patients reaching the end of their lives can significantly benefit from palliative care to alleviate any suffering and pain associated with the progression of their chronic progressive illness (Fine & Davis, 2017).

A large percentage of patients are unwilling to consider palliative care due to the misconception that this type of decision equates to giving up on other types of treatments that are curative (Broglio & Walsh, 2017). This indicates a lack of sufficient education about what palliative care entails on the part of patients. Also, Broglio and Walsh (2017) indicated a tangible difference between palliative care and the care provided that falls under the category of services. Palliative care can be provided to the patient at any point within the progression of the disease that the patient has been diagnosed with and can be combined with curative or maintenance treatments that are meant to restore the patient's health condition to an optimal point or prevent it from further deterioration (Broglio & Walsh, 2017). The goal of palliative care is to enhance the patient's quality of life and address any unpleasant or adverse symptoms that the patient may be experiencing because of treatment (Broglio & Walsh, 2017). The World Health Organization (WHO) (2020) indicated that palliative care is the most appropriate and holistic approach to providing specialized care to terminally ill patients. The need for palliative care has increased for many reasons, including increased life expectancy (Greysen, 2018; WHO, 2020).

Personal challenges focus on the knowledge, attitudes, beliefs, skills, and culture of patients and families, the public, and health care providers. Additionally, some patients lack knowledge of palliative and hospice care treatment (WHO, 2020). Moreover, since palliative care is still relatively new, some health care providers have negative beliefs and attitudes, which presents challenges in providing palliative care for their patients (Abu-Odah et al., 2020).

The Need for Palliative Care Education

As various crises and evolutionary changes occur, the need for personalized care continues to rise exponentially. Palliative care training should be increased to assist physicians and clinicians with caring for ill patients accurately (SCP Health Staff, 2020). According to WHO, the main principles of palliative care include

1. relieving pain and disease symptoms,
2. a normal process is to affirm life and death,
3. neither hastens nor postpones death,
4. spiritual and psychological aspects of care are integrated,
5. assisting patients with remaining as active as possible until death by offering a support system, and
6. helping families cope with the patient's illness by providing a support system to address grief (SCP Health Staff, 2020).

Palliative care improves the well-being of patients and families, leading to reduced length of stay and medical costs (Feld et al., 2016). WHO (2020) reported that only 14% of the 40 million patients who need palliative care receive it (Key Facts 2 & 3). Palliative care is profitable to both patient care and hospital finances. Morrison et al. (2008) found that palliative care patients spent $279 less on direct hospital-associated costs each day, a net savings of $1,696. Research by the national polling firm, Public Opinion Strategies, revealed that 92% of patients consider palliative care for themselves or their families if they have a serious illness (CAPC, 2014). However, while most healthcare organizations offer ELC programs, 60% are not receiving the care (SCP Health Staff, 2020). One way to change this imbalance is by providing training for palliative care usage to hospitalists and intensivists (SCP Health Staff, 2020; WHO, 2020).

According to Yeager (2014), the number of palliative care programs has increased, yet more is needed. Much heterogeneity remains in the infrastructure and delivery of palliative care in U.S. cancer centers (Hui et al., 2010; Meier, 2015). A few programs have palliative care units, and most offer inpatient consultations (Hui et al., 2010; WHO, 2020). Although early access to integrated care should be promoted, most cancer centers do not offer palliative care outpatient services (Hui et al., 2010). Also, Hui et al. (2010) found that most cancer centers reported a palliative care program, although the scope of services and the degree of integration varied widely.

Future of Palliative Care

Research and education will guide the future of palliative care. Hui et al. (2010) found delays in utilizing palliative care and gaps in practice. Furthermore, Hui et al. (2010) noted the urgency to consolidate infrastructures, such as outpatient clinics and palliative care units. These researchers noted the vital need to provide healthcare professionals specific training on palliative care, complete research on quality measures and integration models, educate patients and their families, and advocate for public health policy changes. Therefore, collaboration with all palliative care stakeholders is needed to ensure high-quality care for all critically ill patients (CAPC, 2019; Hui et al., 2010; Zheng, 2016).

With the increasing need for palliative care services, NPs are well equipped to provide the necessary care. NPs can function as palliative care experts due to the specialty education that they have received (Meier & Beresford, 2006). Palliative care access is broadened due to NPs

(Yeager, 2014). In addition, palliative care offers an ideal setting for nursing leaders to build rapport, gain patients’ trust, and effectively communicate (Yeager, 2014). This leads to a partnership and utilizes the patient as a healthcare team member. NPs focus on improving care by enhancing quality and safety standards, positively contributing to the interprofessional team (Yeager, 2014).

Palliative care nurse leaders developed Palliative Care Fellowship program to enhance expertise in the field (Yeager, 2014). More of these palliative care fellowships are being developed by colleges and universities worldwide. However, many more are needed to fill the gap in specially trained palliative care clinicians, physicians, and hospitalists.

The coordination with palliative care teams would greatly benefit hospitalists when caring for terminally ill patients in the hospital setting. Palliative care teams can provide symptom management that is congruent with relieving pain and disease symptoms while increasing the satisfaction of the hospitalist’s delivery of care (Hurd, 2017). Terminally ill patients can be very exhausting to hospitalists. Therefore, palliative care teams can help ease overall clinician stress by aiding in debriefing, voicing different coping strategies, and recognizing the numerous challenges of caring for these patients (Hurd, 2017). Also, Hurd (2017) reported that palliative care professionals are especially adept at relaying unpleasant information and helping patients and families accept the truths of their illness and decide their ultimate goals of care. Therefore, as the population ages and the national healthcare system changes, the palliative care patients’ needs increase, creating opportunities for hospitalists, APRNs, NPs, and nurses who can serve in many different roles to fill the gaps and provide excellent care. However, as the studies noted above, education is lacking, which is vital to training nurse leaders, hospitalists, clinicians, and physicians in palliative care. This relates to the purpose of this DNP project which is to provide the needed and essential education to the hospitalists, physicians, clinicians, clergy, and the specialized care teams throughout the hospital.

Filling the Gap: Hospitalists and Palliative Care

In the last months of life, many terminally ill patients are hospitalized with care guided by hospitalists. For seriously ill patients, consultation with palliative care specialists has promoted patient-centered and family-centered care, ensuring that care is consistent with the patient's goals, values, and preferences. However, many hospitalized patients lack access to palliative care consultation, and specialists have identified key domains of primary palliative care that can be delivered by non-specialists (Anderson, 2017).

Hospitalists have an opportunity to lead prognosis and goals of care communication for their patients. Anderson (2017) explained that hospitalists need training and structural support that may not yet be available to them to succeed in this role. To fill this gap, Anderson (2017) noted that SHM’s Center for Quality Improvement partnered with The Hastings Center, a world-renowned bioethics research institution, to develop a resource room that focused on hospitalists’ role in providing high-quality communication about prognosis and goals of care. The resource room presents a Prognosis and Goals of Care Communication Pathway, highlighting key processes and mapping them onto hospitalist physicians and clinicians (Anderson, 2017). The resource room also includes skill-building tools and resources for individual hospitals, teams, and institutions. The care pathway is grounded in palliative care communication research and the guidance of *The Hastings Center Guidelines for Decisions on Life-Sustaining Treatment and Care Near the End of Life* (Anderson, 2017). The hospitalists, other hospital clinicians, patient and family advocates, bioethicists, social scientists, and other experts identified that the professional values of hospital medicine aligned with communication as part of good care for seriously ill patients (Anderson, 2017). According to Anderson (2017), a collaborative interdisciplinary workgroup convened to construct the care pathway in key processes occurring at admission, during hospitalization, and during discharge planning to support primary palliative care integration into the normal workflow.

Finlay et al. (2018) outlined key considerations for how to build an outpatient palliative care program in an institution by (1) defining the scope and benefits; (2) identifying strategies to overcome common barriers to integration of outpatient palliative care into cancer care; (3) outlining a business case; (4) describing successful models of outpatient palliative care; and (5) examining important factors in design and operation of a palliative care clinic. The researchers provide the advantages and disadvantages of different delivery models and referral methods (triggered vs. physician discretion) and the strategies to make a case for outpatient palliative care that align with institutional values and/or are supported by local institutional data on cost savings.

The support of palliative care specialists can improve the quality of care for hospitalized patients to hospitalists. The interprofessional hospitalist team works together to admit, manage, and provide high-quality patient care. Bezak (2020) reported the need for palliative care teams and hospitalists to work together.

Bezak (2020) drew from his own experience and explained the importance of teamwork, time management, and work-life balance. A typical day for hospitalists is involved managing the active medical problems of 12 to15 patients, completing consults to coordinate care, effectively communicating with the patient, families, and healthcare teams, and addressing EOL goals. The increased complexity in care management leads to more challenging tasks and occupational burnout.

Palliative care specialists possess unique skills, perspectives, and experiences that can enhance collaboration. Bezak (2020) reported variable exposure to palliative care competencies and management due to the lack of formalized educational training. Palliative team guidance can assist in complex symptom management and pain management (Bezak, 2020). Bezak (2020) recommended training since it provides hospitalists with the tools needed to communicate, manage symptoms, and provide family support effectively.

Bezak (2020) noted that a palliative care team consultation could provide a new perspective on the disease process and management. It should also be noted that palliative care improves patients' quality of life with terminal illnesses, although it is still underutilized by oncology patients (Rubens et al., 2018). By relieving distressing symptoms stemming from treatment or because the patient's health condition has progressed past the curative capability of medicine, palliative care can address and improve patient well-being (Rubens et al., 2018).

Hospitalists have highly varied shift schedules, leading to limited continuity and fragmentation in care (Bezak, 2020). Palliative care teams have the expertise to provide helpful insights during consults, leading to enhanced continuity of care. Moreover, pre-existing relationships between palliative care teams and patients can be beneficial. This will assist hospitalists in patient-centered, goal-oriented care (Bezak, 2020).

Palliative care specialists understand that managing terminally ill patients can lead to provider burnout. The specialized skill set of a palliative care team can alleviate the clinician's burden (Bezak, 2020). Improved teamwork between hospitalists and palliative care specialists can be built through consults by sharing coping strategies, discussing care challenges, and demonstrating compassion and resilience (Bezak, 2020).

Therefore, with collaboration between the hospitalist and palliative care team, the hospitalist can provide high-quality, effective, patient-focused care to benefit both patients and families. Hospitalists are in the best position to manage symptoms and have conversations about care priorities for many patients. Clinical training allows hospitalists to efficiently address common gaps in care for people with serious illnesses. For patients with the most complex needs, earlier palliative care consultation improves patient outcomes, improves clinician satisfaction, and reduces hospital utilization and costs. Exacerbated fragments in care lead to unmet palliative care needs in the subspecialty workforce. Training frontline physicians, including hospitalists, to provide primary palliative care has been proposed as one solution to this problem and when to consult chaplains and social workers to address challenging issues.

Chapter 3: DNP Project Plan

Evidence-Based Project/Intervention Plan

This project's goal was to offer hospitalists a professional development program to help them improve patient care. This project introduced the palliative care assessment tool, which will allow hospitalists to become more familiar with palliative care consultations to improve the quality of treatment for critically ill and terminally ill patients in the hospital setting using an educational webinar. The purpose was to improve hospitalists' awareness of palliative care, manage terminally ill patients successfully, and communicate effectively with the palliative specialty team, patients, and their families, among other things.

Purpose, Objectives, and Design of the Project

The PIO question guiding this project is:

(P) Do hospitalists working with end-of-life or critically ill patients provide with
(I) a training session on palliative care, communication, and collaboration techniques,
(O) improved knowledge, skills, and collaborative ability in practice and improved patient care?

The goal associated with this clinical question was to determine whether targeted training sessions for hospitalists on palliative care communication and collaboration techniques would improve hospitalists' level of knowledge and skills in the practice of palliative care. This project was to improve the quality and safety of patients in that it would train hospitalists in terms of how to initiate a conversation with patients and their families regarding palliative care and assess the application of this knowledge via practice assessments. This training and practice assessment tool would allow hospitalists to become more proactive with palliative care consultations.

Improving the quality of care for critically ill patients at the end of curative treatment or EOL leaves them with debilitating side effects and stressed families.

Design

A qualitative mixed method, quasi-experimental, practice change, pre and post-design, was used to answer the research question of (P) Do hospitalists working with EOL or critically ill provided with (I) a training session on palliative care, communication, and collaboration techniques have (O) improved knowledge, skills, and collaboration ability in practice, to improve patient care?

This project was designed with the following phases:

1. Palliative Care Webinar was provided on September 2, 2021, for 32 hospitalists in the selected facility, where Demographic Data and the Palliative Care Assessment Test were collected prior to the webinar.
2. Post-tests were collected 30 days after the education session for nine hospitalists.
3. Practice Outcomes were to be evaluated

Qualitative

Additionally, a qualitative analysis was added due to significant attrition. The remaining participants were interviewed to understand their experience providing palliative care for their patients. The qualitative part sought to measure and understand the Palliative Care Webinar via a qualitative questionnaire with the remaining 9 participants. The qualitative questions and responses were recorded, transcribed and evaluated for trends and similarities.

Setting and Participants

An acute care facility made up of two sister facilities in the Poconos in northeastern Pennsylvania was the setting for the project. Participants included 32 members of a hospitalist practice between two sister facilities made up of MDs, DOs, PAs, and NPs. All participants were de-identified in data collection. Permission to use this group was obtained from the medical director (Appendix A).

Palliative Care Webinar

The Palliative Care Webinar was a 50-minute educational program to give the hospitalist the knowledge and skills needed to deliver high-quality palliative care to seriously ill non-curative adults and their families while improving their quality of life. The objectives for the Palliative Care Webinar were to (1) discuss the transition from curative to palliative care, (2) define palliative care, (3) differentiate palliative vs. hospice, and (4) discuss inclusion/exclusion criteria for a consultation to palliative care. Training consisted of one session with a primary focus on patients transitioning from acute care and curative treatment to palliative care and conducting a patient consultation conversation and session regarding this type of transition.

Procedure

Participants in the Palliative Care Webinar were first asked to sign the informed consent (Appendix B). The participants then completed the Demographic Data (Appendix C) and were followed by taking the Palliative Care Knowledge Pre Assessment Test (PCKPAT) (Appendix D).

The 50-minute Palliative Care Webinar was then provided with a 10-minute question and answer session. The post-test was the same as the pre-test and was planned to be repeated 30 days after completing the webinar**.** The Palliative Care Assessment Tool (Appendix E) was developed for evaluating the anticipated practice change to demonstrate direct patient effects and practice change via a checklist provided to the hospitalists due to the significant attrition.

Measures and Interventions

As part of the study, the sample size was limited, which reduces the reliability of the research compared to studies that use a larger sample.

The Demographic Data assessment consists of six multiple-choice questions relating to age, gender, length of time working, medical preparation, previous palliative care training, and whether or not they can provide necessary referrals. The demographic data were used to describe the hospitalist group and their level of experience with palliative care. This tool was self-created and reviewed by the project advisor.

Palliative Care Knowledge Assessment Tool

The Palliative Care Knowledge Assessment Tool contains twenty-six multiple-choice or true-false questions. This assessment tool was self-developed as no tool was identified that evaluated the concepts of palliative care presented in the Palliative Care Webinar. Five questions (items 2, 19, 20, 21, and 22) were adopted from the PEACE-Q questionnaire (1, 22, 28, 29, 30) with permission from the authors to extract any of the questions to fit this study (Appendix F) (Yamamoto et al., 2013). The items selected for the PCKA were philosophy of care, psychological distress, and communication. The remainder of the questions in the tool was developed by the researcher in partnership with the supervising professor to evaluate the objectives of the education seminar. Items will be evaluated individually. The knowledge score is an interval variable based on the percent correct. Knowledge scores were collected at week 1 (pre-period) and week 8 (post-period).

Reliability and Validity of PEACE-Q

The PEACE-Q was developed to evaluate health care providers' knowledge of primary palliative care. The PEACE-Q response rate was 54% (n = 434). There were 33 items across nine domains (1) philosophy of palliative care, (2) cancer pain, (3) side effects of opioids, (4) dyspnea, (5) nausea and vomiting, (6) psychological distress, (7) delirium, (8) communication regarding palliative care, and (9) community-based palliative care (Yamamoto et al., 2013). The reported intraclass correlation was 0.84, and the Kuder-Richardson Formula 20 (KR-20) test of internal consistency was 0.87 (Yamamoto et al., 2013). There was a significant difference in the scores for each domain and between palliative care specialists and other physicians (Yamamoto et al., 2013). The PEACE-Q instrument showed good internal consistency, test-retest reliability, and known group validity; therefore, it was a validated instrument to measure the knowledge about palliative care among physicians and hospitalists (Yamamoto et al., 2013).

The Palliative Care Practice Outcomes Assessment Tool

The Palliative Care Practice Outcomes Assessment Tool (Appendix G) was developed to evaluate practice change in the implementation of palliative care protocols and discussions. The Palliative Care Practice Outcomes Assessment Tool was adapted from Anderson et al.'s (2017) study that used an Integrating Multidisciplinary Palliative Care (IMPACT) in the intensive care unit (ICU) to identify ICU bedside nurses' needs for training and support in palliative care communication. The IMPACT-ICU tool addressed barriers to integrating palliative care into the ICU and increasing bedside nurses' engagement in palliative care. The IMPACT-ICU was used on 605 patient rounds during Anderson et al.'s study. No validity and reliability data exists for the IMPACT-ICU tool.

The hospitalists were to have used the Palliative Care Practice Outcomes Assessment Tool made specifically for this project as a practice protocol coaching checklist. Each sheet submitted was to represent one patient interaction, and each hospitalist was to complete this assessment for each patient encounter deemed to require palliative care. This measure was to track practice change for 30 days after the education session.

The adapted Palliative Care Practice Outcomes Assessment Tool contained a patient identifier section with three questions and six steps. The patient identifier information was to be utilized only for billing purposes of the practice and would be eliminated by using a black marker and not be collected for research purposes. Each sheet was given a coded number for use in this project. Due to the attrition of participants in this project, the researcher could not utilize this tool.

COVID-19 Impact on Palliative Care Tool (Qualitative)

Instead, a new tool, the COVID-19 Impact on Palliative Care Tool (Appendix H), was used. This tool was developed with the assistance of faculty advisors to evaluate the remaining participants' understanding and experience with palliative care and assess how COVID-19 had impacted palliative care recommendations and referrals. The survey included four key questions. They were recorded via Zoom with participant consent. Once the interviews were completed, their responses to these questions were transcribed verbatim and then evaluated for trends and themes.

Privacy and Confidentiality

This project was submitted for review and approval from the IRB committee (Appendix I). The project included confidentiality measures, as no personally identifiable information was recorded to maintain anonymity, and no information was linked to the participant's responses. Each participant was assigned a random number. The study reported on aggregate findings rather than individual-level information. Moreover, the information gathered is retained securely through password-protected file encryption while transmitting information over the internet and locked doors and drawers within the project facility that are only accessible to the lead investigator. The researcher had access to the data and restricted access to only those approved and authorized. The confidentiality of the data continues to be of paramount importance and will be protected throughout the organization. These privacy and confidentiality safeguards will make it easier to carry out the study procedures on time. All data and project information is stored in a locked cabinet or on an encrypted computer and zip drive and will be kept for three years per IRB and federal guidelines and then destroyed.

Evaluation Plan

The project question was analyzed to determine a relationship between variables utilizing inferential statistics and trends via a mixed-method, quasi-experimental, and qualitative methods. A paired *t*-test was utilized to determine if the dependent variable, knowledge scores, would reveal differences based on time after receiving the independent variable of education and training. Due to the excessive attrition rate of the project participants, a qualitative questionnaire via telephonic/Zoom was incorporated for the remaining nine participants. The analysis included a qualitative COVID-19 Impact on Palliative Care survey. The survey included four key questions and was conducted via telephone, recorded on Zoom, and evaluated utilizing Nvivo for trends.

Demographic data (age, gender, medical preparation, experience) was evaluated with descriptive data and compared with the outcomes of the PCKA assessment tool. The paired *t*-test was utilized to detect differences in pre-and post-phase knowledge scores between the two periods. Trends in responses to questionnaires were analyzed and evaluated utilizing NVivo.

Chapter 4: Results

Sample Description

Thirty-two healthcare providers were invited to participate in the project. This encompassed MDs, DOs, PAs, and NPs that were acute care hospitalists at two sister facilities in the Poconos in northeastern Pennsylvania. However, only nine healthcare providers completed the project. The decrease in participants was attributed to numerous working conditions, including but not limited to increased acuity from COVID-19, increased staff-patient ratio, provider disengagement, and provider burnout.

The participants' demographics that did complete the pretest included 19 (59%) males and 13 (41%) females. The gender demographics for the project were consistent with research findings that reported that a majority of physicians are male (Butkus et al., 2018). The age range for the participants was 25 to 58 years of age. Six participants were ages 25-35, 17 were ages 36-46, eight were 47-57 years of age, and one was 58 years of age.

Medical preparation for this hospitalist group varied with eight MDs, two DOs, 13 PAs, and nine NPs. Additionally, their experience ranged from five to more than 20 years in healthcare. Only three of the 32 had personal training, and 29 did not. As it related to necessary referrals for patients with life-limiting diseases, nine participants completed all referrals and 23 completed all referrals. Due to the impact that COVID-19 had on the hospitalist group, only nine were able to complete it. The remaining nine participants were 56% male and included five MDs, three NPs, and one PA. None of the participants had personal training in palliative care; however, one provider had. One-provider worked at a long-term care facility providing hospice care.

Analysis of Project Questions/Hypothesis

The PIO question guiding this project is:

(P) Do hospitalists working with end-of-life or critically ill patients provide with

(I) a training session on palliative care, communication, and collaboration techniques,

(O) to improve knowledge, skills, and collaborative ability in practice and improve patient care?

Knowledge Scores

Participant knowledge was evaluated using the PCKA. The categories of questions in the PCKA included 1) Philosophy of Palliative Care (PPC), 2) Psychological Distress (PD), 3) Communication questions, and 4) Questions 1, 22, 28, 29, 30, which were from the PEACE-Q questionnaire. Knowledge was evaluated prior to the webinar.

Pre-Test-Post-Test Knowledge

The mean pre-test score was 88.31, with a standard deviation of 7.95. (*M* = 88.31, *SD* = 7.95 (N=32)). In the communication category, all 32 providers answered each question correctly. The category regarding the Philosophy of Palliative Care was the next highest score at 93% correct, or 28 of the 32 providers answered correctly. For the five questions adapted from the PEACEQ tool, 27 of 32 participants or 88%, answered correctly. Lastly, psychological distress, where 86% or 26 providers scored the lowest (Chart 1). The participants' mean test score was 100% in PPC, PQT, and CC. The score for PD was 99%. All participants were still at 100% in CC. The post-test score for PPC showed a gain of 7%. The PEACEQ tool indicated an increase of 22%, and the PD showed an increase of 1% (Chart 1).

The mean post-test score was 99.75, with a standard deviation of (M=99.87, *SD* = 7.95 (N=9). In the Communication category, 100% of the providers answered each question correctly. The category of Professional Development also had a score of 100% correct, or all of the nine remaining providers answered correctly. Regarding the PEACEQ tool, nine participants or 100%, answered correctly. Lastly, in PPC, 99% or 8 providers scored the lowest. (Chart 2).

Chart 1

Knowledge Scores In Question Category Prior to the Training Session 32 Participants

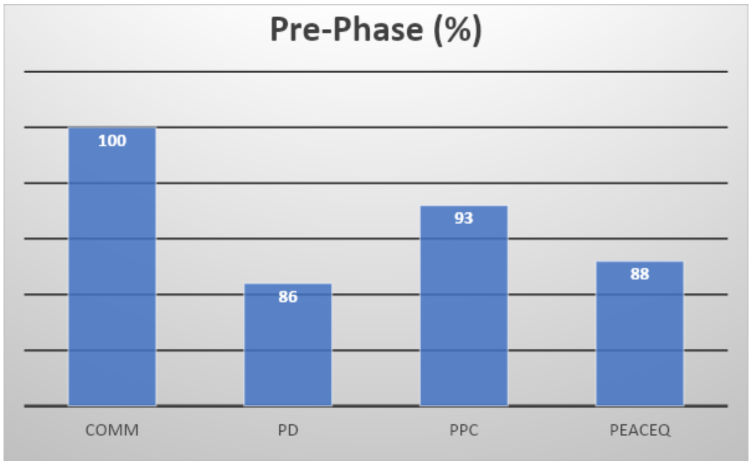
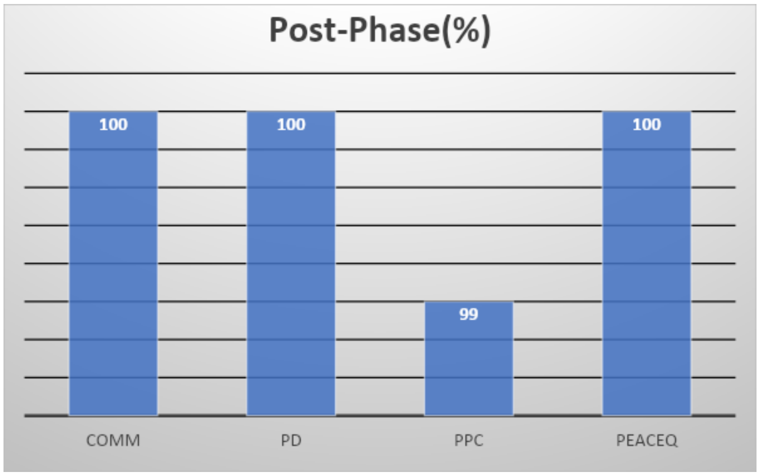


Chart 2

Knowledge Scores in Question Category Post the Training Session 9 Participants



A paired *t*-test was performed to assess knowledge scores for the nine participants who completed the pretest prior to the training session and after the training session. In this instance, the dependent variable was the knowledge score. The denominator was used in estimating the effect sizes. Cohen's d uses the sample standard deviation of the mean difference between the pretest was 87, with the post-test being 99 (Table 1).

Hedges' correction used the sample standard deviation of the mean difference plus a correction factor. Data from the survey was recorded in Excel and later exported to SPSS for analysis. The dependent samples *t*-test revealed a statistically significant difference between pretest and posttest knowledge scores of t (9) = -4.752, p < .001 (pretest-posttest r = 0.586), Cohen’s d = -1.586(CI95% = -2.57, -.561), indicating a medium effect size.

Table 1

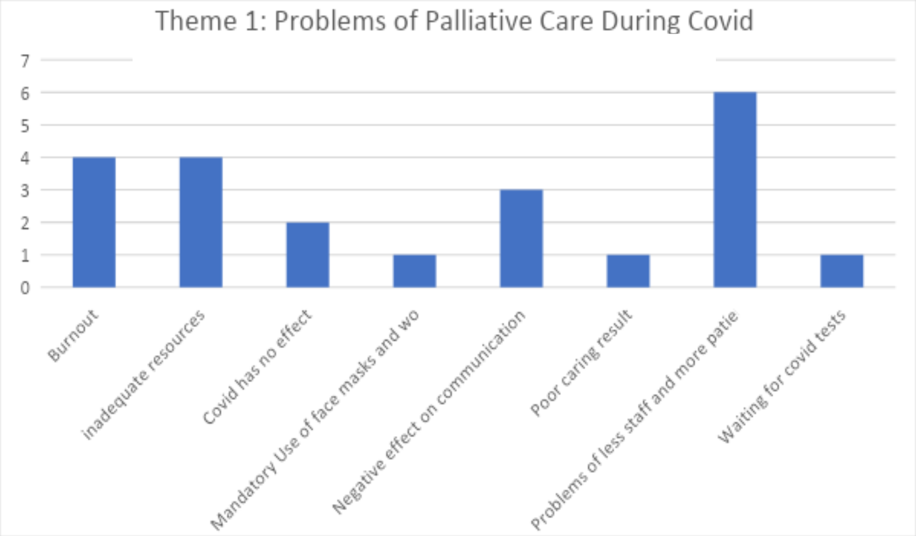
Analysis Between Pre Knowledge Score and Post Knowledge Score

	Outcome				
	Pre Score	Post Score	t	Df	p***
Knowledge Score	87 (8.96)	98.67 (4.00)	-4.752	8	0.001

Note. $p \leq .05$, $** = p \leq .001$. Standard deviations appear in parenthesis.

Chart 3

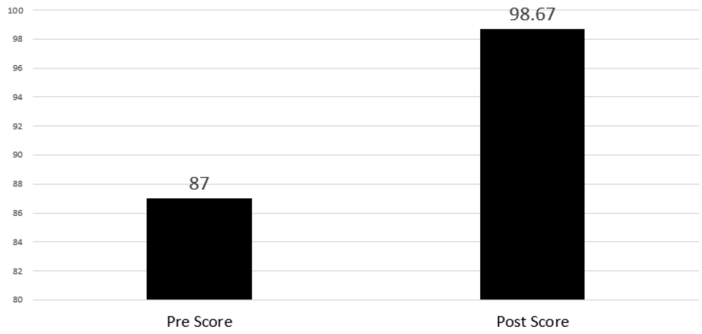
Problems of Palliative Care During COVID-19



Results of Qualitative Analysis

Chart 4

Problems of Palliative Care During COVID-19



Theme 1: Problems During COVID-19

COVID-19 created unusual circumstances for the pre-and post-test scores. They could have been attributed to longer working hours, higher stress levels, lack of protective devices, and the absenteeism rate. The test scores were also run for each of the four categories during COVID-19. In addition, there were also problems with disease epidemics and worries about the organizational and societal support that was necessary to effectively address role conflicts (Sterling, 2021).

The first theme, Problems During Covid, showed specific problems associated with the implementation of palliative care under the constraints of the-COVID-19-pandemic. Subthemes were identified under this theme. These categories were later combined into subthemes: 1) Burnout, 2) Inadequate resources and Covid testing waits, 3) Communication and face masks, 4) Poor caring and less staff/ more patients, and 5) Waiting for COVID-19 tests. Combining all eight subthemes into five subthemes was done to group closely related subthemes.

Subtheme 1.1: Burnout

Participants' responses regarding stress, depression, and burnout due to the influx of patients during the COVID-19 19 pandemic. Because the number of participants changed made a difference in the scores. Four of the nine participants experienced work-related stressors: long shifts, poor staffing, lack of good leadership, and a stressful hospital environment. The COVID-19 pandemic of 2019 has increased these demands on hospital staff. (Sharifi et al., 2021).

Consequences of burnout include poor health, poor patient outcomes, and decreased productivity. These were found by examining Subtheme 1.1: Burnout for a more conclusive report. Participant 0024 stated, "The pandemic has been a challenge. The providers in the hospital setting, hospitalists, and specialists, we are experiencing burnout. We are experiencing

Participant 0024 stated that “There has been some pretty lengthy hospitalization because of this and because of resources being so limited, and it’s been sad.”

The scarcity of equipment and resources for patients and healthcare professionals was one of the most serious shortcomings of palliative care during the COVID-19 pandemic (Mercadante et al., 2020). Face masks, for example, were unavailable for several weeks, resulting in the emergence of a black market. Furthermore, there were no specific rules for physicians accompanying patients to and from their homes. Compared to the same period the previous year, the number of requests for home care help more than doubled, putting a strain on teams who are used to following fewer patients. This was attributable to a decreased likelihood of hospitalization and a scarcity of available beds (Mercadante et al., 2020).

Subtheme 1.2: Inadequate resources and Covid testing waits

In contrast to the above, two participants shared that they did not perceive a direct effect on their work experience due to COVID-19, although they reported that the restriction on movement imposed by the government made in the provision of care is slightly hard.

Subtheme 1.3:Communication and face masks

The third subtheme (1.3), Communication and face masks, was expressed as a problem in providing care. One of the nine participants reported that COVID-19 made mandatory use of face masks and work clothing.

Participant 0004 stated, "I mean, we currently have that extra layer of separation. It’s mandatory to wear scrubs. We have masks on us all day long through the working hours.”

According to the participants' comments, the Subtheme of Negative Effects on Communication included face mask impeding understanding and difficulties in understanding the family's needs. Three of the nine participants shared the fifth subtheme (1.5), Negative Effect on Communication. COVID-19 has affected communications between healthcare providers and patients.

Participant 0030 reported,

> In my personal observations, the only strain I witnessed was concerning communications. I believe this dimension was hugely messed up due to the restrictions that were put in place as strategic measures for the pandemic.

Palliative care workers were confronted with an unprecedented situation in which communication and the human touch were profoundly altered. The increased number of patients being discharged from healthcare facilities and the reduced number of patients admitted to hospitals and hospices further complicated the already difficult situation. Communication with patients is a fundamental skill in palliative medicine (Morrison & Meier, 2004). Doctors elicit fewer than half of their patients' concerns during a typical clinical contact and frequently fail to discuss patients' values, goals of care, and preferences concerning treatment during a typical clinical encounter.

Subtheme 1.4: Poor Caring and Less Staff/ More Patients

The fourth subtheme (1.4) was Poor Caring. One of the nine participants reported that COVID-19 brought about a drop in the caring result in the healthcare system.

Participant 0022 stated that “COVID-19 has become a great challenge. We are doing poorly with palliative care consultation.” Problems of Less Staff and More Patients, gives another perspective to participants' answers concerning the effects of COVID-19 on palliative healthcare workers' experience. One of the nine participants reported that COVID-19 made mandatory use of face masks and work clothing. Three other participants alluded to this without articulating completely.

Participant 0022 stated,

> We need manpower. The demands on us, some days, are unbearable. The patients are much sicker, and very time-consuming. I start my day with 22-24 patients. We are always short at least two or three providers. We have the armed force to help with the staffing situation. So, again like I said, moving parts, we have so many different moving parts that are affecting not only COVID but may also affect palliative care. Patient acuity, patient ratio, load is heavier and poor staffing.

Subtheme 1.5: Waiting for COVID-19 Tests

The fifth and final subtheme (1.5), Waiting for COVID-19 Tests, gives another perspective to participants' answers concerning the effects of COVID-19 on palliative healthcare workers' experience. One of the nine participants reported that they had to wait for the patient's COVID tests before providing palliative care services, a requirement from the receiving facilities.

Participant 0012 stated that "Really, a major barrier is waiting for the patients to have three COVID-19 tests before they get transferred to another facility, but I don't think, you know, I have had a few patients in the hospitals, and I really have a problem with that."

Table 2

Theme 1: Problems of Palliative Care During COVID-19

Theme	Subtheme	Participant Statement
	1.1 Burnout	**0024**: The pandemic has been a challenge—the providers in the hospital setting, hospitalists, and specialists. We are experiencing burnout. We are experiencing depression
	1.2 Inadequate resources and Covid testing waits	**0012**: I don't think that as far as consulting palliative care, I don't think that COVID has affected it.
	1.3:Communication and face masks	**0024:** There has been some pretty lengthy hospitalization because of this and because of resources being so limited, and it's been sad.
		0004: I mean, we currently have that extra layer of separation. It's mandatory to wear scrubs. We have masks on us all day long through the working hours.
	1.4 ***Poor caring and less staff/ more patients***	**0016:** We face a challenge associated to understaffing, which in my view, hinders the effective delivery of services.
	1.5 ***Waiting for COVID-19 Tests***	**0030:** In my personal observations, the only strain I witnessed was concerning communications. I believe this dimension was hugely messed up due to the restrictions that were put in place as strategic measures for the pandemic.

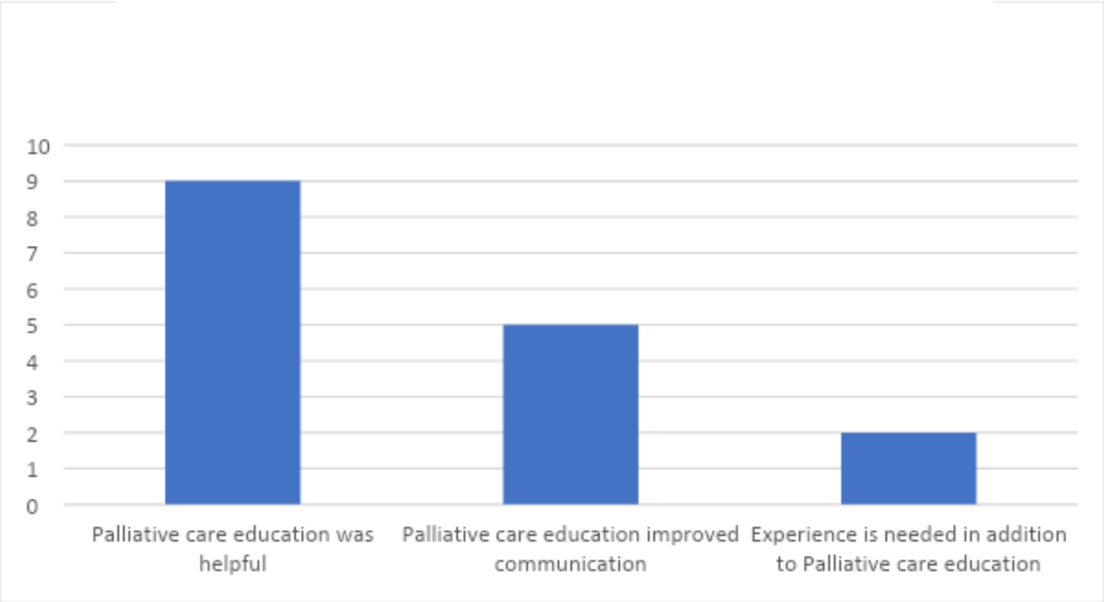
1.6 Poor caring result	**0022:** COVID-19 has become a great challenge. We are doing poorly with palliative care consultation
1.7 Problems of less staff and more patients	**0016:** We face a challenge associated to understaffing, which in my view, hinders the effective delivery of services. **0012:** Really, a major barrier is waiting for the patients to have three COVID-19 tests before they get transferred to another facility, but I don't think, you know, I have had a few patients in the hospitals, and I really have a problem with that.

Theme 2: Palliative Care Education as a Way to Improve Communication

The second theme that emerged was Education Improves Communication. This theme explored improved communication and looked at the participants' perceptions about how helpful the program was. The theme had three subthemes, 1) Education Was Helpful, 2) Improved Communication, and 3) Experience Is Needed.

Chart 5

Improves Communication



Subtheme 2.1: Education was Helpful

Helpfulness of the palliative care education dwelt on the participants' positive reports concerning the provided palliative care education. All of the nine participants reported that the education was helpful.

Participant 003 stated:

> Increased my comfort level of having difficult conversations is important. A lot of times, people are uncomfortable talking about the end of life...but that ability to have those difficult conversations is kind of important, and that was a way to help people to understand their prognosis better. I think that's probably the most important part.

Participant 0030 stated that

> If COVID has affected palliative care that much? I don't know. My facility is small. We did not house a lot of COVID patients. Regardless, there was a unit but did not accommodate a lot of patients. *Subtheme 2.2: Improved Communication*

The second subtheme, Improved Communication, dwelt on the participants' concern about improving their communication with patients. In my personal observations, the only strain I witnessed was concerning communications. I believe this dimension was hugely messed up due to the restrictions that were put in place as strategic measures for the pandemic. But I think the biggest was change, basically that we can't have family members with their loved ones when we're having these problematic conversations and/or when we're transitioning to the end of life. Five out of the nine participants reported that the education program was helpful.

Participant 0023 stated, "I especially appreciated this. I agree. Communication is very important."

Participant 0030 reported,

> For me, communication is iterative. There is no ceiling effect. You have to continuously refine and develop it like various clinical talents in medicine. The creation of ELC plans is also necessary, and unfortunately, this can be done very poorly. A palliative care practitioner meets new dilemmas day in day out, and some of the emergencies we are bound to handle are totally unique cases needing the application of what had been taught into actual practice. I could say I am quite lucky to have mentors who have helped me throughout this journey. Indeed, learning is multidimensional. It's not a one-way traffic but very vast. I believe that the majority of my knowledge gain in your training is communication. The best aspect was learning communication skills.

Subtheme 2.3: Additional Experience Needed

The third subtheme, Additional Experience Needed in addition to palliative care education, dwelt on the participants' beliefs that apart from the palliative care education, experience is needed to function well as a palliative care worker. Two out of nine participants have this notation (Table 3).

Participant 004 stated,

> We face some situations that require the sixth sense. It's something above what can be taught, and so we have to keep on sharing experiences with other practitioners to get that hand on touch.

Table 3

Theme ***2: Problems of Palliative Care During COVID-19***

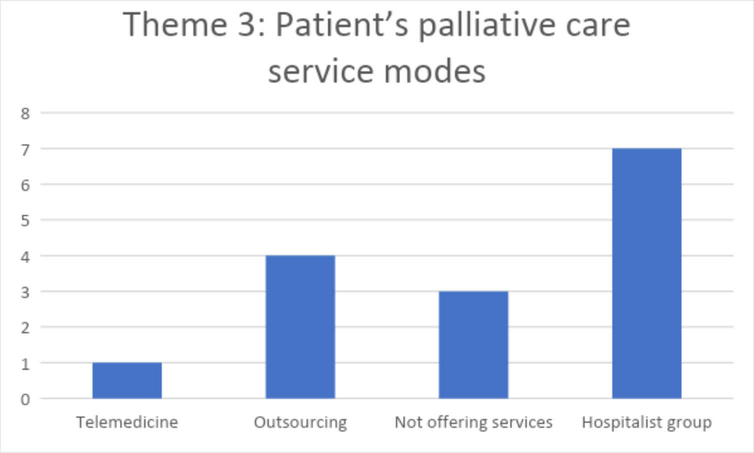
Theme	Subtheme	Participant Statement
	2.1 Palliative care education was helpful	**0016:** I believe that the educational part plays a major role in our communication. Not only to me but to the entire palliative team...
	2.2 Palliative care education improved communication	**0013**: Increased my comfort level of having difficult conversations is important. A lot of times, people are uncomfortable talking about the end of life…
	2.3 Experience is needed in addition to Palliative care education	**0025:** And I think that part of the, I think when palliative medicine is most successful is when it's more of a shared experience.
	2.1 Palliative care education was helpful	**0016:** I believe that the educational part plays a major role in our communication. Not only to me but to the entire palliative team...

Theme 3: Patient's Palliative Care Service Modes

The third theme that emerged was Service Modes. This theme explored the various palliative care services and endeavors employed by the healthcare facilities as perceived by the participants. The theme has four subthemes, 1) Telemedicine and Outsourcing, 2) Not offering services, and 3) Hospitalist group.

Chart 6

Patient's Palliative Care Service Modes



Palliative care provides symptom control and emotional assistance to patients and their families. Palliative care is a multidisciplinary approach to sickness that focuses on enhancing the patient's quality of life (Min et al., 2022). It is applicable at any stage of the illness. Palliative care programs can help patients and their families prepare for the end of life by using advanced care planning and communication methods. These strategies can make the decision-making process easier for patients and their families.

Subtheme 3.1: Telemedicine and Outsourcing

The first subtheme (3.1), Telemedicine, revealed the participants' responses regarding patients' palliative care service endeavors reported by the participants. One out of the nine participants reported using telemedicine to carry out their responsibilities as palliative caregivers.

Participant 0030 stated that "It is only me at night. On the day shift, the providers have been using telemedicine."

Subtheme 3.2: Not offering services

The second subtheme (3.2), Outsourcing, revealed the participants' responses regarding patients’ palliative care service endeavors reported by the participants. Four out of the nine participants reported that they had to outsource palliative care services as they could not handle such services. For example, 0012 stated, “ We don’t have a palliative care physician. In our hospital, patients are discharged to the community, to Allied. They need to follow up with their PCP’s [primary care physician] office.”

Furthermore, 0023 stated that “We outsource the services. In fact, during the pandemic, at one point, we didn’t even have the ability to consult palliative care..”

Subtheme 3.3: Not Offering Services

The third subtheme (3.3), Not Offering Services, reflects the answer of three of the nine participants regarding patients’ palliative care service endeavors.

Participant 0025 responded, “I think about the way the hospital-based (my own personal practice), the hospital-based aspects through affiliated health systems is unfortunately very lacking in a formal palliative care process.”

Participant 0023 stated, "We don’t have a formal palliative program.”

Subtheme 3.4: Hospitalist

The fourth and final subtheme (3.4), hospitalist, reveals participants' position regarding the services covering the palliative care needs of patients in the facility each palliative healthcare worker represents. Seven out of the nine participants recognize the hospitalist group as the service covering the palliative care needs of patients.

Participant 0013 stated, “Well, I worked in the hospitals, and I have seen them primarily admit the majority of patients in the hospital that I worked at. We are doing it. I think that occasionally suggestions for palliative care are made by specialists; probably the most frequent specialist I see making those recommendations are oncology, cardiology and pulmonary, but the majority of palliative care is done with the hospitalist service.”

Theme 3: Patient’s Palliative Care Service Modes

Table 4

Patient’s Palliative Care Service Modes

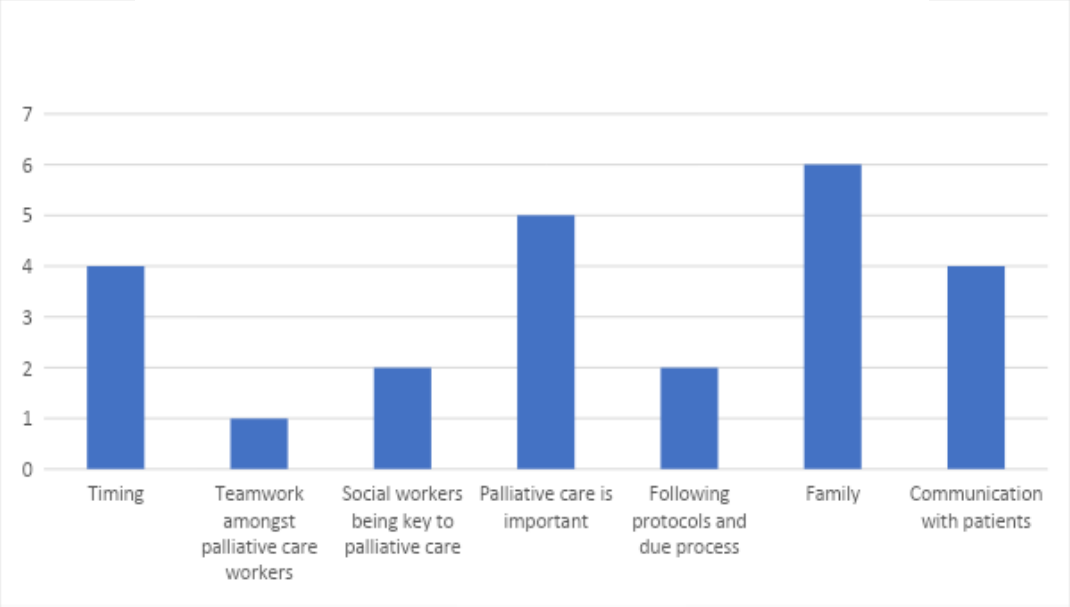
Theme	Subtheme	Participant Statement
	3.1 ***Telemedicine and Outsourcing***	**0030**: It is only me at night. The day shift, the providers have been using telemedicine.
		0023: We outsource the services. In fact, during the pandemic, at one point, we didn’t even have the ability to consult palliative care.
	3.2 Not offering services	**0012**: We don’t have any valuable service in the facility
	3.3 Hospitalist group	**0022**: The hospitalist. Case management plays a role in getting the services coordinated

Theme 4: Key Factors in Palliative Care Giving

The fourth and final theme emerged was Key Factors in Palliative Care Giving. This theme explored the various factors that serve as players in palliative caregiving. The theme has seven subthemes, 1) Timing, 2) Teamwork amongst palliative care workers 3) Palliative care is important, 4) Following protocols and due process, 5) Communication with patients and family .

Table 5

Key Factors in Palliative Care Giving



Mataqi and Aslanpour (2020) stated that palliative care teams collaborate with the patient, his or her family, and other medical professionals to give an additional layer of support. In addition to addressing symptoms and stress, it is important to provide support for both the patient and their family. In order to ensure that everyone is on the same page, the palliative care team communicates with other health practitioners.

Subtheme 4.1: Timing.

The first subtheme (4.1), Timing, revealed the participants' responses concerning the factors influencing palliative caregiving. Four of the nine participants reported that timing is a key factor in palliative caregiving.

Participant 0013 stated that

> I think that time is definitely a limiting factor because for the last several months. When Covid initially the census in the hospital promenade because everyone was afraid of coming to the hospital, but now we see this huge boom in our census. I would say for the

> past six months. Our average census has risen from 75 patients to 130 patients on average, so we've had to increase the number of our caseload. Patient care, I mean palliative, has been difficult.

Subtheme 4.2: Teamwork Amongst Palliative Care Workers/Social Workers Being Key to Palliative Care

The second subtheme (4.2), Teamwork Amongst Palliative Care Workers, reflects a participant's responses concerning the factors that influence palliative caregiving. One of the nine participants reported that timing is a key factor in palliative caregiving.

Participant 0004 stated that

> Palliative care works in conjunction with other teams players. I believe that the topic about end of life touches on every level of healthcare. So, what this means is that the participation of the interdisciplinary team is essential.

> Social Workers Being Key to Palliative Care, reflects two participants' responses concerning the factors that influence palliative caregiving. Two of the nine participants reported that timing is a key factor in palliative caregiving.

Participant 0004 responded, "Social workers play an integral part to facilitate these discussions."

Subtheme 4.3: Following Protocols and Due Process

The fourth subtheme (4.4), Following Protocols and Due Process, reflects two participants' responses concerning the factors that influence palliative caregiving. Two of the nine participants reported that following protocols and due process is a key factor in palliative caregiving.

Participant 0023 stated, “We have to always remember that it’s not what the provider wants. I think we can do a better job and not just always rely on protocols.”

Subtheme 4.4: Family

The fifth subtheme (4.5), Family, reflects four participants’ responses concerning the factors that influence palliative caregiving. Four of the nine participants reported that a patient’s family is a key factor in palliative caregiving.

Participant 0023 stated, “We should include the family, To encourage patients to complete advance directive, together with questions about coordinating their final days.”

Subtheme 4.5: Communication with Patients

The fifth subtheme (4.6), Communication with Patients, reflects three participants’ responses concerning the factors that influence palliative caregiving. Three of the nine participants reported that communication with patients is a key factor in palliative caregiving.

Participant 0016 stated,

> Well, if you say the early conversations are important because sometimes when you introduce the idea, or first of all, Palliative care is important. Palliative care has a bad stigma to putting on your audience, and so sometimes, when you say the word palliative care, people immediately turn off.

Table 6

Theme 4: Key Factors in Palliative Caregiving

Theme	Subtheme	Participant Statement
	4.0 Palliative care is important	**0016**: I want to emphasize that palliative care is very important and critical. I mean like, if you are in hospice and decide to return to the hospital for end-of-life care and cannot have your whole family, it can be distressing and traumatizing.
	4.1 Timing	**0013**: I think that time is definitely a limiting factor because for the last several months. When Covid initially the census in the hospital promenade because everyone was afraid of coming to the hospital.
	4.2 Teamwork amongst palliative care workers/Social workers	**0004**: Palliative care works in conjunction with other teams players. I believe that the topic about end of life touches on every level of healthcare. So, what this means is that the participation of the interdisciplinary team is essential **0004**: Social workers play an integral part to facilitate these discussions. .
	4.3 Following protocols and due process	**0023**: We have to always remember that it's not what the provider wants. I think we can do a better job and not just always rely on protocols.
	4.4 Family	**0004**: We should include the family, To encourage patients to complete advance directive, together with questions about coordinating their final days.
	4.5 Communication with patients	**0012**: Communicating with patients to help them understand palliative care. It could be a useful tool to help keep some of these patients out of the hospital.

Chapter 5: Discussion

Practice Inquiry and Purpose Discussion

Observations and Limitations

Did this DNP project, with a palliative care webinar focus on communication and collaboration for hospitalists to improve knowledge, skill, and collaboration?
Improved knowledge was particularly appreciated in communication in the category of Psychological distress, which would be anticipated to improve their palliative care skills and ability. The skill acquired through education provided enhanced communication and collaboration techniques utilized in the healthcare setting. It was discovered that a training session does improve the knowledge of hospitalists. In the psychological distress category, 86% or 26 providers scored the lowest (Chart 1). Post webinar reveals the score for PD increased from 86% to 99%. Hospitalists reported improved communication skills and the ability to provide enhanced outcomes for palliative care patients. Additionally, some staff contracted COVID-19, which caused components of the project to be missed. The results were impacted due to the addition of qualitative research, which provided the opportunity for hospitalists to provide perceptions and experiences related to the project question.

The position of the project results is positive due to hospitalists' recognition of personal vulnerabilities when providing palliative care treatments. The educational training assisted with addressing those vulnerabilities. Additionally, the educational training improved the hospitalist's knowledge, skills, and abilities when providing ELC.

Observations

After completing the project, it was interesting to see the hospitalist's varying responses when asked what they would want other hospitalists to know about palliative care. Each hospitalist performs the same job within the same facility and receives educational training. Additionally, the hospitalists were very consistent in their response that communication was a very important aspect of palliative care. Although communication was considered important, many providers believed other hospitalists should know about other components of palliative care, such as fostering relationships, symptom management, EOL communication, advanced directives, and the emphasis on family. This demonstrates that individual perception of important job requirements may not be consistent, and education may need to be catered to the hospitalist's individual needs.

It was learned that stressors from the COVID-19 pandemic, such as staff turnover rates, may not be considered stressors for all healthcare professionals. Some hospitalists believe turnover is a normal part of staffing in hospitals. Hence, it is inevitable despite COVID-19. For this reason, accommodations should be made to consistently address staff turnover to ensure palliative care patients continue to receive high-quality care.

Limitations

Significant attrition occurred due to provider shortages as a result of increased acuity stemming from the COVID-19 pandemic, increased COVID-19 mandates, increased staff-patient ratio, increased provider burnout, provider disengagement, provider illness due to COVID-19, staffing becoming a burden within the two facilities from which participants were drawn, and participants desiring to limit their workload down to a minimum given these identified limitations

Convenience sampling was another limitation of the project. Participants were limited to hospitalists working at two sister hospitals in PA. The United States has more than 50,000 hospitalists working throughout the nation (Saint et al., 2018). There may have been additional hospitalists who worked in the palliative care setting and met the criteria to participate in the project. However, these hospitalists did not get the opportunity to participate because they were not employed at one (or both) of the sister hospitals within PA.

Additionally, a convenience sampling approach was used, increasing bias and resulting in a sample not representative of the general population. The sample size was limited, which reduces the reliability of the research compared to studies that use a larger sample. It is critical to consider the differences, characteristics, and aspects of the ideal population and individuals who may be excluded from the research to reduce the risk of sampling bias.

Evaluation of the measures was another limitation to this study. Time was not a factor for project completion; however, the resource of people was a factor. Timing was a factor. If this study was done without COVID being a factor, analysis of practice change could have occurred, outcomes would have been better evaluated.

Implications for Future Projects/Research

Project findings revealed that enhanced education, specifically related to communication, referrals, and outsourcing, can positively affect the care provided to palliative care patients. The next step in professional practice is to examine if the quality of care for palliative care patients increases after hospitalists are provided educational training compared to the quality of care prior to training. According to Dudgeon (2018), palliative care is very complex and may require the reflection of various outcome measures to determine quality. When evaluating pre-education and post-education quality of care, facilities should utilize a culmination of nationally recognized data such as the efficiency of referrals in conjunction with patient/family-centered outcomes such as satisfaction. The set of data pre-education and post-education can be compared to evaluate the effectiveness of palliative care educational training in practice.

It will be beneficial for the project to be replicated within the palliative care setting at other facilities. Each facility has its unique challenges when providing palliative care. The project can be implemented to determine if educational training can address vulnerabilities related to palliative care challenges other than the quality of care. The project should also be implemented in the palliative care setting providers. Then it can be determined if education training in the palliative care setting is effective for all palliative care providers or if it is limited to novice providers.

The project can also be replicated and implemented in other specialty care areas, including but not limited to mental health, nursing homes, or home-based primary care. The conditions of specialty care related to the variances in knowledge are similar. Implementation of the project will require educational training specific to the other specialty area (e.g., mental health). The project outcome, which reflects changes in the quality of care, can remain the same.

Additionally, practice application related to the project consists of completing a thorough analysis of outcome variances between providers. For example, all providers obtain education on effective communication. However, each provider communicates differently with patients depending upon the patient’s individualized needs. If the researched outcomes vary from one provider to the next, evaluation of communication techniques or individual provider differences (e.g., non-verbal communication, length of patient interactions) should be evaluated.

Implications for Practice/Health Policy/Education

Project findings revealed that providing education and training specific to palliative care can optimize the care to treat palliative care patients. The provider must have the knowledge, skills, and attitudes to demonstrate clear and effective communication. Additionally, providers must be skilled in building patient rapport to have difficult conversations about EOL wishes and ensure that dignity is maintained with patients.

Additionally, the hospitalist's enhanced knowledge of palliative care can reduce the propensity to use curative treatments to stabilize care. Omitting aggressive treatments such as intensive care admissions or emergent treatments can reduce the risk of patients' unneeded suffering during their ELC. This allows the patient's final wishes to be followed and die with dignity.

Based on the project findings, the suggested change for hospital education is to offer specialized education to palliative care hospitalists. The education should encompass effective communication, EOL conversations regarding final wishes, and palliative care life-sustaining treatment. According to Zemplenyi et al. (2020), palliative care consults can increase with structured education. The specialized education can equip the hospitalist with the skills

Conclusion

The purpose of the project was to determine if education and training would enhance collaboration and communication amongst palliative care hospitalists and the patient care teams. Project findings revealed that palliative education and training enhanced the hospitalist's knowledge of palliative care specialty. The moderating variable of the COVID-19 pandemic hindered important aspects of palliative care, including effective communication, facial expressions and gestures, and increased isolation. Enhanced communication skills are necessary for providing comprehensive, effective palliative care considering the pandemic. Offering provider education and training specific to palliative care can increase patient-staff communication. The COVID-19 pandemic elicited another challenge related to the lack of palliative care resources within facilities. The lack of resources can make it very difficult to meet the needs of this unique population. To successfully overcome this challenge, facilities should ensure enough providers are trained to care for palliative patients or utilize technology such as telemedicine. Lastly, failure to properly equip hospitalists with palliative care knowledge may lead to poor quality of life for patients during their EOL transition.

References

Abbott, J., Johnson, D., & Wynia, M. (2020). Ensuring adequate palliative and hospice care during COVID-19 surges. *JAMA, 324*(14), 1393-1394. doi: 10.1001/jama.2020.16843

Abu-Odah, H., Molassiotis, A., & Liu, J. (2020, April). Challenges on the provision of palliative care for patients with cancer in low- and middle-income countries: A systematic review of reviews. *BMC palliative care*, *19*(Art. 55), 1-16. https://doi.org/10.1186/s12904-020-00558-5

Adventist Health Portland. (2020). *Nursing professional practice model at Adventist Health, Portland*. https://www.adventisthealth.org/portland/about-us/careers/nursing-careers/professional-practice-model/

Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119-1025 (March 23, 2010). https://www.hhs.gov/sites/default/files/ppacacon.pdf

Ahtisham, Y., & Jacoline, S. (2015, May-August). Integrating nursing theory and process into practice: Virginia Henderson's need theory (Case Study). *International journal of caring sciences, 8*(2), 443-450.http://www.internationaljournalofcaringsciences.org/docs/23_ahtisham.pdf

Anderson, W. G. (2017, May 1). Filling the gap: Hospitalists and palliative care. *Hospitalist*. https://www.the-hospitalist.org/hospitalist/article/136985/hospice-palliative-medicine/filling-gap-hospitalists-palliative-care?_t_q=palliative+care&_t_tags=language%3aen%2csiteid%3a051325ae-96a2-4438-8895-d4aa00760ca5&_t_hit.id=web_content/b767803f77d4ad5c9bdf8e4eee51be59f9b8a4f9&_t_hit.pos=37

Anderson, W. G., Puntillo, K., Cimino, J., Noort, J., Pearson, D., Boyle, D., Grywalski, M., O'Neill-Page, E., Cain, J., Herman, H., Barbour, S., Turner, K., Moore, E., Liao, S., Ferrell, B., Mitchell, W., Edmonds, K., Fairman, N., Joseph, D., Pantilat, S. Z. (2017, September). Palliative care professional development for critical care nurses: A multicenter program. *American journal of critical care, 26*(5), 361-374. https://doi.org/10.4037/ajcc2017336

Ard, N., Beasley, S., Nunn-Ellison, K., & Farmer, S. (2018, October). Fundamentals of terminology related to Accreditation Commission for Education in Nursing. *Teaching and learning in nursing, 13*(4), 16-20. doi:10.1016/j.teln.2018.04.003

Baines, M. (2011, May). From pioneering days to implementation: Lessons to be learnt. *European journal of palliative care*, *18*(5), 223-227. https://www.stchristophers.org.uk/about/history/pioneeringdays

Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251 (August 5, 1997). https://www.congress.gov/bill/105th-congress/house-bill/2015/text

Barnes, H., Richards, M. R., McHugh, M. D., & Martsolf, G. (2018). Rural and nonrural primary care physician practices increasingly rely on nurse practitioners. *Health affairs, 37*(6). doi: 10.1377/hlthaff.2017.1158

Beresford, L. (2016, October). 10 things hospitalists need to know about palliative care. *The hospitalist* [Online Article]. https://www.the-hospitalist.org/hospitalist/article/121441/hospice-palliative-medicine/10-things-hospitalists-need-know-about

Bezak, K. B. (2020, January 6). *5 Ways to improve hospitalist-palliative collaboration*. Center to Advance Palliative Care. https://www.capc.org/blog/palliative-pulse-the-palliative-pulse-january-2019-5-ways-to-improve-hospitalist-palliative-care-collaboration/

Bloom-Feshbach, K., Berger, R. E., Dubroff, R. P., McNairy, M. L., Kim, A., & Evans, A. T. (2021). The virtual hospitalist: A critical innovation during the COVID-19 crisis. *Journal of general internal medicine, 36*, 1771-1774. doi: 10.1007/s11606-021-06675-y

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, *4*, 2333393617742282.

Broglio, K., & Walsh, A. (2017, April 16). Referring patients to hospice or palliative care. *Nurse Practitioner, 42*(4), 49-55. doi:10.1097/01.NPR.0000511008.14090.1d

Burman, M. E. (2020). *Making sense of a complementary and alternative medicine: Analysis of a family nurse practitioner program*. University of Wyoming, School of Nursing. http://gallery.carnegiefoundation.org/collections/castl_he/mburman/MBurman/Portfolio.html

Butkus, R., Serchen, J., Moyer, D., Bornstein, S., & Hingle, S. (2018). Achieving gender equity in physician compensation and career advancement: A position paper of the American College of Physicians, Annals of Internal Medicine, 168(10), 721-723. https://doi.org/10.7326/M17-3438

Buttorff, C., Ruder, T., &Bauman, M. (2017). *Multiple chronic conditions in the United States* (No. TL-221-PFCD). Rand. doi:10.7249/TL221

Campbell, D. T., & Stanley, J. C. (1963). *Experimental and quasi-experimental designs for research*. Houghton Mifflin.

Carlson, R., Burkett Vetter, A., Hauer, M., Forton, M., Jerardi, K., & Herrmann, L. E. (2020). The role of the advanced practice provider and the evolving health care landscape. *Hospital pediatrics, 10*(11), 1010-1013. doi: 10.1542/hpeds.2020-0186

Carmel, C. M., & Small S. P. (2019, Winter). The nurse practitioner role is ideally suited for palliative care practice: A qualitative descriptive study. *Canadian oncology nursing journal*, *29*(1), 4-9. doi:10.5737/2368807629149

Carroll, H. A., Toumpakari, Z., Johnson, L., & Betts, J. A. (2017). The perceived feasibility of methods to reduce publication bias. *PloS one*, *12*(10), e0186472. doi.org/10.1371/journal.pone.0186472

Center to Advance Palliative Care (CAPC). (2014). *Get palliative care for policymakers*. https://getpalliativecare.org/resources/policymakers/2014/

Center to Advance Palliative Care (CAPC). (2019, September). *America's care of serious illness: A state-by-state report card on access to palliative care in our nation's hospitals* (Updated May 2020). Center to Advance Palliative Care and the National Palliative Care Research Center. https://reportcard.capc.org/wp-content/uploads/2020/05/CAPC_State-by-State-Report-Card_051120.pdf

Center to Advance Palliative Care (CAPC). (2020). *Quality standards and national initiatives*. https://www.capc.org/quality-standards-and-national-initiatives/

Center for Medicare Advocacy. (2016, July 26). *Medicare hospice care: Palliative vs. curative*. https://medicareadvocacy.org/medicare-hospice-care-palliative-vs-curative/

Centers for Medicare and Medicaid Services. (2013). *Medicare and Medicaid Statistics Supplement* (2013 edition, Chapter 2, Table 2.1: Medicare enrollment: hospital insurance and/or supplementary medical insurance programs for total, fee-for-service and managed care enrollees as of July 1, 2012: Selected calendar years 1966-2012). https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareMedicaidStatSupp/2013

Cervantes, L., Zoucha, J., Jones, J., & Fischer, S. (2016, November/December). Experiences and values of Latinos with end stage renal disease: A systematic review of qualitative studies. *Nephrology nursing journal, 43*(6), 479-493. https://library.annanurse.org/anna/articles/1356/view

Chow, K., & Dahlin, C. (2018). Integration of palliative care and oncology nursing. *Seminars in Oncology Nursing, 34*(30, 192-201. doi: 10.1016/j.soncn.2018.06.001

Clark, D. (2004). History, gender, and culture in the rise of palliative care. In S. Payne, J. Seymour, & I. Ingleton (Eds.), *Palliative care nursing. Principles and evidence for practice* (1st ed., Part I, Chapter 2, pp. 39-54). Open University Press.

Clark, D. (2007, May). From margins to centre: A review of the history of palliative care in cancer (Historical Review). *Lancet oncology*, *8*(5), 430-438. https://doi.org/10.1016/S1470-2045(07)70138-9

Clark, D., &Seymour, J. (1999). Reflections on palliative care: Sociological and policy perspectives. Open University Press.

Clark, D., Small, N., Wright, M., Winslow, M., &Hughes, N. (2005). *A bit of heaven for the few? An oral history of the hospice movement in the United Kingdom*. Observatory Publications.

Creswell, J. W., & Hirose, M. (2019). Mixed methods and survey research in family medicine and community health. *Family medicine and community health*, *7*(2).

Cushing, L. (2020, September 28). *A legacy of disruptive innovation*. Kaiser Permanente. https://about.kaiserpermanente.org/our-story/our-history/a-legacy-of-disruptive-innovation

Daly, B., Hantel, A., Wroblewski, K., Balachandran, J. S., Chow, S., DeBoer, R., Fleming, G. F., Hahn, O. M., Kline, J., Liu, H., Patel, B. K., Verma, A., Witt, L. J., Fukui, M., Kumar, A., Howell, M. D., & Polite, B. N. (2016, October). No exit: Identifying avoidable terminal oncology intensive care unit hospitalizations. *Journal of oncology practice, 12*(10), 908-911. doi:10.1200/JOP.2016.012823

deLima Thomas, J., Leiter, R. E., Abrahm, J. L., Shameklis, J. C., Kiser, S. B., Gelfand, S. L., Sciacca, K. R., Reville, B., Siegert, C. A., Zhang, H., Lai, L., Sato, R., Smith, L. N., Kamdar, M. M., Greco, L., Lee, K. A., Tulsky, J. A., & Lawton, A. J. (2020, August). Development of a palliative care toolkit for the COVID-19 pandemic. *Journal of pain and symptom management*, *60*(2), e22–e25. https://doi.org/10.1016/j.jpainsymman.2020.05.021

Dinibutun, S. R. (2020). Factors associated with burnout among physicians: An evaluation during a period of COVID-19 pandemic. *Journal of healthcare leadership, 12*, 85-94. doi: 10/2147/JHL.S270440

Dudgeon, D. (2018). The impact of measuring patient-reported outcome measures on quality of and access to palliative care. *Journal of palliative medicine*, 21(S1). http://doi.org/10.1089/jpm.2017.0447

Ecarnot, F., Meunier-Beillard, N., Seronde, M. F., Chopard, R., Schiele, F., Quenot, J. P., & Meneveau, N. (2018, October). End-of-life situations in cardiology: A qualitative study of physicians' and nurses' experience in a large university hospital. *BMC palliative care, 17*(1), 1-12. doi:10.1186/s12904-018-0366-5

Feld, E., Horn, L., & Phillips, S. E. (2016, October 9). Referral practices of medical oncologists to palliative care for patients with metastatic non-small cell lung cancer. *Journal of Clinical Oncology*, *34*(26), 108-108. doi:10.1200/jco.2016.34.26_suppl.108

Field, M. J., & Cassel, C. K. (1997). *Approaching death: Improving care at the end of life*. Institute of Medicine.

Fine, P. G., & Davis, M. S. (2017, Spring). Lessons from the hospice benefit for advanced illness care. *Generations, 41*(1), 58-67.https://www.ingentaconnect.com/contentone/asag/gen/2017/00000041/00000001/art00012

Finley, E., Rabow, M. W., & Buss, M. K. (2018, May 23). Filling the gap: Creating an outpatient palliative care program in your institution. *American Society of Clinical oncology educational book*, *38*, 111-121. doi:10.1200/EDBK_200775

Fox, S., Fitzgerald, C., Dening, K. H., Irving, K., Kernohan, W. G., Treloar, A., Oliver, D., Guerin, S., & Timmons, S. (2018, July). *Better palliative care for people with dementia: Summary of interdisciplinary workshop highlighting current gaps and recommendations for future research*. *BMC palliative care*, *17*(Art. 9), 1-11. https://doi.org/10.1186/s12904-017-0221-0

Gadd, H., & Tryon, L. (2016). Building Biblical founded faith and values through a campus-wide healthy lifestyle project. *Journal of biblical foundations of faith and learning, 1*(1), 1-25. https://knowledge.e.southern.edu/jbffl/vol1/iss1/7/

Greysen, S. R. (2018, October 12). Paradigm shifts in palliative care. *Hospitalist*. Society of Hospital Medicine. https://www.the-hospitalist.org/hospitalist/article/177196/hospice-palliative-medicine/paradigm-shifts-palliative-care/page/0/1?channel=27628

Greysen, S. R., Cenzer, I. S., Auerbach, A. D., & Covinsky, K. E. (2015, April). Functional impairment and hospital readmission in Medicare seniors. *JAMA internal medicine*, *75*(4), 559-565. doi:10.1001/jamainternmed.2014.7756

Hallowell, N. (2022). End-of-life palliative care. *Today's geriatric medicine, 7*(5), p.16. https://www.todaysgeriatricmedicine.com/article/0914p16.shtml

Hawley, P. H. (2014, January 1). The bow tie model of 21st-century palliative care. *Journal of pain and symptom management*, *47*(1), E2-E5. doi:10.1016/j.jpainsymman.2013.10.009

Hayes, S. L., Salzberg, C. A., McCarthy, D., Radley, D. C., Abrams, M. K., Shah, T., &Anderson, G. F.(2016, August). High-need, high-cost patients: Who are they and how do they use health care? A population-based comparison of demographics, health care use, and expenditures. *Commonwealth fund issue brief*, *26*, 1-14. Retrieved from https://pubmed.ncbi.nlm.nih.gov/27571599/

Hickner, J. (2017, August). Getting it right at the end of life. *Journal of family practice, 66*(8), 486.https://cdn.mdedge.com/files/s3fs-public/Document/July-2017/JFP06608486.PDF

Hillard, M. T. (2021). Protecting patient goals in palliative care and hospice. *Ethics & medics, 46*(10), 1-2. doi: 10.5840/em2021461017

Hui, D., Elsayem, A., De la Cruz, M., Berger, A., Zhukovsky, D. S., Palla, S., Evans, A., Fadul, N., Palmer, L., & Bruera, E. (2010, March 17). Availability and integration of palliative care at US cancer centers. *JAMA*, *303*(11), 1054-1061. doi:10.1001/jama.2010.258 Hurd, C. J. (2017, Winter). Effective education for palliative care: Communication as a procedure. *ICU management and practice*, *17*(4), 220-221. https://healthmanagement.org/uploads/article_attachment/hurd-effectiveeducationpallcare-2017-v17-i4.pdf

Ihrig, T. (2019, December 27). Trends in hospice and palliative care for 2020. *Crossroads News*. https://www.crossroadshospice.com/hospice-palliative-care-blog/2019/december/27/trends-in-hospice-palliative-care-for-2020/

Institute of Medicine (IOM). (2003). *When children die: Improving palliative and end-of-life care for children and their families*. National Academies Press. doi:10.17226/10390.

Institute of Medicine (IOM). (2015). *Dying in America: Improving quality and honoring individual preferences near the end of life*(Consensus Study Report). National Academies Press. https://doi.org/10.17226/18748

Jones, P. S., James, B. R., Owino, J., Abemyil, M., de Beltrán, A. P., & Ramal, E. (2017, October-December). A distinctive framework for Adventist nursing. *Journal of Adventist education*, *79*(5), 4-13. http://jae.adventist.org

Kennedy, R., Abdullah, N., Bhadra, R., Bonsu, N., Fayezizadeh, M., & Ickes, H. (2019, April-June). Barriers to effective use of palliative care services in the acute care setting with emphasis on terminal noncancer diseases. *Indian journal of palliative care, 25*(2), 203-209.doi:10.4103/IJPC.IJPC_201_18

Kübler-Ross, E. (1969). *On death and dying: What the dying have to teach doctors, nurses, clergy, and their own families* (1st ed.). Scribner.

Kuhn, T.S. (1997). The structure of scientific revolutions (3rd ed.). Chicago, IL: University of Chicago Press.

Kuhn, T.S. (1997). *The structure of scientific revolutions (3rd ed.).* Chicago, IL: University of Chicago Press.

Kuhn, T. S. (1996). *The structure of scientific revolutions* (3rd ed.). University of Chicago Press.

Kutner, L. (1969, Summer). Due process of euthanasia: The living will, a proposal. *Indiana law journal*, *44*(4, Art. 2), 539-554.https://www.repository.law.indiana.edu/ilj/vol44/iss4/2

Lacy, I. (2018, April 11). Understanding palliative care: An important part of practicing hospital medicine. *The Hospitalist* [Online Article], HM 18. Society of Hospital Medicine. https://www.the-hospitalist.org/hospitalist/article/162616/hospice-palliative-medicine

Loscalzo, M. J. (2008, January). Palliative care: An historical perspective. *Hematology, American Society of hematology education program*, *2008*(1), 465. https://ashpublications.org/hematology/article/2008/1/465/95868/Palliative-Care-An-Historical-Perspective

Manzano, J. G., Gadiraju, S., Hiremath, A., Lin, H. Y., Farroni, J., & Halm, J. (2015, September). Unplanned 30-day readmissions in a general internal medicine hospitalist service at a comprehensive cancer center. *Journal of oncology practice, 11*(5), 410-415. doi:10.1200/JOP.2014.003087

Mataqi, M., & Aslanpour, Z. (2020). Factors influencing palliative care in advanced dementia: a systematic review. *BMJ supportive & palliative care*, *10*(2), 145-156.

Mayo Clinic Staff. (2017, August 15). *What is palliative care*? Mayo Clinic. https://www.mayoclinic.org/tests-procedures/palliative-care/about/pac-20384637

Mayo Clinic Staff. (2019, January 30). *Hospice care: Comforting the terminally ill*. Mayo Clinic. https://www.mayoclinic.org/healthy-lifestyle/end-of-life/in-depth/hospice-care/art-20048050

McPherson, C. (2018). Difficulties for a practitioner preparing a family for the death of a parent: A narrative inquiry. *Mortality, 23*(3), 247-260. doi:10.1080/13576275.2017.1339677

Medicare Resource Center. (2020). *Curative care: What is curative care*? Medicare Resources. https://www.medicareresources.org/glossary/curative-care/

Meier, D. E. (2014). *Palliative care: Facts and stats*. Center for Advanced Palliative Care. https://media.capc.org/filer_public/68/bc/68bc93c7-14ad-4741-9830-8691729618d0/capc_press-kit.pdf

Meier, D. E. (2015, November 17). *The status of palliative care in the United States: An update* (Webinar Slides). Center to Advance Palliative Care and National Palliative Care Research Center. https://media.capc.org/recorded-webinars/slides/3435_1722_report_card_2015_capc_webinar_11_17_15.pdf

Meier, D. E., & Beresford, L. (2006, June). Advanced practice nurses in palliative care: A pivotal role and perspective. *Journal of palliative medicine,* 9(3), 624-627. doi:10.1089/jpm.2006.9.624

Mercadante, S., Adile, C., Ferrera, P., Giuliana, F., Terruso, L., & Piccione, T. (2020). Palliative care in the time of COVID-19. *Journal of pain and symptom management*, *60*(2), e79-e80.

Mierendorf, S. M., & Gidvani, V. (2014, Spring). Palliative care in the emergency department. *Permanente journal, 18*(2), 77-85. doi:10.7812/TPP/13-103

Min, L., Saul, D. A., Firn, J., Chang, R., Wiggins, J., & Khateeb, R. (2022). Interprofessional geriatric and palliative care intervention associated with fewer hospital days. *Journal of the American geriatrics society*, *70*(2), 398-407.

Morgan, S. J., Pullon, S. R., Macdonald, L. M., McKinlay, E. M., & Gray, B. V. (2017). Case study observational research: A framework for conducting case study research where observation data are the focus. *Qualitative health research*, *27*(7), 1060-1068.

Morrison, R. S., Penrod, J. D., Cassel, J. B., Caust-Ellenbogen, M., Litke, A., Spragens, L., Meier, D. E., & Palliative Care Leadership Centers' Outcomes Group. (2008, September). Cost savings associated with US hospital palliative care consultation programs (Comparative Study). *Archives of internal medicine*, *168*(16), 1783-1790. doi:10.1001/archinte.168.16.1783

Morrison, R. S., & Meier, D. E. (2004). Palliative care. *New England Journal of medicine*, *350*(25), 2582-2590.

Mroueh, R., Haapaniemi, A., Saarto, T., Grönholm, L., Grénman, R., Salo, T., & Mäkitie, A. A. (2019, May). Non-curative treatment of patients with oral tongue squamous-cell carcinoma. *European archives of oto-rhino-laryngology*, *276*(7), 2039-2045. doi:10.1007/s00405-019-05456-y

Nabili, S., & Shiel, W. C. (2020). *What is a hospitalist*? Medicine Net. https://www.medicinenet.com/what_is_a_hospitalist/views.htm

National Consensus Project for Quality Palliative Care. (2004, October). Clinical practice guidelines for quality palliative care(1st ed.). *Kansas nurse*, *79*(9), 16-20. https://pubmed.ncbi.nlm.nih.gov/15573672/

National Consensus Project for Quality Palliative Care. (2018). *Clinical practice guidelines for quality palliative care*(4th ed.). https://www.nationalcoalitionhpc.org/ncp

Nurse Practitioner Associates for Continuing Education (NPACE). (2020, May 15). *Nurse practitioners and palliative care: What to know and how to help*. https://www.npace.org/nurse-practitioners-and-palliative-care-what-to-know-and-how-to-help/

Omnibus Reconciliation Act of 1989, Pub. L. No. 101-239, H.R. 3299, 101st Cong. (December 19, 1989). https://www.govtrack.us/congress/bills/101/hr3299

Pantilat, S. Z. (2002, July). End-of-life care for the hospitalized patient. *Medical clinics of North America*, *86*(4), 749-770. doi:10.1016/s0025-7125(02)00017-2

Parker, J.(2020).Palliative care growth a 2020 priority. *Hospice News*. https://hospicenews.com/2019/12/23/palliative-care-growth-a-2020-priority-among-providers-policymakers/

Pitorak, E. F. (2003, September). Learning to have difficult conversations to increased hospice referrals. *Home healthcare nurse, 21*(9), 629-632. https://journals.lww.com/homehealthcarenurseonline/Citation/2003/09000/Learning_to_Have_Difficult_Conversations_Leads_to.16.aspx

Roberts, B., Wright, S. M., Christmas, C., Robertson, M., & Wu, D. S. (2020). COVID-19 pandemic response: Development of outpatient palliative care toolkit based on narrative communication. *American Journal of hospice and palliative medicine*, *37*(11), 985-987. https://doi.org/10.1177/1049909120944868

Rolnick, J. A., Asch, D. A., &Halpern, S. D. (2017, June 1). Delegalizing advance directives: Facilitating advance care planning. *New England journal of medicine*,*376*, 2105-2107. doi:10.1056/NEJMp1700502

Rubens, M., Ramamoorthy, V., Saxena, A., Das, S., Appunni, S., Rana, S., Puebla, B., Suarez, D. T., Khawand-Azoulai, M., Medina, S., & Vlamonte-R., A. (2018). Palliative care consultation trends among hospitalized patients with advanced cancer in the United States, 2005 to 2014. *American journal of hospice and palliative medicine, 36*(4), 294-301. doi: 10.1177/1049909118809975

SCP Health Staff. (2020, June 1). *The need for palliative care training in hospital and critical care medicine* (Best Practices). SCP Health. https://www.scp-health.com/healthcare-executives/blog/the-need-for-palliative-care-training-in-hospital-and-critical-care-medicine

Saint, S., Vaughn, V. M., Chopra, V., Fowler, K. E., & Kachalia, A. (2018). Perception of resources spent on defensive medicine and history of being sued amongst hospitalist: Results from a national survey. Journal of Hospital Medicine, 13(1), 26-29.

Sharifi, M., Asadi-Pooyaa, A. A., & Mousavi-Roknabadi, R. S. (2021). Burnout among healthcare providers of COVID-19: A systematic review of epidemiology and recommendations. *Archives of academic emergency medicine, 9*(1), e7. doi: 10.22037/aaem.v9i1.1004

Shiel, W. C. (2020). *Medical definition of hospice care*. Medicine Net. https://www.medicinenet.com/script/main/art.asp?articlekey=24267

Simmons University. (2014, November 13). *History of nurse practitioners in the United States*. https://online.simmons.edu/blog/history-nurse-practitioners/

Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965). http://www.jspayne.com/php/SummaryGet.php?FindGo=Social_Security_Amendments_of_1965

Society of Hospital Medicine (SHM). (2020). *Hospital medicine 101: What is a hospitalist*? Society of Hospital Medicine. https://www.hospitalmedicine.org/about/what-is-a-hospitalist/

Sperling, D. (2021). Nurses' challenges, concerns and unfair requirements during the COVID-19 outbreak. *Nursing ethics*, 09697330211005175.

Sung, C., & Herbst, J. L. (2017). The ethics of caring for hospital-dependent patients. *BMC Medical ethics, 18*(1), 1-7. doi:10.1186/s12910-017-0238-1

Stanford School of Medicine. (2020). *Where do Americans die? Palliative care*. Stanford School of Medicine. https://palliative.stanford.edu/home-hospice-home-care-of-the-dying-patient/where-do-americans-die/

Stentz, J. E., Clark, V. L. P., & Matkin, G. S. (2012). Applying mixed methods to leadership research: A review of current practices. *The leadership quarterly*, *23*(6), 1173-1183.

The Joint Commission. (2020). *Prepublication standards*. The Joint Commission. https://www.jointcommission.org/standards/prepublication-standards/

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for specialists in pediatric nursing*.

Thrive AP. (2012, October 8). *Five most expensive FNP programs: Nurse practitioner students*. https://thriveap.com/blog/5-most-expensive-fnp-programs

Tierney, W. M., Dexter, P. R., Gramelspacher, G. P., Perkins, A. J., Zhou, X.-H., & Wolinsky, F. D. (2001). The effect of discussions about advance directives on patients' satisfaction with primary care. *Journal of general internal medicine*,*16*(1), 32-40.doi:10.1111/j.1525-1497.2001.00215.x

United Nations, Department of Economic and Social Affairs Population Dynamics. (2019a). *Revision of world population prospects 2019* (Series of Excel Files). https://population.un.org/wpp/

United Nations, Department of Economic and Social Affairs Population Dynamics. (2019b, October 10). Our world is growing older: UN DESA releases new report on ageing. https://www.un.org/development/desa/en/news/population/our-world-is-growing-older.html

United States Census Bureau. (2018, March 13). *Older people projected to outnumber children for first time in US history* (No. CB 18-41; Revised September 6, 2018). United States Census Bureau. https://www.census.gov/newsroom/press-releases/2018/cb18-41-population-projections.html

University of Rochester Medical Center School of Nursing. (2020). *Why choose the NP program*. University of Rochester Medical Center. https://son.rochester.edu/academics/masters/np/index.html

Vincent, J.-L., & Creteur, J. (2019). The critically ill patient. In R. Bellomo, J. A. Kellum, & Z. Ricci (Eds.), *Critical care nephrology* (3rd ed., Chapter 1, pp. 1-4.e1). Elsevier. https://doi.org/10.1016/B978-0-323-44942-7.00001-7

Vogt, W. P., Gardner, D. C., & Haeffele, L. M. (2012). *When to use what research design*. Guilford Press.

Wallace, C. L., Wladkowski, S. P., Gibson, A., & White, P. (2020). Grief during the COVID-19 pandemic: considerations for palliative care providers. *Journal of pain and symptom management*, *60*(1), e70-e76.

Weathers, E., O'Caoimh, R., Cornally, N., Fitzgerald, C., Kearns, T., Coffey, A., Daly, E., O'Sullivan, R., McGlade, C., &Molloy, D. W. (2016, September). Advance care planning: A systematic review of randomized controlled trials conducted with older adults. *Maturitas*,*91*, 101-109. doi:10.1016/j.maturitas.2016.06.016

Weathington, B. L., Cunningham, C. J., & Pittenger, D. J. (2010). Research methods for the behavioral and social sciences.

Wheeler, B. (2018, December 18). *The ABC's of Curative, Palliative, and Hospice Care*. Hope Health: Touching Lives. https://www.hopehealthco.org/blog/the-abcs-of-curative-palliative-and-hospice-care/

Wheeler, M. S. (2016, December). Primary palliative care for every nurse practitioner. *Journal for nurse practitioners*, *12*(10), 647-653. https://www.npjournal.org/article/S1555-4155(16)30503-7/fulltext

World Health Organization. (2020, August 5). *Palliative care*. World Health Organization. https://www.who.int/news-room/fact-sheets/detail/palliative-care

Yadav, K. N., Gabler, N. B., Cooney, E., Kent, S., Kim, J., Herbst, N., Mante, A., Halpern, S. D., &Courtright, K. R. (2017, July). Approximately one in three US adults completes any type of advance directive for end-of-life care. *Health affairs: project hope*, 36(7), 1244-1251.doi:10.1377/hlthaff.2017.0175

Yamamoto, R., Kizawa, Y., Nakazawa, Y., & Morita, T. (2013, November). The palliative care knowledge questionnaire for PEACE: Reliability and validity of an instrument to measure palliative care knowledge among physicians. *Journal of palliative medicine*, *16*(11), 1423-1428. https://doi.org/10.1089/jpm.2013.0112

Yeager, K. (2014, March 27). The role of advanced practice nursing in palliative care. *Oncology Nursing News*. https://www.oncnursingnews.com/publications/oncology-nurse/2014/March-2014/The-Role-of-Advanced-Practice-Nursing-in-Palliative-Care

Yilmaz, K. (2013). Comparison of quantitative and qualitative research traditions: Epistemological, theoretical, and methodological differences. *European journal of education*, *48*(2), 311-325.

Yin, R. K. (2015). *Qualitative research from start to finish*. Guilford publications.

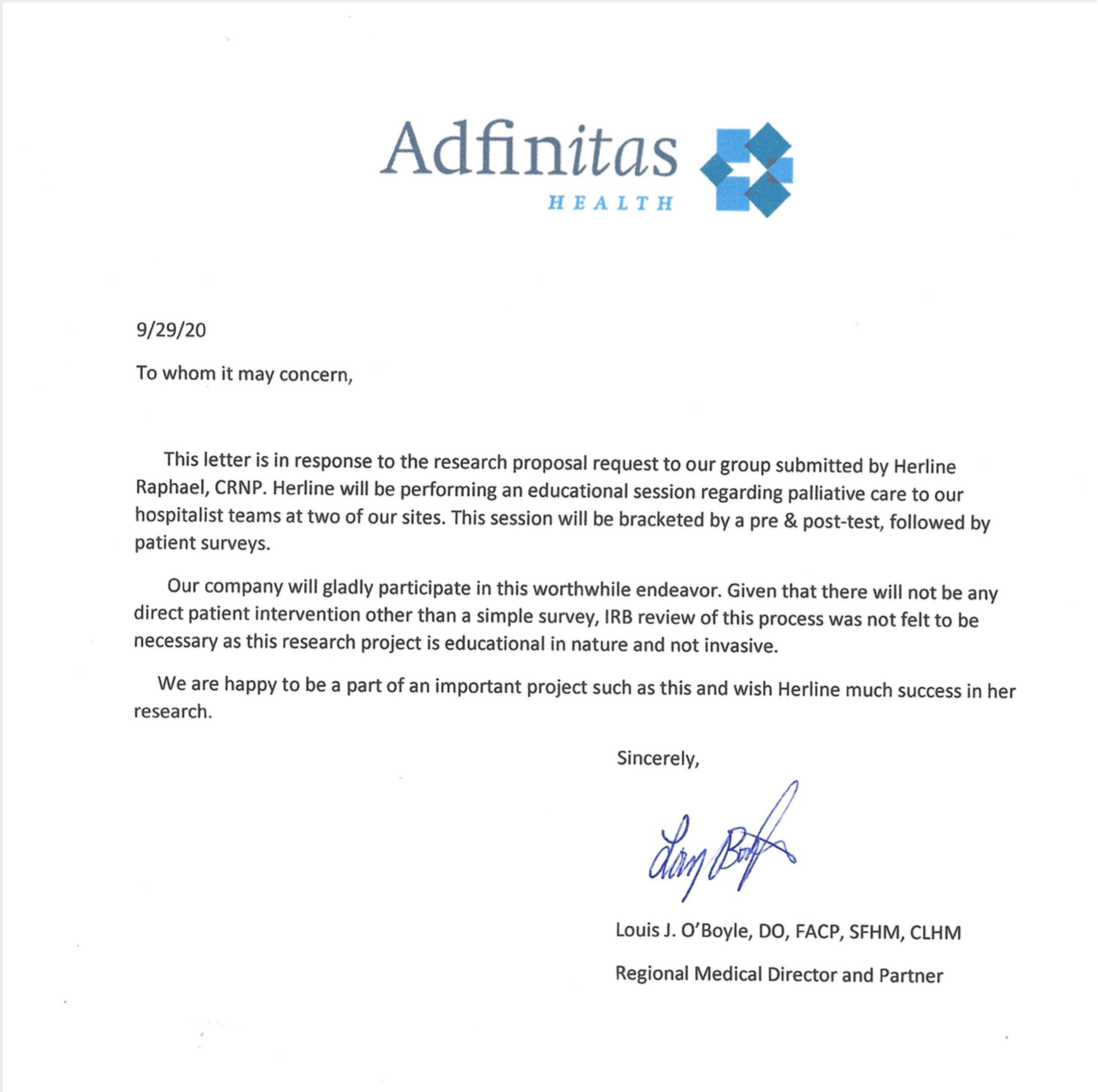
Zemplenyi, A. T., Csikso, A., Csanadi, M., Molken, M., Hernandez, C., Pitter, J. G., Czpionka, T., Kraus, M., & Kalo, A. (2020). Implementation of palliative care consult service in Hungary: Integration barriers and facilitations. BMC Palliative Care, 19(1). https://doi.org/10.1186/s12904-020-00541-0

Zheng, Y. J. (2016, April 30). On palliative care in the United States. *Berkeley political review magazine* [Online]. https://bpr.berkeley.edu/2016/04/30/on-palliative-care-in-the-united-states/

Appendices

Appendix A

Letter from Medical Director



Adfinitas
HEALTH

9/29/20

To whom it may concern,

This letter is in response to the research proposal request to our group submitted by Herline Raphael, CRNP. Herline will be performing an educational session regarding palliative care to our hospitalist teams at two of our sites. This session will be bracketed by a pre & post-test, followed by patient surveys.

Our company will gladly participate in this worthwhile endeavor. Given that there will not be any direct patient intervention other than a simple survey, IRB review of this process was not felt to be necessary as this research project is educational in nature and not invasive.

We are happy to be a part of an important project such as this and wish Herline much success in her research.

Sincerely,

Louis J. O'Boyle, DO, FACP, SFHM, CLHM

Regional Medical Director and Partner

Appendix B

Informed Consent

Appendix C

Demographic Data

This information should only be collected with your informed consent – no need to collect it again.

1. What is your gender?
    a. Male
    b. Female
2. What is your age? _____________
3. What is your medical preparation?
    a. MD
    b. DO
    c. PA
    d. NP
4. How long have you been a hospitalist? _____________
5. Have you had personal training (CME, CEU) on palliative care?
    a. Yes
    b. No
6. Do you provide all necessary referrals for patients with life-limiting diseases?
    a. Yes
    b. No
    c. Sometimes
    d. I don’t know

Appendix D

Palliative Care Pre & Post Knowledge Assessment Test

1. What is palliative care?
    - A. Care that only helps terminally ill patients to die
    - B. Care that is patient-centered and optimizes quality of life
    - C. Care that is patient and family-centered and optimizes quality of life
    - D. Pain management only

2. Describe the Philosophy of palliative care.
    - A. Palliative care is synonymous with terminal care.
    - B. Addresses the physical needs of the patient only
    - C. Is an approach that improves the quality of life of the families facing the problems associated with a life-threatening illness.
    - D. It is not holistic, patient-centered, comprehensive, and multidimensional

3. Palliative Care begins as the last resort.
    - A. True
    - B. False
    - C. Neither

4. The characteristics of a patient who should receive palliative care but not curative treatment.
    - A. The patient has limited ability to care for himself.
    - B. The patient has received curative treatment and is benefiting from it.
    - C. The patient qualifies for an appropriate clinical trial.
    - D. There is evidence that further treatment would be effective.

5. Describe a disease course characterized by slow decline with periodic crises and sudden death with a significant functional decline in the last few months of life?

   A. Congestive Heart Failure (CHF)
   B. Chronic Obstructive Pulmonary Disease (COPD)
   C. Hepatic Failure
   D. All the above

6. The number of people 65 and older is increasing, and the number of people with chronic end-stage disease is also increasing; therefore, this makes the need for palliative care more pressing?

   A. True
   B. False

7. What percentage of the American population will experience sudden death?

   A. About 5%
   B. About 15%
   C. About 30%
   D. About 40%

8. Palliative care is a therapeutic option for the dying patient who is experiencing unendurable suffering that is not amenable to any standard medical treatment measures.

   A. True
   B. False

9. To initiate Palliative Care, the patient has to have 6 months to live.

   A. True
   B. False

10. Effective palliative care requires a broad multidisciplinary approach that includes only Nurse practitioners, Physician Assistants, and Nurses?

    A. True

    B. False

    C. Neither

    D. All the above

Case #1. Mr. Rogers is a 94-year-old male with progressive dementia associated with behavioral disturbance.

11. Patients in this category tend to have progressive and significant debility in the last year of life.

    A. True

    B. False

    C. Neither

Case #2. Mrs. Row is a 64-year-old female with a history of Systolic CHF with an Ejection Fraction of 30%, Chronic Obstructive Pulmonary Disease (COPD) on 3 liters of oxygen around the clock. For the past 3 months, she has had a total of 12 emergency room visits exhibiting acute respiratory distress with severe hypoxia, Acute COPD exacerbations, and pneumonia.

12. Patients in this category experience a disease course characterized by a slow decline with periodic crises and sudden death. With a significant functional decline in the last few months of life, the patient will require which disciplinary referral?

    A. Physical and Occupational Therapy

    B. Nursing

    C. Home Care Services

    D. All the above

13. Mrs. Row’s daughter inquired about a Living Will. The provider will initiate

    A. Do Not Resuscitate conversation.
    B. Educate family and patient about the non-curative disease process
    C. Initiate Palliative Care consult
    D. All the above

14. Appropriate multidisciplinary consultation for Mrs. Row does not include?

    A. Case Management
    B. Palliative Care specialist
    C. Speech Therapy
    D. All the above

15. What is a POLST (Physician Orders for Life-Sustaining Treatment) form?

    A. A POLST form replaces an advance directive.
    B. The POLST form is a portable medical order for specific medical treatments the patient would want immediately (based on his/her diagnosis, prognosis, and goals of care).
    C. The form is intended as a substitute to advance directives, in that it serves as a translational tool and a continuity of care assurance.
    D. All the above

16. Advance care planning are documents used for communicating the patient’s medical wishes, which include Do not Resuscitate, Living will, and a POLST?

    A. True
    B. False
    C. Neither

17. An advance directive is a form in which an individual:

   A. Do not appoint a person or persons to make health care decisions for the individual if and when the individual loses the capacity to make health care decisions (often called a “healthcare proxy”).
   B. Does not provide guidance or instructions for making health care decisions, typically in end-of-life care situations (often called a “Living Will”).
   C. All the above
   D. None of the above

18. An advance directive is a medical order.

   A. True
   B. False
   C. Neither

19. When a patient has a high level of psychological distress, providers are <u>not</u> recommended to examine whether the patient has suicidal ideation.

   A. True
   B. False
   C. Neither

20. When communicating with the patient, an open-ended question means that it cannot be answered with a simple ‘yes’ or ‘no,’ and requires an unrestricted answer based on the subject’s feelings. This is <u>not</u> the best approach.

   A. True
   B. False
   C. Neither

21. When providers convey bad news, they should not ask the patient's concerns and understanding about the disease.

    A. True
    B. False
    C. Neither

22. It is better to repeatedly use the word 'non-curative' when telling the patient about their terminally ill disease.

    A. True
    B. False
    C. Neither

23. Which of the following is true regarding the disciplinary healthcare team involved in Palliative Care?

_____ A Social Worker is not usually part of the team.

_____ The members of the team are the same across palliative care settings.

_____ Families are very knowledgeable about team members.

_____ The chaplain is not part of the team.

24. Which of the following is not a barrier to the optimum use of palliative care at the end of life?

_____ Reimbursement policies

_____ Easily determined prognoses

_____ Lack of well-trained healthcare professionals

_____ Attitudes of patients, families, and clinicians

25. Would it be helpful to include a reminder during admissions H&P to address End-of-Life Palliative care needs?

_____ Yes

_____ No

_____ Maybe

26. Please indicate all that apply to patient criteria for Palliative care consultation.

_____ End-stage pulmonary restrictive diseases, such as (Pulmonary fibrosis, COPD, and emphysema)

_____ ESRD associated with Cardiorenal syndrome

_____ Diabetes Mellitus Type 2

_____ Lupus

_____ Stage IV Metastatic Cancer

_____ Congestive Heart Failure (CHF) w/EF less than 25% or life vest

_____ 3 or more consecutive readmissions for aforementioned conditions.

Does the patient have less than 6 months to live?

_____ Yes

_____ No

Appendix E

Palliative Care Assessment Tool

Completed by: (Name of provider)

Hospital Admission Date: _____/_____/______

_____ Yes

_____No

Is palliative care already consulting on patients?

Patient Information (Place patient sticker below)

Patient Name:

MRN:

_____ Age:

_____ Sex:

Primary Service: Hospital Medicine

STEP 1: Identify Patients to Screen for Palliative Care Needs

Does your patient have a serious illness?

_____ Yes

_____No

Please check one to indicate the disease category for the patient's primary serious illness:

_____ End-stage pulmonary restrictive diseases, such as (Pulmonary fibrosis, COPD, and emphysema)

_____ ESRD associated with Cardiorenal syndrome

_____ Stage IV Metastatic Cancer

_____ Congestive Heart Failure (CHF) w/EF less than 25% or life vest

_____ 3 or more consecutive readmissions for aforementioned conditions.

_____ Does the patient have less than 6 months to live?

_____ High risk for death or long-term functional impairment (e.g., s/p cardiac arrest, chronic critical illness)

STEP 2: Screen for and a development plan to address palliative care needs

Full team palliative care consult recommended (or already involved)

STEP 3: Provider Involvement in Communication

1. Have you discussed the patient's prognosis and goals of care with the patient?

_____ Yes

_____ No

2. Have you discussed the patient's prognosis and goals of care with the patient's family?

_____ Yes

_____ No

Please check at least one if you answer “no” to questions 1-2.

3. What factors have challenged your involvement in the above discussions for this patient?

_____ Lack of skill/training

_____ Lack of time

_____ Family not available

_____ Cognitive impairment

STEP 4: Education provided to patient and or family.

Please check all that describe the education and support you provided.

_____ Palliative Care Communication Initiated

_____ Defining/describing palliative care

_____ Explained transition from non-curative to End-of-Life

_____ Interdisciplinary Consultations

_____ Initiate discussion about Living wills, CODE status, and POLST form

STEP 5: Interdisciplinary consultation and support provided to the patient

Palliative Care Specialist:

_____ Yes

_____ No

Case management/Social Services:

_____ Yes

_____ No

Chaplain:

_____ Yes

_____ No

Home Care Services (Nursing, Physical Therapy, and Occupational Therapy)

_____ Yes

_____ No

Confirm Code Status:

_____ Yes

_____ No

Initiate POLST form:

_____ Yes

_____ No

STEP 6: Patient Outcome

1. Date of Discharge: _____/_____/______

2. Date of Expiration: _____/_____/______

3. Were Palliative Care and interdisciplinary team members consulted during the hospitalization?

_____ Yes

_____ No

4. Patient disposition:

_____ Expired

_____ Home

_____ Skilled nursing facility

_____ Acute care hospital (transferred)

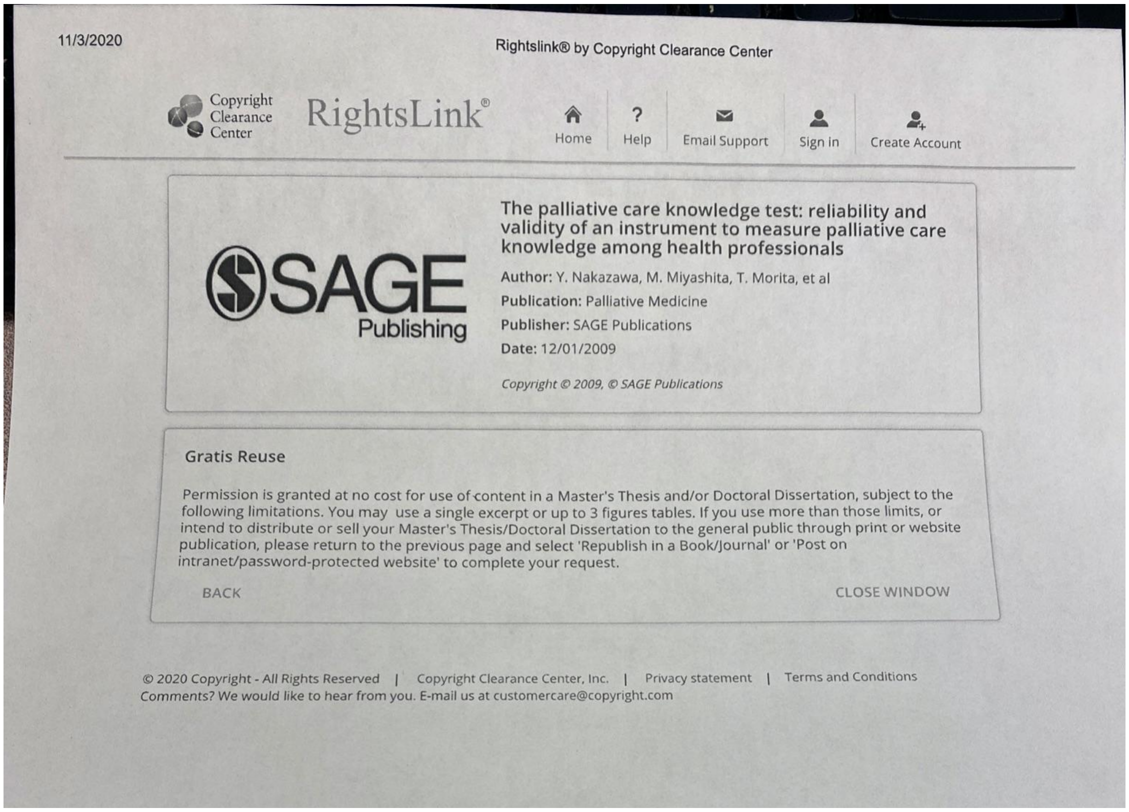
_____ Long term acute care

_____ Acute Rehab

Other: _________________

Notes: Adapted from "Palliative Care Professional Development for Critical Care Nurses: A Multicenter Program," by W. G. Anderson, K. Puntillo, J. Cimino, J. Noort, D. Pearson, D. Boyle, M. Grywalski, E. O'Neill-Page, …S. Z. Pantilat, 2017, *American Journal of Critical Care, 26*(5), pp. 372-373.

Appendix F



11/3/2020

Rightslink® by Copyright Clearance Center

The palliative care knowledge test: reliability and validity of an instrument to measure palliative care knowledge among health professionals

Author: Y. Nakazawa, M. Miyashita, T. Morita, et al

Publication: Palliative Medicine

Publisher: SAGE Publications

Date: 12/01/2009

Copyright © 2009, © SAGE Publications

Gratis Reuse

Permission is granted at no cost for use of content in a Master's Thesis and/or Doctoral Dissertation, subject to the following limitations. You may use a single excerpt or up to 3 figures tables. If you use more than those limits, or intend to distribute or sell your Master's Thesis/Doctoral Dissertation to the general public through print or website publication, please return to the previous page and select 'Republish in a Book/Journal' or 'Post on intranet/password-protected website' to complete your request.

© 2020 Copyright - All Rights Reserved | Copyright Clearance Center, Inc. | Privacy statement | Terms and Conditions

Comments? We would like to hear from you. E-mail us at customercare@copyright.com

Appendix G

Southern Adventist University
School of Nursing
DNP Scholarly Project EOP SLO Synthesis
Herline Raphael

PICO/Research question:

The PIO question guiding this project is:

(P) Do hospitalists working with end-of-life or critically ill patients provide with

(I) a training session on palliative care, communication, and collaboration techniques,

(O) improved knowledge, skills, and collaborative ability in practice and improved patient care?

1. **Cultural Competence:**
   Mentor Christian responsiveness and caring to a global culture through sensitivity and competence for patient traditions and values.

   Discuss how your proposed Scholarly Project could demonstrate Cultural Competence?

   The project will aim to train hospitalists on engaging in the end of life and palliative care discussion in ways that respect the cultural backgrounds and beliefs of patients.

2. **Evidence Based Practice:**
   Translate quality research findings and outcomes to solve problems for quality personalized outcomes.

   Discuss how your proposed Scholarly Project could demonstrate Evidence Based Practice?

   The project will aim to obtain research about how this type of conversation has been engaged in other hospitalist environments and the types of training initiatives that have shown the most optimal results in sufficiently preparing hospitalists for this aspect of patient care.

3. **Health Promotion:**

Propose evidence-based methods that prevent disease and promote human flourishing through the utilization of a wholistic framework to educate and empower healthy lifestyle choices.

Discuss how your proposed Scholarly Project could demonstrate Health Promotion?

The project will allow hospitalists to ensure that patients are able to reach the best possible health outcomes in relation to their present health conditions, prognosis, and symptoms.

4. **Patient Centered Care:**
Facilitate inter/intra professional healthcare to achieve personalized, compassionate, and coordinated whole person care.

Discuss how your proposed Scholarly Project could demonstrate Patient Centered Care?

The project will generate a training program for hospitalists that will allow them to tailor the end of life and palliative care discussion to the specific situation of the patient, as well as the needs of the patient. This will allow hospitalists to appropriately tailor care for the individual patient, as opposed to applying a blanket approach to the care of all patients.

5. **Quality and Safety:**
Evaluate current evidence and outcomes of practice in health care systems to ensure a just culture that minimizes the risk of harm and promotes safety and quality of care.

Discuss how your proposed Scholarly Project could demonstrate Quality & Safety?
What are the quality and safety concerns with your project?

The project will focus on improving the discussion that is engaged in by patients and hospitalists and improve the manner in which hospitalists engage in this type care. The quality and safety concerns with my project are ensuring that patients receive the referrals and community care that their health condition requires. Furthermore, training will also allow hospitalists to improve the overall safety of end of life and palliative care that is provided to patients as it will prompt hospitalists to carefully evaluate the alternatives that are available to the patients and critically assess the safety of such alternatives.

6. **Informatics and Innovation:**
Analyze healthcare outcomes using knowledge of nursing, computer and information sciences to ethically and innovatively manage data, information, and technology.

Discuss how your proposed Scholarly Project could demonstrate Informatics and Innovation?
What technology would be helpful to you?

The project will allow me to utilize the technology that is available to me in order to engage in background research on this topic. Additionally, I will apply the evidence that I obtain to generate novel training initiatives that can propel end of life and collaborative care forward. The technology that would be helpful to me would be the facility's EHR, as I will require access to the EHR in order to carry out a patient chart audit.

7. **Teamwork and Collaboration:**
   Organize effective inter/intra professional teams to promote quality health outcomes and reduce risk.

   Discuss how your proposed Scholarly Project could demonstrate Teamwork and Collaboration?
   Who are the team members that you think would be helping you with implementation of project?

   The project will allow me to work with different groups of providers to put together a new training approach. I will be able to utilize the knowledge and skills of different interprofessional individuals and providers, who will all contribute to the project. The team members that would be helping me with implementation of the project would be hospitalists and nurses.

8. **Professionalism:**
   Advocate for Christ-centered excellence in nursing roles and professional behaviors throughout the inter/intra professional team.

   Discuss how your proposed Scholarly Project could demonstrate Professionalism?

   I expect to be able to apply this characteristic to my project as I will be working in a professional environment. As such, my teamwork with other individuals will hinge on mutual respect and communication, which will embody professionalism.

Appendix H

COVID-19 Impact on Palliative Care Tool

1. Do I have your permission to record this interview?

2. Tell me how the COVID-19 pandemic has affected your ability to provide palliative care as a hospitalist?

3. How did palliative care education affect your communication skills with patients in your care?

4. Which services might be covering the palliative care needs of patients in your facility?

5. What would you want other hospitalists to know about palliative care?

Appendix I

Palliative Care, Communication, and Collaboration for Hospitalists Webinar

HOSPITALIST PALLIATIVE CARE EDUCATION OUTLINE

This 50-minute educational program aims to give the Hospitalist the knowledge and skills to deliver high-quality palliative care to seriously ill non-curative adults and their families while improving their quality of life.

This session focuses on:

- Communication Skills for Patient and Family Support
- Assessing and Managing individual needs of Patients
- Patient Care Delivery
- Interdisciplinary Team Support
- Ethical Principles and Challenges

Topics Covered:

- Introduction, history, and philosophy of palliative care
- Common disease states in palliative care, Known as Non-curative illnesses
- Defining advance directors, DNR, POLST, and living will
- Identify Interdisciplinary team members
- Professional practice issues

Learning Outcomes:

After completing this course, the participants will be able to:

- Integrate the theoretical and empirical knowledge of palliative care.
- Effectively consult the Appropriate interdisciplinary team member.

- Acquire the communication and clinical expertise essential to working with patients and families.
- Acquire the communication and clinical expertise essential to working with interdisciplinary teams
- Make appropriate recommendations for advanced directives

Appendix J

Palliative Care Provider Partial Interview Transcription

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

Participant 0004: Well, the superficial things, first, I didn't look like this before the beginning of the pandemic. I mean, we currently have that extra layer of separation, its mandatory to wear scrubs. We have masks on us all day long through the working hours. In my view, this has the palliative community and communication with people negatively. Facial expressions are very useful, especially in communication, but in this aspect, we cannot even go as far as hug them. We tend not to even be able to have a smile or anything with patients and their family. So being able to communicate was very problematic. Telemedicine were clearly great, but we had challenges where people just didn't have the technology at home. Honestly, communication has been a challenge, it's been terribly difficult for patients and families, but we tend to do our best. I feel the situation would have been a little better with the devoid of all these, which almost seemed impractical.

Interviewer: How did palliative care education affect your communication skills with patients in your care?

0004: In my opinion, regarding your question. I don’t know how to best phrase it, but I believe the pandemic has brought out the importance of being prepared. The webinar was useful in every dimension, including polishing the communication skills that we learn in the training. In our admissions, we ensure we perceive what their goals for care are, make sure that they have a health care proxy, DNR goals. I think that the education system offered is just a practical part, we could call it a blueprint, so to me, it’s just an outline.

We face some situations that require the sixth sense, it's something above what can be taught, and so we have to keep on sharing experiences with other practitioners to get that hand on touch.

Interviewer: Which services might be covering the palliative care needs of patients in your facility?

0004: The hospitalist group. Otherwise, we outsource.

Interviewer: What would you want other hospitalists to know about palliative care?

0004: Palliative care works in conjunction with other teams players. I believe that the topic about end of life touches on every level of healthcare. So, what this means is that the participation of the interdisciplinary team is essential. Social workers play an integral part to facilitate these discussions. We should include the family, To encourage patients to complete advance directive, together with questions about coordinating their final days.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0012: You know, I don't think that as far as consulting palliative care, I don't think that COVID has affected it. Honestly, we only have one true palliative care program and a place which we can consult that is Allied. I have worked there before as a hospitalist, and I think the problem with them is that they have inadequate staff, and I think that has nothing to do with COVID. They have a hard time maintaining staff, so I think as far as consulting palliative care, I don't normally do it that often because I know that they don't have the staff to handle it, but again nothing to do with COVID. Now with the pandemic, it has been more difficult for them. Keeping staff has presented more of a challenge. The patients wait here for a while, occupying a hospital bed because we have nowhere to send them. Really, a major barrier is waiting for the patients to have three Covid test before they get transferred to another facility, but I don’t think, you know, I have had a few patients in the hospitals, and I really have a problem with that.

Interviewer: How did the palliative care education affect your communication skills with patients in your care?

0012: Ooh, I am sure. I mean, I was a palliative nurse practitioner. I often transfer people to hospitals, so I think, you know, having that background and the experience that comes with it totally helps, and you know, I am probably more likely to pick out the people who would benefit from palliative care more than somebody who is really not educated in it.

Interviewer: Which services might be covering the palliative care needs of patients in your facility?

0012: We don’t have any valuable service in the facility. We provide palliative care consultation. I communicate with the social workers a lot. We don’t have a palliative care physician. In our hospital, patients are discharged to the community, to Allied. They need to follow up with their PCP’s office.

Interviewer: What would you want other hospitalists to know about palliative care?

0012: For the patients that just come back over and over, if we had enough palliative resources in the area, it would be definitely beneficial to help keep patients from the hospital. Communicating with patients to help them understand palliative care. It could be a useful tool to help keep some of these patients out of the hospital.Keeping patients out of the hospital but also catering for their emotional needs and symptoms too.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0013: I think that time is definitely a limiting factor because for the last several months. When COVID initially the census in the hospital promenade because everyone was afraid of coming to the hospital, but now we see this huge boom in our census. I would say for the past six months. Our average census has risen from 75 patients to 130 patients on average, so we’ve had to increase the number of our caseload. Patient care, I mean palliative, has been difficult. As I mentioned in our phone conversation, we recently condense a facility, the local hospitals are not treating patients. I feel like we are the COVID center of the area. We are starting the day with several more patients than we had when I started this job, so you know those conversations usually take time, and while I am guilty of having to make the conversations be shorter than they would typically be in the past. I think there is provider burnout is generally where it’s like I am not interested in staying here any longer at the end of my shift, and sometimes the family cannot come, and visiting hours are very restricted, so a lot of conversations we have are over the phone than in person and that probably not a good as quality as an in-person conversation would be. I obviously try to do my best, but the quality of my palliative care is not the best. It can be better when I start the day with ten patients as opposed to when I start on with 22 patients.

Interviewer: How did palliative care education affect your communication skills with patients in your care?

0013: Increased my comfort level of having difficult conversations is important. A lot of times, people are uncomfortable talking about the end of life. My first nurse practitioner position was in palliative care, and that was in 2013; and since that time, I haven't worked full time in palliative care for all that time. I kind of got involved in masters in palliative care, mostly in the outpatient arena, but that ability to have those difficult conversations is kind of important, and that was a way to help people to understand their prognosis better. I think that's probably the most important part.

Interviewer: Which services might be covering the palliative needs of patients in your facility?

0013: Well, I worked in the hospitals, and I have seen them primarily admit the majority of patients in the hospital that I worked at. We are doing it. I think that occasionally suggestions for palliative care are made by specialists; probably the most frequent specialist I see making those recommendations are oncology, cardiology and pulmonary, but the majority of palliative care is done with the hospitalist service.

There are no inpatient palliative care services, which fall on the hospitalist's team. There are outpatient palliative care resources that we can refer to, especially upon discharge, but in my facility, there is none that I am aware of the hospital.

Interviewer: What would you want other hospitals to know about palliative care?

0013: Well, if you say the early conversations are important because sometimes when you introduce the idea, or first of all, Palliative care is important. Palliative care has a bad stigma to putting on your audience, and so sometimes, when you say the word palliative care, people immediately turn off. It can take several days of slowly chipping away out of the idea before people kind of come around and say like, okay ", we are not just killing someone," so I think the early conversation is very important. I don't really know how to tackle this, but a systematic way of teaching. That on the patient's fourth admission for the same thing in three months. That should trigger initiating a palliatives care conversation. With hospitals, there are a lot of turnovers, so on the first and the second day, we should just have palliative conversation. It will definitely help bring a holistic approach to palliative patient care.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0016: Well, palliative care has always had challenges. A lot of it starting from inadequate or lack of resources to understaffing, etcetera. The pandemic has just been a meager pointer to illuminate into our failures as a team, the government included. It was a pointer to the facilities, to the entire health care sector, that we are really not doing enough with palliative care. We are really lagging behind. I think the pandemic has also brought many and maybe some opportunities. Therefore, most physicians, both personal integrative physicians and specialists, practice palliative care. As part of this, we as physicians must always pay close attention to our patients, trying to understand their goals for their health and how they need to be cared for overtime. It dawned on us that our system isn’t well designed to attempt this, and there are many variations on how it's done. There is a lot of reluctance in the adoption of end of life care, although I think the patients who had a better design before we went back to the current type of crisis we are in might have had an opportunity to improve the care they needed. And I think one of the things that's emerging from the crisis is that right now it's important to have conversations with patients about how they want to be cared for, what is necessary for them, so that they get the most effective care that they can you want to. This cannot be taken lightly anymore. It becomes little easier to handle a patient who has a documented plan beforehand than the latter and in some cases, there is no family to help solve or curb the situation.

Interviewer: How did palliative care education affect your communication skills with patients in your care?

0016: I believe that the educational part plays a major role in our communication. Not only to me but to the entire palliative team. I think that the reason this project was infused into our facilities was to give us an idea of what would be expected of us in palliative care situation. Hence in my view, this is very essential even for the trainees and should be regarded with utmost seriousness. There would be a great disparity between to practitioners handling the same patients, however with one of them having a zero educational background of how to do so while the other bearing educational background in communication skills. For example, we will be able to note some differences on contexts such as when the specialist needs to be a little sensitive. An instance is how to be able to give hope to my patients while at the same time telling them the truths of their situations and diagnosis. In addition, sensitive context, poorly communicated information may further stress the patient, and I believe emphasizing this quality in palliative care is recommendable.

Interviewer: Which services might be covering the palliative needs of patients in your facility?

0016: My facility is little advanced though not to the level we want to see it to. In relation to palliative care, I think our hospitalist team is among the developed specialty that offer both inpatient and outpatient services. These are insured with both Medicare and

Medicaid, so it kind of caters for diversity. We face challenges associated to understaffing which in my view hinders the effective delivery of services.

Interviewer: What would you want other hospitals to know about palliative care?

0016: I want to emphasize that palliative care is very important and critical. I mean like if you are in hospice and decide to return to the hospital for end of life care and cannot have your whole family it can be distressing and traumatizing. As a parent, as a grandparent, can you imagine not being there for your dying child? That was awful. We ensure that we bridge this gap by providing services that ensure wishes of the patients and the family are catered for. I think the peace that comes with the reception of palliative care is immeasurable. It is having the knowledge that you did the best you can for your family, was there for them through it all and in cases where the patients succumb, the family is able to move on with the peace that they did their best. Also, as practitioners, it does not feel as awful as it would when the care had not been initiated.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0022: COVID-19 has become a great challenge. We are doing poorly with palliative care consultation. But we do, once in a while, we refer end stage COPD, end stage CHF and people who meet criteria for palliative care to that local health care program. The service is not effective, it needs to be expanded. It is to be revamped and expanded, not only expanded: you cannot expand something that’s not working well. It needs to be revamped with some clear goals and some clear protocols and then expanded. Furthermore. we need manpower. The demands on us, some days are unbearable. the patients are much sicker, very time consuming. I start my day with 22-24 patients. We are always short at least 2 or

3 providers. We have the armed force to help with the staffing situation. So, again like I said, moving parts, we have so many different moving parts that are affecting not only COVID but may also affect palliative care. Patient acuity, patient ratio, load is heavier and poor staffing. Time is a factor.

Interviewer: How did the palliative care education affect your communication skills with patients in your care?

Interviewer: Which services might be covering the palliative care needs of patients in your facility?

0222: The hospitalist case management plays a role in getting the services coordinated.

0222: Prior to the training you provided, a lot of us don't really have a great education in palliative care. There are not enough educational programs available for us. We have to outsource that education if needed. The training you provided clarified the dichotomy of not being able to effectively consult the patients that needs to be evaluated before going in the community or that needs to have services coordinated for them in the community. It clarified the needs and resources available to the patient.

Interviewer: What would you want other hospitalists to know about palliative care?

0222: It's not easy where I am working. Palliative care should be initiated early, as early as during the admission process.

Thank you very much for your time.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0023: Providing Palliative care has been marginal. Up until 1 year ago, I loved practicing hospital medicine. In fact, I still do. But it has become burdensome. This pandemic has made our lives interesting. I've never seen such high acuity, the stress, the demands, the strain. The exhaustion. Every day is the same story of being understaffed and not enough resources. Time is a barrier. To be honest, I have not been consulting the patients. Maybe one or 2 hospice cases.

Interviewer: How did the palliative care education affect your communication skills with patients in your care?

0023: I'm not a specialist in palliative care but obviously we should consult palliative care in the hospital. Your training emphasized to start communicating early. I especially appreciated the. I agree, communication is very important. Incorporating the interdisciplinary team members can also facilitate improved quality of life.

Interviewer: *Which services might be covering the palliative care needs of patients in your facility?*

0023: The hospitalist group. We don’t have a formal palliative program. We outsource the services. In fact, during the pandemic, at one point we didn’t even have the ability to consult palliative care. Not enough outsource staffing agencies. When it comes to the 14-day Mark when COVID patients are still in the hospital, that's when the question comes to that family then here's where we have to decide we come across that bridge.

Interviewer: What would you want other hospitalists to know about palliative care?

0023: To identify the patients that meet criteria during admission and to recognize that palliative care plays a key role in appropriate discharge. Unfortunately, medicine is not just about taking care of the patient and ordering medicine, it’s about establishing better relationships with the patients and family. Gaining their trust early. Empathizing with patients and families about their specific needs. We have to always remember that it’s not what the provider wants. I think we can do a better job and not just always rely on protocols.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0024: In many cases, it has been difficult getting people admitted to a palliative program, a lot of inpatient units are not accepting people that are recently COVID positive and as we know with the testing, a lot of people persistently have viral DNA in their, uhm, on their tests for months out even though, they are not communicative to other people. A lot of programs have had different varying rules and so we have been able to make people comfortable in hospitals and unfortunately that has taken several days in some's cases. And families are appreciative of it, I think with the visiting rules being a little more laxed than they were earlier in the pandemic, people are able to see our efforts a little better now. With people that are focused on comfort care, the rules are a little more liberal, in terms of the amount of people at the bedside and that's really the most important thing for the comfort measure patient is to have their family with them much more that we can do. So that's a good development in all of this and that we now have the knowledge that we can protect families and allow them to be there. Whereas as in the beginning of the pandemic, I think everyone can agree that that was a very sad time when people had to die without their loved ones there. The biggest challenge for palliative care during this pandemic, is COVID is such a slow burning disease. We've seen some people bounce back terribly, we thought were getting better and we may have missed an opportunity to provide palliative care because we didn't even realize how sick they were. I have seen people go home on two liters of oxygen and come back with rip roaring pulmonary fibrosis, a week later and we thought we were going in the right direction. So, in those cases, no, we didn't catch them in time to give them a good comfort level care, because we really thought that we were treating to heal and so, it's been a challenge. COVID-19 is very unpredictable. The pandemic has been a challenge, the providers in the hospital setting, hospitalists, specialists, we are experiencing burnout, we are experiencing depression, we are experiencing an influx or increase in patients to provider ratio. We are very busy, the system is busy, the system is taxed, I have seen seen countless nurses leave the profession or go to other places. I am working at a place that sorts of absorbs a lot of the COVID patients from neighboring hospitals, uhm, as a lot of hospitals have chosen to condense COVID care to protect other service lines. So, when you work in those units, I think there is a lot of burnouts and there is a lot of, it's like the breeding ground of depression. Going back to what I said earlier that a lot of palliative care programs don't accept people because they don't wanna spread COVID in the hospitals to non-COVID patients that are there and placements at skills and rehabs have been delayed and it sort of unfortunately maybe created, more debility in people that could have otherwise had a better outcome if they gotten out of the hospital sooner. A lot of people have sort of been stuck in the hospital longer, and we know that longer hospitalizations are never a good thing. There has been some pretty lengthy hospitalization because of this and because of resources being so limited and it's been sad.

Interviewer: How did the palliative care education affect your communication skills with patients in your care?

0024: I think more knowledge was gained. This training was helpful in that it helped me to provide more focused care. I pay attention to the criterias. I am more aware of the community resources. To be honest, for the patients that meet palliative care criteria, I've been reminded to do better.

Interviewer: Which services might be covering the palliative care needs of patients in your facility?

0024: Case worker, the hospitalist.

Interviewer: What would you want other hospitalists to know about palliative care?

0024: I'd like them to know that families are ever appreciative of a phone call in these times, that uhm, and it doesn't have to be just one family member, sometimes more than one has to hear it. Be willing to communicate with families, get on a conference call with more than one. A lot of times we've related to the main family contact that has been in charge of the patient during hospitalization, but sometimes, you need to go the extra step and unfortunately, these encounters take time and that's one thing that we don't have an infinite amount of during the day. Our census has been high. Time is scarce. Palliative care is a lot of readying people for difficult decisions and conversations that they are not ready for and getting out of your comfort zone with people, because everyone has they own preconceived personal biases that they are coming with, and experiences that they have had in the past. We have to prepare people by using phrases that we don't want to miss the opportunity to provide comfort. You know, a lot of times, we choose palliative care, way too late in the game for most diagnosis, not just COVID. It's usually way too late, especially when you reach the hospital setting. It has to be a bigger challenge in the out-patient setting, because we have, in the inpatient setting you get to see people so closely, it's so hard in the outpatient setting, but usually when they get the hospitalist, you know, it's almost a no-brainer to start talking about palliative care. COVID-19 is tough though, COVID is hard because we've seen some people that don't fit the mold of the typical COVID patient that you expect to not do well, because it's been sad, you've seen people that are younger, that you didn't expect that were gonna have a rough course. So, in a lot of cases, we missed the chance to provide the right comfort early on, because we were so blinded by, you know, these are the demographics that are gonna do badly, this is a person in their forties, they should not be having a problem with COVID, they are not overweight but unfortunately, I even had a thirty-two-year-old in my service one day, they didn't die, but it was shocking to me to see a thirty-two-year-old needing oxygen in the hospital. A lot of people have said 'doc, am I am going to get through this?' and you want to choose your words carefully and say, you know, I really want you to, and I think you are going to and the odds are in your favor, but I cannot guarantee you a hundred percent, once you've gotten to me.

Interviewer: **How did the palliative care education affect your communication skills with patients in your care?**

0025: I have not been the recipient of a substantial amount of formal education as pertaining to palliative medicine. I am certainly engrieved within internal medicine which obviously is a robust discipline. I think my comfort level in engaging in these discussions and helping patients and families navigate through the spectrum has increased more so through practice and recent webinar interaction.

Interviewer: Which services might be covering the palliative care needs of patients in your facility?

0025: The Hospitalist Team. I think about the way the hospital based (my own personal practice), the hospital-based aspects through affiliated health systems is unfortunately very lacking in a formal palliative care process. There are palliative medicine and in specifically hospice entities and mostly in the communities which, you know, only facility and enhance the spectrum of palliation and I, full disclosure, I have affiliation with a community based hospice agency,, uhm, and for several years acted as the associate medical director, and obviously that entails a multi-disciplinary strategy, often led by nursing staff, home health aides, social services, clergy and other disciplines that would like to enhance an individual's quality as opposed to quantity.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0025: It has certainly been impactful for a number of reasons but not only those patients that have been afflicted by COVID but patients that may be hospitalized for, you know, any unrelated disease stage. And I think that part of the, I think when palliative medicine is most successful is when it's more of a shared experience. I find that the patients are better equipped to navigate through the spectrum of end of life, with the focus being upon symptom-based approach, when, you know, when partnering with loved ones, with families, with friends and what COVID has done is COVID has greatly impacted that. COVID-19 has isolated individuals in hospitals due to quarantine, due to visitation restrictions and I think it's then a detriment to the goals of seeking palliation and then doing so in a timely fashion because often times a palliative action course is decided on far too late in the disease spectrum, I don t think that the patients and families and loved ones can truly benefit under the current climate. As we alluded to not having a focused or devoted palliative service, uhm, as I said, the isolation that the patients experience whether its directly COVID or indirectly COVID and I think that as providers, you cited the overwhelming back load or the burdens of nature and not to mention the fact that these discussions are difficult to have and not everyone is as skilled or more so as willing to take on the discussion, so I think it is a multi-fasted answer.

Interviewer: What would you want other hospitalists to know about palliative care?

0025: I think just engaging in a conversation and allowing the conversation to be free flowing and fluid, but uhm, one in which is ground in honesty. I sound personally and more so recently, patients and in particular families are looking for more of a direct approach, not necessary an emotionless approach but direct approach in which the disease is quickly identified at a reasonable prognosis whether that be with disease modifying therapy or without can be napped and most importantly one in which the voices is given to the patients or directing the trajectory of care and it doesn't always comminate in palliation, but often times it does but I think providing that, you know, that option and also revisiting it and revisiting it as appropriated. At certain instances, I think it is only of benefit most importantly to patients but providers as well.

Interviewer: Tell me how COVID has affected your ability to provide palliative care as a hospitalist?

0030: if COVID has really affected palliative care that much? I don't know, my facility is small, we did not house a lot of COVID patients. Regardless, there was a unit but did not accommodate a lot of patients. In my personal observations the only strain I witnessed was concerning communications. I believe this dimension was hugely messed up due to the restrictions that were put in place as strategic measures for the pandemic. But I think the biggest was change basically that we can't have family members with their loved ones when we're having these problematic conversations and/or when we're transitioning to the end of life.

Interviewer: How did palliative care education affect your communication skills with patients in your care?

0030: For me, communication is iterative, there is no ceiling effect. You have to continuously refine and develop it like various clinical talents in medicine. The creation of end-of-life care plans is also necessary, and unfortunately this can be done very poorly. A palliative care practitioner meets new dilemmas day in day out, and some of the emergencies we are bound to handle are totally unique cases needing the application of what had been taught into actual practice. I could say I am quite lucky to have mentors who have helped me throughout this journey. Indeed, learning is multidimensional. It’s not a one way traffic but very vast. I believe that the majority of my knowledge gain in your training is communication. The best aspect was learning communication skills.

Interviewer: Which services might be covering the palliative needs of patients in your facility?

0030: We definitely do a lot of outsourcing. Our hospital has very limited palliative resources. It is only me at night. The day shift, the providers have been using telemedicine. To me, It is not a very effective strategy compared to one-on one interaction.

Interviewer: What would you want other hospitals to know about palliative care?

0030: Implementation of a palliative care plan is a critical affair that requires thorough screening. The takeaway is to work and treat every individual difference uniquely and in seclusion. keep the patients at home.