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Evidence-Based Strategies Used by Primary Care Providers in Early Hospice Referrals

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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2020

Abstract

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by

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MSN, Walden University, 2012

BSN, De La Salle University -EAC, 1992

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Despite scientific evidence suggesting that hospice care improves quality of life (QOL) at end of life (EOL), terminally ill patients are being referred to hospice too late. A considerable number of terminally ill patients are referred directly from the inpatient unit. Often, these patients have not had a goal-of-care conversation (GOC) with their primary care provider (PCP) nor have they been offered hospice care until hospitalization. It is imperative that PCPs, advocate and support patients and families during all stages of life including EOL. This doctoral project was completed for the purpose of identifying strategies used by PCPs that enhance timely hospice referrals. Guided by Kolcaba's theory of caring, a systematic literature review was conducted using the Joanna Brigg's Institute Systematic Review process and the Preferred Method Items for Systematic Reviews and Meta-Analyses (PRISMA). Following PRISMA guidelines, eight evidence-based sources were included in the review. All publications met the inclusion criteria of sources written between 2010 to 2020, strategies used by PCPs that enhance timely referrals to hospice, original studies, cancer and non-cancer diagnosis, and articles written in English. Reported in themes, findings from the literature indicate that provider training and healthcare staff education, nurse-led strategies, patient and family teaching, academic education and research, and specialist support are current strategies used to enhance timely referrals of patients for hospice care. Implications of positive social change include improving quality of care at EOL, customer satisfaction, and creating a culture that is confident, competent, and open to engaging in difficult conversations about GOC at EOL.

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Dedication

I dedicate this project to my parents and my beloved son, Zayveon, I am who I am because of you. You make me want to be better. Thank you for your encouragement and for always believing in me.

This project is also dedicated to my late grandfather, Eduardo Matados. My grandfather's vision of me as a nurse and scholar propelled me into the profession. He taught me to lead, serve, and love selflessly. His words continue to give me hope, faith, and strength.

Acknowledgments

First and foremost, praises and thanks to God Almighty, for His faithfulness and all the blessings throughout my journey in completing my Doctor in Nursing Practice degree.

I would like to express my sincere gratitude to my project committee chair, Dr. Edna Hull for her guidance throughout this project. Her enthusiasm, sincerity, and dedication to teaching and mentoring future nursing leaders is admirable and inspiring. I am grateful for her words of encouragement, empathy, and patience. It was a great privilege and honor to have worked and studied under her guidance.

I am extremely grateful to my parents for their love, prayers, caring, and sacrifices for educating me and preparing me for my future. I am thankful for son, for his love, understanding, prayers, encouragement, and continuing support throughout my studies and completion of this project.

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Section 1: Nature of the Project

Introduction

Studies have shown that hospice care improves quality of life (QOL) at the end of life (EOL) for patients and their families while also controlling healthcare costs (Franklin & Stiles, 2014; Rolden, Bodegom, & Westendorp, 2014; Zhang, et al., 2009). Timely hospice referrals bring physical and emotional comfort for the patient and their families (Franklin & Stiles, 2014). Unfortunately, despite its known positive benefits, hospice care is almost an afterthought in that a significant number of patients are being referred to hospice care too late (Mattes & Sloane, 2015). In order to achieve quality EOL, medical providers must consider referral to hospice services early enough for patients to experience the benefits of hospice fully. Bischoff, Sudore, Miao, Boscardin, and Smith (2013) suggested that quality EOL care is likely to be achieved when a patient is admitted to hospice more than 72 hours prior to death.

The current trend in hospice use shows a disconnect between research and practice in that despite the great benefits of hospice services, there is poor utilization and patients are being referred too late. Some of the reasons for this disconnect have been associated with the healthcare providers’ discomfort in having the goals of care (GOC) discussions (Dobbins, 2016), reluctance in the prognostication of a patient’s chance of survival (Seaman, 2013), and healthcare providers’ report on lack of knowledge and skills in delivering serious news and determining when it is time to offer hospice care (Ethier, Paramsothy, You, Fowler, & Gandhi, 2018). In a survey, Piggott et al. (2019) suggested that oncologists need to be equipped with strong communication skills to help patients and families in GOC conversations at EOL. In order to close the gap, primary care providers (PCPs), the gatekeepers of healthcare and where the center of healthcare services originate, must identify and use evidence-based strategies that enhance timely hospice referrals (Solis, Mancera, & Shen, 2018).

My goal for this doctor of nursing practice (DNP) project was to critically appraise studies and synthesize findings from the literature on current evidence-based strategies used by PCPs for initiating timely hospice referrals. This capstone project correlates with DNP Essentials I and III, which are the scientific underpinnings for practice and clinical scholarship and analytical methods for evidence-based practice (American Association of Colleges of Nursing [AACN], 2006). The DNP project will bring about positive social change by improving the quality of care at EOL, customer satisfaction, and creating a culture that is confident, competent, and welcomes difficult conversations about the GOC at EOL in the primary care setting.

Problem Statement

Despite the scientific evidence suggesting the benefits of hospice in improving the QOL at EOL, hospice referrals continue to lag (Franklin & Stiles, 2014; Mattes & Sloane, 2015; Rolden et al., 2014). A significant number of terminally ill patients who could benefit from hospice care are referred too late (Mattes & Sloane, 2015). I currently work as a nurse practitioner in a skilled nursing facility. The facility also has a designated hospice unit. At the time that this project was conceptualized, a significant number of hospice patients died in less than a month after being admitted to the hospice unit. Most of the patients are referred directly from the hospital and have rarely been offered hospice prior to the hospital admission. The GOC discussions as well as hospice referrals are rarely done by PCPs.

The gap between research and practice is not unique in my organization. Evidence suggests that this disconnect is due to the healthcare providers' discomfort in having GOC discussions (Dobbins, 2016), reluctance in the prognostication of the patient's chance of survival (Seaman, 2013), and lack of knowledge and skills in delivering serious news and determining when it's time to offer hospice care (Ethier et al., 2018). Piggott et al. (2019) also suggested that oncologists need to be equipped with strong communication skills to help patients and families in GOC conversations at EOL. GOC generally pertains to the process where deliberation and decision-making regarding the use versus non-use of life sustaining treatments for seriously ill and hospitalized patients take place (Roze des Ordons, Sharma, Heyalnd, & You, 2015).

In order to close this practice gap, the PCP in the primary care setting is the ideal person to initiate GOC discussions. The primary care setting is the focal point of healthcare services. PCPs are the gatekeepers of healthcare, especially for Medicare beneficiaries. Therefore, PCPs must identify and use evidence-based strategies that enhance timely hospice referrals (Solis et al., 2018). For the purpose of this project, PCPs are defined as physicians and non-physician professionals such as nurse practitioners (NP) and physician assistants (PA) who provide primary health care (Peters, 2018). In this project, I focused on identifying strategies used by PCPs that enhance timely hospice referrals. Findings generated from this capstone project will inform the practice of NPs and other nurses working in the primary care settings, as well as other healthcare professionals who provide primary care. Moreover, the result of this DNP project will lead to a timely hospice referral, improving quality EOL.

Purpose

The disconnect between the evidence suggesting the benefits of hospice care and the lag in hospice use is concerning in that it suggests that a significant number of terminally ill patients are receiving futile interventions at EOL. Despite the strong evidence of hospice’s positive benefits, the evidence also suggests that terminally ill patients are not being referred in a timely manner (Mattes & Sloane, 2015). In order to address this practice issue, it is imperative that healthcare providers be equipped with the knowledge and skills that are required to confidently identify patients and refer them in a timely manner for admission to hospice care. Therefore, my intent for this EBP project was to search for evidence-based strategies that are used by PCPs that enhance timely hospice referrals. Using a systematic literature review approach, the practice-focused question that guided this project was: what evidence-based strategies used by PCPs for initiating timely hospice referrals have emerged in the literature in the last 10 years?

Nature of the Doctoral Project

My goal for this DNP project was to find the best evidence-based strategies that enhance timely hospice referrals for terminally ill patients in the primary care setting. My goal was to improve the quality of care at EOL, patient care outcomes, customer satisfaction, and control healthcare cost. More specifically, I developed this DNP project for the purpose of addressing the practice gap between the benefits of hospice and the problem of late referrals of patients admitted to hospice services. I conducted a systematic literature review to complete this project. I used both primary and secondary sources to answer the practice-focused question of this project. Primary sources included reviews of journal articles, dissertations, and conference proceedings. Secondary sources included reviews of textbooks, systematic reviews, meta-analyses, and integrated reviews.

In the literature search, I focused on answering the practice-focused question: What are the best strategies used by PCPs for initiating timely hospice referrals? I completed the systematic literature review to retrieve and appraise relevant sources published in the last 10 years. In consultation with the university library liaison, I followed specific procedural steps for carrying out the review. These steps included formulation of a clearly stated review question, identification of the scope of the review, definition of explicit inclusion and exclusion criteria for selecting sources, and performance of a comprehensive search of the literature to locate relevant studies using electronic search engines. Additionally, the review included the analysis, synthesis, and reporting of findings to answer the practice-focused question. I completed the analysis, synthesis, and reporting by following the established inclusion and exclusion criteria, using a literature matrix (Appendix A), and identifying themes that answered the practice-focused question (appendix B). Finally, I addressed recommendations for practice and future studies.

Significance

Stakeholders for this capstone project include all terminally ill patients, their families, PCPs, and other healthcare providers providing care to patients with a terminal diagnosis or life-limiting illness. For patients and families, this project will help improve the GOC experience and enhance timely referrals improving QOL at EOL. It will also provide a body of information that will inform practice in caring for and serving terminally ill patients for PCPs and other healthcare providers. Findings generated from this project will also add to the body of knowledge that informs nursing practice. The information gathered in this project may also be used in guiding the practice of healthcare providers when caring for those chronically ill patients who may not necessarily qualify for hospice care but may be eligible for palliative care services. Finally, a timely hospice referral will improve the quality of care at EOL and family/caregiver satisfaction which could in turn lead to increased use of hospice services by those who need it. This positive experience can lead to a culture change where patients and their families understand the value of hospice care during the final moments as well as allow an individual to die with dignity.

Summary

In this section I discussed the topic of the DNP project, which is to present current evidence outlining the benefits of hospice care in improving the QOL at EOL. I also discussed the practice gap between the benefits of hospice and the lack of utilization and provision of timely referrals. I also gave an overview of the nature of the project. This included the goal of the project, which is to find the best evidence-based strategies that enhance timely referrals for terminally ill patients in the primary care setting, and a brief discussion of the steps that I carried out to complete the systematic literature review. In the next section, I will cover the concepts, models, and theories informing the project, the project's relevance to nursing practice, local background and context, and the role of the DNP student.

Section 2: Background and Context

Introduction

Hospice care has been shown to improve QOL at EOL with reductions in healthcare costs (Franklin & Stiles, 2014). Despite these strengths, evidence suggests that an increased number of patients are not referred to hospice at all or in a timely manner (Franklin & Stiles, 2014; Mattes & Sloane, 2015; Widick, & Makani, 2019; Rolden et al., 2014). The lack of healthcare providers' confidence in conducting GOC discussions, prognostication, and lack of knowledge and skills in delivering serious news has been identified as barriers to a patient's timely referral to hospice (Dobbins, 2016). In this DNP project, I focused on searching the evidence-based literature outlining the strategies used by PCPs for enhancing timely hospice referrals. I conducted a systematic literature review to answer the practice focused question: What evidence-based strategies used by PCPs for initiating timely hospice referrals have emerged in the literature in the last 10 years?

Concepts, Models, and Theories

I used several concepts, models, and theories to inform and guide the development of this DNP project. In the next section, I provided a description of these sources. Last, I presented a glossary of terms used in the project.

Joanna Briggs Institute's Systematic Review Process

I used the Joanna Briggs Institute's Systematic Review (JBI-SR) process to complete the DNP project (Joanna Briggs Institute [JBI], 2018). The JBI model of evidence-based healthcare was developed and updated in 2016 by the JBI. JBI is an international, non-profit, evidence-based practice healthcare research center based in the University of Adelaide, Australia. JBI collaborates with over 70 entities internationally (JBI, 2018). JBI describes a systematic review as a comprehensive and unbiased synthesis of significant research using a rigorous and systematic approach (Aromataris & Munn, 2017; Lockwood et al., 2018). A Systematic review is an explicit methodological review of evidence that is guided by a clearly formulated question to identify, select, and critically appraise relevant primary research. Additionally, in carrying out a systematic review, the researcher extracts and synthesizes data from the literature that are included in the review (JBI, 2018). The stages of JBI-SR are development of the proposal protocol, stating the questions or hypothesis, identifying the criteria that will be used to select literature, outlining the strategy that will be used to identify relevant literature, establishing how the quality of the primary studies will be assessed, detailing the method of data extraction, and synthesis and summary (Godfrey & Harrison, 2015).

The development of the review protocol entails the plan to ensure the scientific rigor of the study and minimize biases (Godfrey & Harrison, 2015). It serves as a structured method to maintain focus on the chosen topic for review. It must contain the review question, criteria for the literature review, databases that will be used for searches, the method on how the quality of primary studies will be assessed, specific details that needs to be extracted from studies, and synthesis strategies (Godfrey & Harrison, 2015). The second stage of JBI-SR is the statement of the review question. In this stage, the researcher may use the Population/Problem/Population, Intervention, Control/Comparison/Context, and Outcome (PICO) method in developing answerable questions addressing the concepts involved (Aromaratis & Pearson, 2014; Godfrey & Harrison, 2015). The development of the review question leads to the next stage, the development of the inclusion and exclusion criteria. The inclusion criteria must address participants, interventions, and outcomes. The research methodologies that will be considered for inclusion may also be specified at this stage (i.e. clinical trials, randomized controlled trials, case studies, etc.). In outlining the strategy in finding relevant literature, a decision tree is useful. Suggested steps included in the search process by Godfrey and Harrison (2015) include:

1. Finding key words: listing relevant words that may be used in describing the topic.
2. Initial search: performing a limited search of MEDLINE and CINAHL by using the key words and preliminary subject headings then saving the *on topic* and *gold standard* articles that are considered appropriate for the review (p. 8).
3. Second search: performing a second search in a wider range of databases using the relevant subject headings and key words.
4. Hand search: performing a hand search of reference lists of articles that have already been selected and choose any article that might be related to the topic.
5. Selecting studies: reviewing all articles for appropriateness by going over the title and abstract or full article if abstract is not available.
6. Maintaining a detailed record of all searches: recording databases searched, years and/or other limitations, subject headings and keywords, total number of

articles displayed for each search strategy, number of articles that were included and excluded (Godfrey & Harrison, 2015).

The assessment of the quality of the primary studies involves the selection and critical appraisal process. During the selection process, the researchers are guided by the question “should the paper be retrieved?” whereas during the critical appraisal, researchers are guided by the question “should the study be included in the review?” (Godfrey & Harrison, 2015, p.11). The main purpose of the critical appraisal of literature is to limit the biases while establishing the validity of the study. The last stage in JBI-SR is data extraction, where the pertinent data are summarized in order to provide the necessary details and evidence to answer the research question (Godfrey & Harrison, 2015).

Preferred Method Items for Systematic Reviews and Meta-Analyses (PRISMA)

I also used the Preferred Method Items for Systematic Reviews and Meta-Analyses (PRISMA) (Moher, Liberati, Tetzlaff, Altman, and The PRISMA Group, 2009) as a guide to complete the DNP project and to compliment the JBI-SR protocol. Although PRISMA is a stand-alone systematic review process, I used the PRISMA checklist and flow diagram to further strengthen the methods of JBI-SR.

PRISMA is the recommended guideline for authors to use when reporting a systematic literature review or meta-analysis. It can also be used for reporting systematic reviews of other types of research. The use of PRISMA also improves the quality of the reporting of the review (Moher, et al., 2009). In June 2005, 29 participants including review authors, methodologists, clinicians, medical editors, and a consumer met in a 3-day consortium to revise and expand the QUality Of Reporting Of *M*eta-analyses

(QUOROM) checklist which evolved into what is now called the PRISMA checklist (Moher, et al., 2009). Along with it, the group also approved the flow diagram.

The PRISMA checklist consists of 27 items that need to be met when reporting a systematic review or meta-analysis. The checklist also addresses the process in all the stages of the JBI-SR mentioned previously, but in a more detailed manner. The PRISMA checklist outlines specific criteria in each section. The sections are:

1. Title: where the report is identified as a systematic review, meta-analysis, or both.
2. Abstract: provides a structured summary which includes background, objectives, data sources, study eligibility criteria, participants and interventions, study appraisal and synthesis methods, results, limitations, conclusions and implications of key findings, and systematic review registration number.
3. Introduction: addresses rationale for the review and provides an explicit statement of question/s being addressed using the PICO method.
4. Methods: covers protocol and registrations, eligibility criteria, information sources, search, study selection, data collection process, data items, risk of bias in individual studies, summary measures, synthesis of results, risk of bias across studies, and additional analysis.
5. Results: addresses some of the same items in the methods such as: study selection, study characteristics, risk of bias within studies, results of individual studies, synthesis of results, risk of bias across studies, and additional analyses.
6. Discussion: addresses the summarization of the main findings, strengths, and relevance; limitations of the study; and provides a general interpretation of the

results in the context of other evidence and last, and implications for future research.

7. Funding: describes the sources of funding for the systematic review and other support (Moher, et al., 2009).

Comfort Care Theory

The comfort care theory is a middle range nursing theory that was developed by Katherine Kolcoba in the 1990s. It was developed by examining literature from several disciplines, including nursing (archaic, historical, and contemporary), medicine, psychology, psychiatry, ergonomics, and English (Petripin, 2016). The theory is conceptualized and operationalized as a holistic outcome. Comfort is a holistic outcome as it affects the multifaceted aspects of a person in that the interventions in one aspect of a person indirectly enhances the other aspects. The basic assumptions of the comfort care theory are: “(a) human beings have holistic responses to complex stimuli, (b) comfort is a desirable holistic outcome that is specific to nursing, and (c) human beings strive to meet basic comfort needs” (Kolcoba, 1994, p. 1178).

The comfort care theory has two dimensions. The first dimension consists of three states which are relief (the experience of meeting a specific need), ease (the state of calm and contentment), and transcendence (the state when ordinary powers are enhanced). The second dimension of comfort is the context in which comfort occurs. These are physical (bodily sensations), psychospiritual (internal awareness of self), social (interpersonal, family, and cultural relationships), and environmental (light, noise, ambience, color, etc.; Kolcoba, 1994, 1995; Petripin, 2016).

The comfort care theory fits this DNP project in that comfort is a desirable outcome at the end-of-life. It is essential for a peaceful death as a dying person requires psychological strength and acceptance. The comfort care theory stands on these concepts and is operationalized to elicit a holistic outcome. A person's response to a stimulus is multifaceted in that what affects one aspect may enhance the others. The theory informs the care of a terminally ill patient first by supporting that comfort is a desirable goal. A timely patient referral into hospice care by identifying the strategies that enhance a hospice referral meets all dimensions of comfort. Once a patient is enrolled in hospice, comfort is promoted by addressing and relieving symptoms that cause suffering, allowing the patient to die with dignity. Furthermore, comfort goes past physical bounds of the patient's well-being in that it can be achieved also by addressing the psychospiritual, social, and environmental issues that will promote comfort (Kolcoba, 1994, 1995).

Key Terms

Healthcare providers: licensed medical personnel other than a PCPs.

Hospice care: defined as medical care provided to patients diagnosed with a terminal illness and with a life expectancy of less than 6 months. It includes symptom control, pain management, palliative care, and other supportive services (Mulville, Widick, & Makani, 2019).

Palliative care: an approach that improves the quality of life of patients and their families who are faced with problems associated with life-threatening illness through prevention and relief of suffering via early identification and treatment of symptoms like pain and other physical problems, psychosocial, and spiritual regardless of the cause or diagnosis (Buss, Rock, & McCarthy, 2017).

Relevance to Nursing Practice

Research has shown that timely referral to hospice care can enhance the quality of life at the EOL. Timely hospice referral yields positive outcomes for patients, families, and caregivers because of a decrease in the use of unnecessary hospital-based services. Timely hospice referral also decreases deaths in the hospital setting. Furthermore, hospice services reduce medical cost (Franklin & Stiles, 2014; Mattes and Sloan, 2015; Mulville et al., 2019; Rolden et al., 2014). Ironically, despite the overwhelming evidence suggesting the benefit of timely hospice referral, studies suggest that hospice referrals are being made too late ((Franklin & Stiles, 2014; Mattes and Sloan, 2015; Mulville et al., 2019; Rolden et al., 2014). Moreover, current oncologic benchmarks suggest that patients should be enrolled in hospice approximately 3 months prior to death; ironically many patients survive less than 1 month after hospice referral (Mattes & Sloan, 2015; Mulville et al., 2019). In a retrospective review of oncology patients' hospice timely referrals, Mulville et al. (2019) found that hospice patients spent a median of 10 days in hospice care, 71% (n = 161) of patients were in hospice 30 days or less, and 56% of patients were in hospice 10 days or less. This information confirms that terminally ill patients are admitted into hospice care too late and short of the oncologic benchmark suggesting that terminally ill patients should be enrolled in hospice 3 months prior to death.

The current issue is not unique to oncology patients or the hospital setting in that hospice care in nursing homes has become a common practice (Mattes & Sloan, 2015; Miller, 2015). Also, according to Miller (2015), 60% of patients enrolled in Medicare hospice had non-cancer diagnoses, but the proportion was about 80% in nursing homes. Additionally, 67% of older adults with dementia die in nursing homes. Similarly, Miller (2015) reported that in 2012, the median length of hospice stays in nursing homes was 27 days. Mattes and Sloane (2015) stated that although hospice utilization has doubled recently, 30% of the patients admitted into hospice died within 3 days and 40% were transferred from intensive care units suggesting that the patients most likely received futile interventions at EOL.

The reasons for the disconnect between the positive benefits of hospice care and late referral are the healthcare provider's discomfort in conducting a GOC discussion (Dobbins, 2016), reluctance to prognostication of patient's survival (Seaman, 2013), and healthcare provider's lack of knowledge and skills in delivering serious news and appropriate timing to offer hospice care/referral (Ethier, et al., 2018). Schmit et al. (2016) found that most medical residents had inadequate training in EOL conversations during medical school and residency. Despite the lack of training, EOL conversations during residency are common and are often unsupervised (Schmit et al. (2016).

Some of the strategies that were previously employed in an attempt to enhance timely hospice referrals are:

1. Educating patients and healthcare professionals about EOL and services available through hospice such as symptom control, pain management, palliative care, and other supportive services (Mulville et al., 2019).
2. Selective staff recruitment and staff training to increase palliative care expertise (Miller, 2015).
3. Incorporating a nurse navigator who can explain hospice care and its benefits without changing the patient's wishes if he/she still wants life-prolonging measures (Mulville et al., 2019).

My goal for this DNP project was to search for evidence-based strategies that are used by PCPs that enhance timely hospice referral through a systematic literature review approach. The collection and synthesis of best practices will guide PCPs in timely hospice referrals, hence improving QOC at the EOL for terminally ill patients.

Context and Role of the DNP Student

The DNP project is a systematic literature review. Therefore, it was not bound by a setting but instead structured using inclusion and exclusion criteria. The inclusion criteria included literature written between 2010 to 2020, strategies used by PCPs that enhance timely referrals to hospice, original studies, cancer and non-cancer diagnosis, and articles written in English.

I am a master's prepared nurse with over 25 years of diverse experience. My most recent experience gave me an opportunity to manage the care of patients in the hospice unit. During this time, I observed that a large number of terminally ill patients were being referred to hospice too late. Moreover, there were a significant number of PCPs, hospitalists, and medical residents who, through observation, did not feel comfortable conducting the GOC conversation and requesting our service meet with the patient and family. Acknowledging the practice problem, I assumed the role of leader in search of solutions. Searching for solutions included articulating the problem and reviewing theories to understand the problem. Thus, my leadership role included identification of the practice problem and carrying out a systematic literature review with plans to implement strategies to address the problem in clinical practice setting. Last, recognizing that the practice problem occurred in my clinical setting I faced obstacles and implemented a plan to address potential biases or conflicts of interest. Potential biases were managed by concealing my organization's name and employees. Researcher subjectivity was avoided by following the theories and methods that were used to complete the systematic literature review. Moreover, I collaborated with the university's library liaison during the literature search to ensure that a comprehensive and unbiased literature search was conducted therefore, minimizing subjectivity and faulty methods of data collection. Last, I was guided and mentored by the committee chair during the entire process of the project to ensure accurate project design and implementation.

Summary

In this chapter I discussed the comfort care theory, the model that informs the DNP project, and the utilization of the JBI-SR process and PRISMA steps as guiding frameworks. The comfort care theory fits the DNP project as comfort is a desirable outcome at the end-of-life. Comfort is essential for a peaceful death as a dying person requires psychological strength and acceptance. The comfort care theory stands on these concepts and is operationalized to elicit a holistic outcome. The comfort care theory goes beyond the physical bounds of the patient’s well-being. Timely referral to hospice services meets all the previously mentioned dimensions of comfort. While the benefits of hospice care have been well documented in the literature, timely referrals of patients for hospice care by PCPs is a problem. Thus, using a systematic literature review approach, this DNP project was designed to address this gap in practice. Section 3 of the project includes identification and discussion of sources of evidence and the method for the collecting and analyzing sources of evidence used to answer the practice-focused question.

Section 3: Collection and Analysis of Evidence

Introduction

Studies have shown that hospice care improves QOL at EOL and reduces healthcare costs. Unfortunately, despite these positive outcomes, evidence suggests that a significant number of patients are referred to hospice too late (Franklin & Stiles, 2014; Mattes and Sloan, 2015; Mulville et al., 2019; Rolden et al., 2014). My goal for this DNP project was to complete a systematic literature review identifying the current evidence-based strategies used by PCPs for enhancing timely referral to hospice care. I used the JBI-SR and PRISMA model as guides for conducting the review. In this section of the project, I present the sources of evidence, the tools used for collection, and the process used for analysis and synthesis of data.

Practice-focused Question

Although there is ample evidence suggesting that hospice care is imperative in ensuring QOL at EOL, timely hospice referrals have been a long-standing challenge occurring in the primary care setting. Terminally ill patients are referred too late into hospice care (Franklin & Stiles, 2014; Mattes and Sloan, 2015; Mulville et al., 2019; Rolden et al., 2014). This disconnect between evidence and practice is a concern as it suggests that an increased number of terminally ill patients are receiving futile interventions at EOL. My goal for this DNP project was to identify the current state of evidence-based strategies used by PCPs for enhancing timely hospice referrals. Conducting the systematic literature review, sources were searched to answer the practice-focused question: what evidence-based strategies used by PCPs for initiating timely hospice referrals have emerged in the literature in the last 10 years?

Sources of Evidence

My goal for this systematic literature review was to locate the best evidence-based strategies used by PCPs for enhancing timely hospice referrals for terminally ill patients admitted to the primary care setting. I included primary sources of evidence to answer the practice-focused question. Primary sources are original sources of information written by the person or researcher who developed the idea, conducted the study and included details of the problem, methodology, results, and discussion as described by the researcher (Oermann & Hayes, 2016). According to Oermann and Hayes (2016), secondary sources of evidence include literature reviews, descriptions of clinical projects, and discussions of models and theories reported in articles, books, and other references written by an author other than the original author. I used a systematic literature review as it is the most appropriate approach for aligning with the purpose of this DNP project and for answering the practice-focused question: What evidence-based strategies used by PCPs for initiating timely hospice referrals have emerged in the literature in the last 10 years?

Published Outcomes and Research

As previously stated, I conducted a systematic literature review to answer the practice-focused question. With the university library liaison’s assistance, I performed a systematic literature search to retrieve peer-reviewed relevant sources published in the last 10 years. I followed specific procedural steps for carrying out the review. These steps included formulation of a clearly stated review question, identification of the scope of the review, definition of explicit inclusion and exclusion criteria for selecting sources, and performance of a comprehensive and exhaustive search. The literature search to locate relevant studies was completed by using multiple electronic databases including CINAHL, PubMed, Medline, Proquest, Cochrane and Google Scholar. Because my focus was on current sources of evidence, I narrowed the scope of my search to include sources of evidence published within the last 10 years. I used key search terms to locate relevant sources included *hospice, palliative, terminal, end of life, end-of-life, primary care, primary health care, primary healthcare, family practice, community care, general practice, generalists, referral,* and *consults*. I also used Boolean phrases such as *and or* to separate synonymous words to seek for more relevant results. Types of literature and sources searched included research studies, clinical practice articles, theoretical articles, editorials, commentaries on policies and professional organizational websites supporting hospice and palliative care. Finally, I performed a hand search of the reference list of each article in an effort to provide an exhaustive, comprehensive review of the literature.

Protections

As this is a systematic review of the literature, there were no human subjects or partner organization. However, I completed Form A of the DNP Scholarly project manual as a requirement for completion of this project. Additionally, I submitted the form to the Institutional Review Board (IRB) of the university. Pannuci and Wilkins (2010) posited that bias occurs when an error is introduced into sampling by favoring one outcome over another. To ensure that there was no researcher bias, I followed the established parameters of the literature search (i.e. inclusion and exclusion criteria) and inclusion of all information, whether favorable or not, based on the focus of the literature search.

Analysis and Synthesis

I performed the literature review using the inclusion and exclusion criteria established. I used a literature review matrix table (Appendix A) to help organize and record data as well as the PRISMA flow diagram as a decision aid in choosing and selecting eligible literature. I also arranged the data in order of significance or strength using the hierarchy of evidence for evidence-based practice by Ackley, Swan, Ladwig, and Tucker (2008). The hierarchy of evidence follows:

> Level I: systematic literature review or meta-analysis of all relevant randomized controlled trials (RCTs),
>
> Level II: evidence obtained from at least one well-designed RCT,
>
> Level III: evidence obtained from RCT without randomization,
>
> Level IV: evidence obtained from well-designed case control or cohort studies,
>
> Level V: evidence from systematic reviews of descriptive and qualitative studies,
>
> Level VI: evidence from descriptive or qualitative study, and
>
> Level VII: evidence from the opinion of authorities and/or reports of expert committees (p. 7).

Furthermore, I critically appraised the sources of evidence using additional sources such as JBI appraisal checklist and the Fineout-Overholt, Melnyk, Stillwell, and Williamson (2010) rating scale for appraising sources of evidence.

Summary

In summary, although there is overwhelming evidence suggesting that hospice care yields positive outcomes, improves QOL at EOL, and reduces cost; hospice referrals continues to lag (Franklin & Stiles, 2014; Mattes & Sloan, 2015; Mulville et al., 2019; Rolden et al., 2014). Thus, the purpose of this DNP project was to answer the practice-focused on current evidence-based strategies used by PCPs for initiating early hospice referrals. This chapter included sources of evidence, methods of data organization, plans for data analysis and synthesis used to answer the practice-focused question along with the plans for addressing human subject protection. In the next chapter, I will address findings, implications, recommendations, strengths, and limitations of the project.

Section 4: Findings and Recommendations

Introduction

Timely referral of terminally ill patients to hospice care brings physical and emotional comfort to both patient and family members; yet despite these benefits, current trends in hospice use shows a disconnect between research and practice in that terminally ill patients are being referred to hospice too late (Mattes & Sloane, 2015). My goal for this DNP project was to find the best evidence-based strategies used by PCPs that enhance timely hospice referrals. In searching for sources of evidence, I focused on answering the practice-focused question of what are the best strategies used by PCPs for initiating timely hospice referrals? In the section, I addressed topics including sources of evidence, findings and implications, recommendations as well as strengths and limitations of the project.

Sources of Evidence

To complete this DNP capstone project, I collaborated with the university library liaison and conducted an exhaustive and comprehensive literature review searching the databases of CINAHL, PubMed, MEDLINE, ProQuest, Google Scholar, and Cochrane. I used key search terms including *hospice, palliative, terminal, end of life, end-of-life, primary care, primary health care, primary healthcare, family practice, community care, general practice, generalists, referral, consults, timely, enhance,* and *enabler.* I also used Boolean phrases *and or* to separate synonymous words to seek for more relevant results. Additionally, I used a literature matrix table (Appendix A) to summarize the results from the search. In order to provide the most recent evidence addressing the practice-focused question, I focused the search on the identification of relevant sources of evidence to include published literature between 2010 and 2020. Additional criteria applied to the selection of sources for this review included selecting sources focusing on cancer and non-cancer diagnosis and written in English. Finally, I conducted a hand search of the reference list of each article for an exhaustive and comprehensive literature review.

The initial literature search using key terms *hospice, palliative, terminal, end of life, end-of-life, primary care, primary health care, primary healthcare, family practice, community care, general practice,* and *generalists y*ielded 20,259 articles. I then filtered the search choosing full text only, peer reviewed, and articles published between 2010 to 2020. This step resulted in 9,251 articles. I then added the key words *refer* and *consult* and selected subject terms in the third search category box which yielded 246 articles. For the third step, I added the key term *timely* in the fourth search box and selected text in the search category box. This step yielded 36 articles. This step serves as the beginning phase of the PRISMA Flow Diagram (Figure 1). I repeated this process two more times using the key words *enhance* and *enabler* in the third step. This step did not yield any additional articles. Finally, I performed a hand search of the reference list for a thorough and exhaustive search of the literature.

I reviewed the titles and abstracts and included articles if they had relevant information that addressed the practice-focused question. I recorded my search process to track search strategies. As previously stated, I also used the PRISMA flow diagram (Moher, et al., 2009) to document a systematic process in determining which articles met the inclusion criteria for the review (Figure 1). Out of 36 articles reviewed, two articles met the inclusion criteria.

Recognizing the limited resources solely addressing the strategies used by PCPs to enhance timely referrals, I consulted with the DNP committee chair and together decided to expand the literature search to examine additional avenues that facilitated timely referrals to hospice and palliative care. Thus, I conducted an expanded search in collaboration with the committee chair. This stage of the review included the addition of the search key term *nurses*. This step yielded six additional sources which led to a total of eight sources included in the review. All eight articles met the inclusion criteria for the review. Next, using several published resources (Ackey et al., 2008; Fineout-Overholt et al., 2010; JBI, 2018) to critically appraise evidence for integration into clinical practice, all eight sources were reviewed and assigned a level of evidence. I then added the data extracted from these additional resources into the literature review matrix (Appendix A) to record and organize the additional sources of evidence.

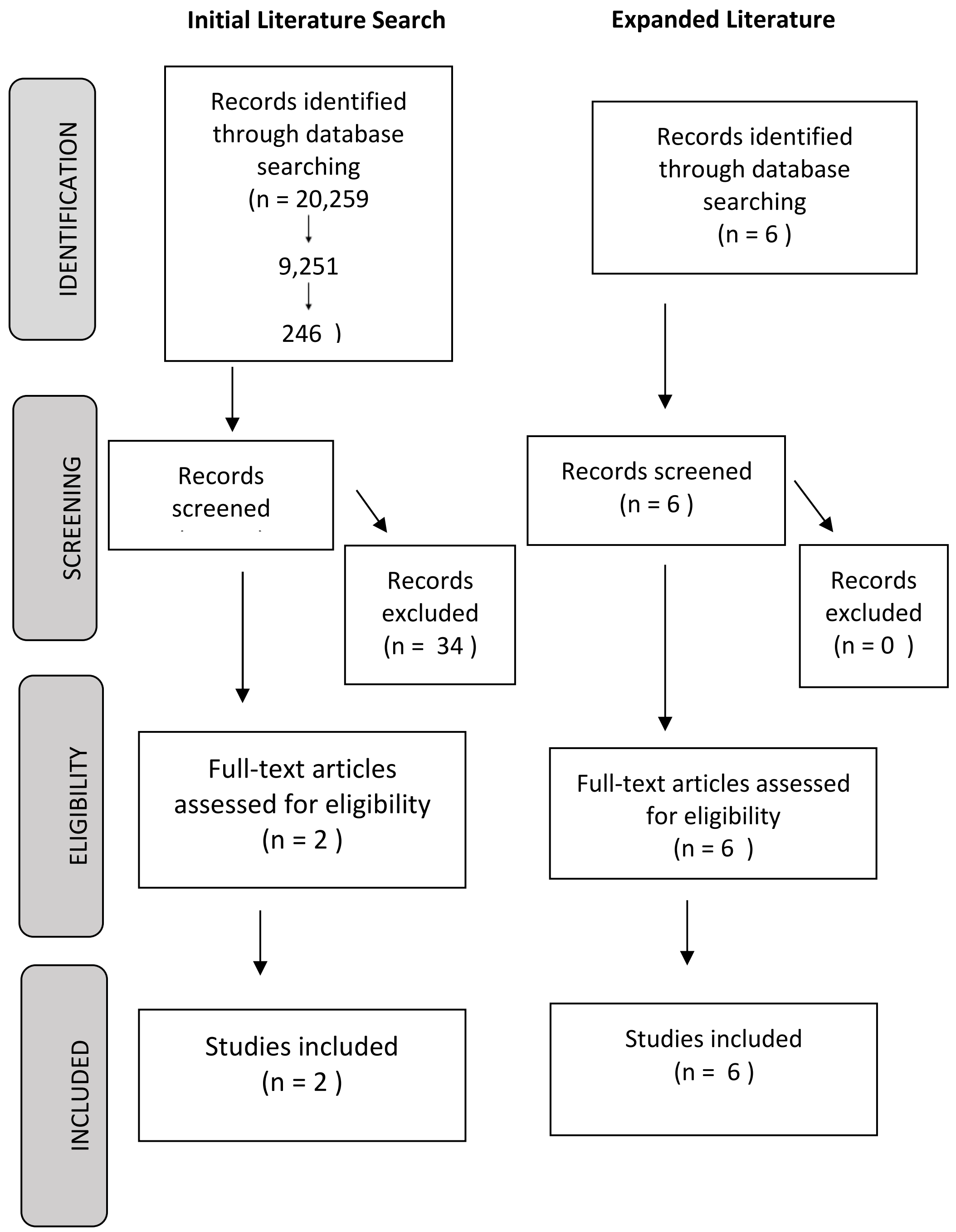

Figure 1. PRISMA flowchart

Findings and Implications

My goal for this DNP project was to find the best evidence-based strategies used by PCPs that enhance timely hospice referrals. Following the extraction of the sources meeting the criteria of the review, I identified several themes reflecting current strategies that enhance timely hospice referrals: provider training/ healthcare staff education and nurse-led interventions. Additional themes included patient and family teaching, academic education and research, and last, specialist support. The section that follows serves as a discussion of findings supporting these themes. Appendix B serves as a list of identified themes and evidence-based strategies.

Provider Training and Healthcare Staff Education

Following a randomized control trial, Thoonsen et al. (2016) conducted qualitative interviews with general practitioners on their views of an education and training program on palliative care. The researchers evaluated the general practitioners' (GP) experiences following participation in a training program identifying palliative care patients, using a RADbound indicator for Palliative Care needs (RADPAC) and anticipatory care planning using Problems Square. Nine GPs and six consultants participated in the study.

Thoonsen et al. (2018) found that most GP participants reported small changes in their attitude and their way of thinking about palliative care and how to provide it. Furthermore, the training program widened their views on palliative care and realized that other patients with chronic diseases may also benefit from its timely initiation. The RADPAC tool helped GPs become aware of patients who may benefit from palliative care. Although most GP participants did not continue to use the assessment tool, several reported that they integrated the indicators in their daily practice. Additionally, several GPs reported continued difficulty in communicating EOL issues with palliative care patients with chronic obstructive pulmonary disease (COPD) or congestive heart failure (CHF) as many patients do not realize that their condition is life-limiting. Some interviewees reported that the training increased their awareness and directed more attention to patients who may benefit from palliative care. Among those who reported this, GPs also mentioned that they noted a change in how they predicted, communicated, and anticipated future problems allowing them to discuss these issues more regularly and proactively with their patients. Overall, the GPs reported positive experiences on the use of Problem Square as it helped them consider actual and possible future problems, needs, and scenarios addressing all dimensions, and it prevented problems from being overlooked.

In the same study, consultants who participated in a focus group reported that although they consider themselves capable partners with GPs in proactive palliative care planning, they were not able to answer each question asked by interviewers (Thoonsen et al., 2016). Consultants expressed the need to know where to retrieve information when in doubt, or when they lack the expertise on palliative care. They also admitted that they could benefit from extra training on proactive palliative care planning for patients with COPD and CHF (Thoonsen et al., 2016).

Mulville et al. (2019) conducted a retrospective review aimed at identifying barriers impacting timely referrals to hospice for oncologic patients near EOL. The study was performed by reviewing electronic health records (EHR) of 413 deceased patients with malignancies who passed away between January 1, 2015 to December 31, 2015. The researchers found that 44% of the deceased patients were enrolled in hospice and 56% were non-hospice patients (Mulville et al., 2019). While reasons for treatment such as symptom relieve or curative measures were not included in the report, treatment received by both groups showed that the largest percentage of hospice patients received aggressive treatment such as radiation and chemotherapy (26%) or a combination of radiation, chemotherapy, or surgery (Mulville et al., 2019). Researchers also noted that the non-hospice group received only chemotherapy at 21%, followed by a combination of treatment modalities with 18% receiving chemotherapy, radiation, and surgery (Mulville, et al., 2019). There was also a significantly greater proportion of hospice patients who received radiation plus chemotherapy than non-hospice patients. Additionally, most patients who enrolled in hospice (71.4%) spent less than 30 days in hospice with 83 of those patients spending 10 days or less enrolled in hospice (Mulville, et al., 2019). Overall, the median number of days spent in hospice care was 10 days with 56% of patients who were in hospice dying in the hospital (Mulville et al., 2019). Unfortunately, these findings fall in line with the current evidence indicating that most hospice referrals are made too late (Mulville et al., 2019). These findings also fall short in meeting the current oncologic benchmark of having patients enrolled in hospice three months prior to death (Mattes & Sloane, 2015; Mulville, et al., 2019). Thus, the significant number of treatment interventions and low number of hospice enrollment days revealed in the study suggest that terminally ill patients are likely receiving aggressive medical treatment at EOL with questionable inclusion of GOC conversations between providers and family members. As repeatedly mentioned, timely hospice referrals are critical to a quality EOL thus, actions must be taken to promote longer patient stays in hospice care. Similar to Thoonsen et al. (2016), Mulville, et al. (2019) identified that prognostic inaccuracy by physicians contribute to shorter number of days in hospice and poor quality EOL care. Therefore, the education and training of medical providers on prognostication could potentially facilitate timely hospice referrals. Moreover, patients and healthcare professionals must be educated on EOL issues and services available through hospice to include the benefits of hospice care. Researchers also suggested the introduction of palliative care early in the diagnosis and/or treatment phases, especially outpatient palliative care services, as it has been shown to lead to more appropriate use of hospice and enhanced end-of-life care (Mulville, et al., 2019).

Since palliative care has been shown to enhance timely hospice referrals, the provision of a palliative care setting may also be beneficial. A systematic review by Carey et al. (2019) was carried out to examine the type and prevalence of barriers and enablers to the provision of palliative care reported by PCPs. Findings showed that more than 50% of the sources reviewed reported the lack of confidence in PCPs in general or in relation to specific tasks with palliative care as a barrier to the provision of palliative care (Carey et al., 2019). The lack of confidence was reported to spread across several areas including treatments, symptom management, and psychological and communication issues (Carey et al., 2019). Furthermore, some of the most common barriers affecting timely hospice referrals included bureaucratic procedures, communication between healthcare professionals, primary care provider’s personal commitments, and their skills or confidence (Carey et al., 2019). The most common enablers are education and training of staff to assist with care delivery, better communication between professionals, and templates to facilitate referral to other patient services available after hours. Additionally, several studies reported that experience, training, and the older age of PCPs are positively related to confidence in palliative care delivery (Carey et al., 2019). Other reported enablers included diversifying the palliative care workforce with more nurses available to provide out-of-hours care, and more respite workers trained in palliative care, as well as increasing access to multidisciplinary support and out-of-hours telephone support. As with Thoonsen et al. (2016) and Mulville et al. (2019), the outcome of this systematic review validates the need for healthcare staff education and training as a source for enhancing timely referrals of patients for hospice care. Furthermore, comprehensive training of PCPs to address lack of confidence is important. This should include training at the undergraduate level as well as ongoing professional development opportunities. Future research is needed to develop and evaluate robust training programs that address the provision of palliative care in primary care settings.

Nurse-led Interventions

In an observational pilot study, Kirk et al. (2019) assessed a nurse-led intervention for two home health agencies with similar census and average lengths of stay. Each agency identified a registered nurse (RN) and a clinical manager to participate in the intervention. The clinic manager was responsible for identifying patients meeting the criteria as *high risk* or *frail* using the established criteria and notifying staff RNs of the need for further evaluation for hospice or palliative care. The RNs administered the screening questions to eligible patients or proxies, reviewed results of screening questions and obtained consents to follow up with their physician regarding hospice or palliative care, and if authorized, initiated referral for hospice care using the agency's referral process. Of the 29 patients meeting the criteria for *high risk* or *frail*, 28 (96.6%) were enrolled in the pilot study and screened (Kirk et al., 2019). However, only 4 of 27 patients who screened positive for hospice eligibility enrolled in hospice (Kirk et al., 2019). The high enrollment and completion rate of screening suggests that patients are willing to discuss GOC, needs, and preferences. While patients may not be inclined to enroll in hospice after the initial encounter, continued GOC conversations and patient and family education are beneficial and could potentially lead to hospice enrollment.

In the previous mentioned study by Mulville et al. (2019), researchers also suggested another nurse-led strategy - the use of nurse navigators. Nurse navigators coordinate and integrate diverse health services for patients. They guide patient transitions through the health system ensuring continuity of care and educate patients on self-management (Coyne et al., 2020). Nurse navigators were found to be beneficial in transitioning patients early into hospice. A nurse navigator's interaction with patients from diagnosis through treatment and until EOL places them in an ideal position to open a dialogue with patients about EOL issues without being seen as biased (Mulville et al., 2019).

Rochon and Emard (2019) also studied the outcome of a system redesign at the Visiting Nurses Association (VNA) of Care New England. The purpose of the redesign was to improve the home health nurse's skills in caring for patients with advanced illness, engaging patients in discussions of advance directives, communicating the patient's decision to the entire healthcare team, and providing care through the NP home visit. The program was designed to have an NP collaborate with the home healthcare nursing staff through a weekly case conference focusing on palliative care needs and prognostic signs of advanced illness. During the case conference the NP discussed disease trajectory signs and symptoms with the nurses, along with mentoring and educating them on how it impacts GOC and advance care directives. Another NP was assigned to home visits. While the home health agency receives most referrals from home healthcare nurses, the NP also receives referrals from patients/families, acute consult service, primary care, and other specialty services. After 5 years, the program increased the daily hospice census from 31 to 92 average per patient day (300%). The average length of stay per patient enrolled in hospice also increased 230% (Rochon & Emard, 2019). The nurses' knowledge of patient preferences for EOL care with documentation in the EHR increased from 8% to 78% (Rochon & Emard, 2019). The Home Healthcare Compare Center for CMS results reported by Rochon and Emard (2019) were:

1. Improvement in managing pain increased from 37.3% in 2014 to 78% in 2017.
2. The 60-day emergency department use without hospitalization declined resulted in increased CMS national rating of 42 percentile in 2014 to 61.3 percentile in 2016.

3. Satisfaction measure increased with a 4.5 star in a 3-year period rating in quality of patient care.
4. The Home Health Care Consumer Assessment of Healthcare Providers and Systems ranking on “who rated the agency with highest rank” increased from 58.2% in 2014 to 85.5% in 2017.
5. The percentage of who would recommend the agency went from a national ranking of 60.4% in 2014 to 86.4% in 2017.

The positive outcome of this study suggested that implementation of nurse-led interventions has merits in increasing hospice and possibly enhancing timely hospice referrals thereby positively impacting the quality of EOL (Rochon & Emard, 2019). Allowing nurses to function at the full extent of education, training, and scope of practice impacts and improves the quality of care and decreases the cost of healthcare.

In a retrospective study with qualitative analysis, Pattison et al. (2015) evaluated how much time critical care outreach teams (CCOT) spend with patients who are subsequently subject to limitations of medical treatment (LMOT) and EOL decisions and how much influence the team has on those decisions. The study revealed that referrals to CCOTs were initiated primarily by nurses (66.7%), followed by junior physicians and fellows (32.4%), and 0.9% by a consultant (Pattison et al., 2015). The time spent in minutes by the CCOT for patients with LMOT or EOL transition was substantially longer than the mean time for the 890 patients referred for outreach (mean 45; SD 84.4 min). The mean duration for all CCOT episodes for 108 patients was 135 minutes (SD 99.1 min, median 90 min, interquartile range 165-250 mins), with a total time expenditure of

848 hours (50,880 min) out of the total time for all 890 referrals of 236,295 minutes or 21.5% of all clinical contact time (Pattison et al., 2015). With these data, it is evident that CCOT's input carries considerable weight in influencing EOL decisions. Additionally, the high number of referrals initiated by nurses suggests that nurses can play a key role in streamlining referrals to CCOT, possibly prevent aggressive medical care at EOL, and enhance timely hospice referral.

Riggs et al. (2017) also conducted a retrospective study examining the incidence and predictors of hospice enrollment using telephonic outreach by a nurse following a referral to a community-based specialist care program. The study found that 59.2% of 299 patients enrolled in hospice after the telephone contact and before a home visit from a member of the palliative care team while 40.8% enrolled after a home visit by the palliative care team (Riggs et al., 2017). The mean length of stay for hospice patients who enrolled after the telephone outreach alone was 100 days (median = 25 days) (Riggs et al., 2017). Again, these results suggest that nurses practicing at the top level of their education, training, and scope of practice play a major impact in improving access to hospice.

Patient and Family Teaching

In the previously mentioned study by Mulville et al. (2019), terminally ill patients spent a short period of time in hospice falling short of the oncologic benchmark which suggests patients should enroll in hospice within three months prior to death. The data also suggested that patients received aggressive medical care at EOL. Mulville et al.

(2019) posited that patient and family members will benefit from education regarding EOL issues and hospice services and its benefits.

Schnieter et al. (2018) also noted the importance of a nurse-led intervention in a retrospective review evaluating the role of specialty palliative care consultation (PCC) on EOL outcomes among terminally ill gynecologic patients. The study involved an EHR review of deceased gynecologic patients between October 2006 and October 2016. The study showed that many patients, 40-60%, pursued aggressive medical care despite the incurable nature of illness. While the reason is unclear, it remains imperative that patients and family members are engaged in GOC discussions in order to understand the patient's goals of care and understanding of disease and treatment options.

Academic Education and Research

Thoonsen et al. (2016), found that although there have been positive outcomes from the training program, GPs and consultants continue encountering challenges in identifying patients with organ failure and initiating palliative care due to hesitance to discuss EOL aspects with these patients. Furthermore, consultants stated that they also needed additional resources and training where they lack expertise and proactive palliative care for patients with COPD and CHF (Thoonsen et al., 2016). Carey et al. (2019), also found that one of the most common barriers to palliative care in the primary care setting is the provider's lack of confidence overall as well as specific tasks in palliative care. With this, both studies suggested that there is a need for comprehensive training for medical providers to address lack of knowledge and confidence. The education may include training at the undergraduate level or ongoing professional development. Future research to develop and evaluate robust training programs addressing confidence in initiating and transitioning to EOL care are needed.

Specialist Support

Three sources found that specialist support has merit in enhancing timely hospice referrals (Carey et al., 2019; Mulville et al., 2019; Schnieter et al., 2018). For the purpose of this study, specialist support is defined as palliative care specialists who provide consultation or supportive care concurrently with the PCP. Carey et al. (2019) highlighted the need of PCPs to have access to a palliative care specialist and multi-disciplinary support when caring for patients at the EOL. In contrast, Mulville et al. (2019) suggested that an early palliative care referral, preferably outpatient, can prevent aggressive medical care at EOL and lead to timely hospice referral. Additionally, the referral needs to be initiated early in the diagnosis and/or treatment (Mulville et al., 2019). Schneiter et al. (2018) found that a PCC increases the likelihood that patients will enroll in hospice and will have documented advance care planning. Furthermore, patients with a PCC experienced lower rates of aggressive end of life care (Schneiter et al., 2018).

Implications

Providing quality EOL care is fundamental in the provision of hospice care. As the comfort care theory suggests, comfort is a desirable outcome at the EOL. It goes beyond the physical being of the patient in that it is also achieved by addressing the patient's psychospiritual, social, and environmental issues (Kolcoba 1994; 1995). Early referral to hospice services allows patients to receive the maximum benefit of hospice care. It prevents unnecessary aggressive medical interventions at the EOL, promotes comfort by addressing and relieving symptoms that cause suffering, gives patients control of their EOL care, and allows patients to die with dignity, therefore, meeting all dimensions of the comfort care theory.

Efforts to achieve early hospice referral will require a comprehensive approach by PCPs and other health care providers. There is also a need for staff education and training on the importance of timely referrals of patients for hospice and palliative care. Last, initiatives should be considered in addressing implications for positive social change.

Education

It is essential that the academic education curriculum for medical and nursing students be designed to address hospice and palliative care, EOL issues, advance care planning, and the holistic approach of EOL care. Additionally, ongoing professional development addressing knowledge and proficiency in identifying patients appropriate for hospice and palliative care services, as well as accurate prognostication is beneficial for PCPs and nurses.

Practice

It is important to note that nurses can make a major impact in improving patient access for an early referral to hospice. As noted in the nurse-led strategies identified in this systematic literature review, organizations must continue to create and support a climate where nurses are empowered to function at the highest level of their education, training, and scope of practice. Moreover, organizations must create processes and provide resources so that nurses can lead and initiate conversations regarding patient’s possible need for transitioning to hospice care.

Patient / Family Teaching

It has been frequently cited that terminally ill patients often receive aggressive medical care at EOL and are referred too late to receive hospice care (Franklin & Stiles, 2014; Mattes and Sloan, 2015; Mulville et al., 2019; Rolden et al., 2014). While the reason for this is multifactorial, one must consider the patient and family's knowledge deficit and unrealistic expectations also contribute to the problem. Healthcare providers inclusive of physicians, NPs, PAs, and nurses must make a considerable effort to teach patients and families regarding the diagnosis, severity of the illness, advance care planning, and other EOL issues.

Early palliative care referrals were also identified to enhance timely hospice referral. Palliative care referrals must be initiated early in the patient's diagnosis and/or treatment. Also, a collegial relationship with the palliative care specialist may be beneficial as it may improve the PCP's confidence and comfort in referring patients to the specialist that could lead to early transition into hospice care (Carey et al., 2019; Mulville et al., 2019; Schnieter et al., 2018).

Positive Social Change

The healthcare community has a responsibility to increase public awareness regarding hospice care and its benefits. This responsibility can be achieved by normalizing and removing the stigma of hospice care, palliative care, GOC discussions, and EOL issues through public education (Kruczynski, 2015). This can be accomplished by educating one patient and family at a time or through public campaigns. Education must focus on the importance of patient choice and informed decisions regarding GOC at

EOL. Furthermore, information must be clear that palliative and hospice care do not mean physician failure or treatment withdrawal but rather a shift of treatment towards symptom management and comfort care at EOL (Kruczynski, 2015). Education campaigns may be delivered through social media, radio, television, brochures and/or other reading materials placed in doctor's offices, health departments, and/or hospitals (Wakefield, Loken, & Hornik, 2010).

Recommendations

The purpose of this DNP project was to find the best evidence-based strategies used by PCPs to enhance timely hospice referrals. Based on an analysis and synthesis of the literature, recommended solutions include medical providers and healthcare staff education and training (Carey et al., 2019; Thoonsen et al., 2017), nurse-led interventions (Kirk et al., 2019; Rochon & Emard, 2019; Riggs et al., 2017), patient and family teaching (Rochon & Emard, 2019; Schnieter et al., 2018), inclusion of hospice and palliative care in academic education of healthcare workers (Carey et al., 2019; Thoonsen et al., 2017), and specialist support (Mulville et al., 2019; Pattison et al., 2015). Therefore, it is recommended that the academic education and training of physicians and nurses should be designed to address hospice and palliative care (Carey et al., 2019; Thoonsen et al., 2017). Healthcare organizations should prioritize educating their staff who are involved in caring for terminally ill patients on EOL issues such as advance care planning, goal clarification, disease process and symptom management, identification of eligible patients, and creating processes that promote a collaborative approach among the healthcare team (Carey et al., 2019; Kirk et al., 2019; Rochon & Emard, 2019; Thoonsen et al., 2017). These processes may involve providing assessment tools that will aid in identifying patients who may be eligible for hospice and palliative care. PCP education on GOC discussions and prognostication is needed. Further research is needed to examine the strategies the PCPs use to enhance timely hospice referrals. Geriatricians also provide primary care for the older adults and therefore can also be included in the cohorts of future studies of PCPs. Also, further research inquiries are needed to define and set criteria for establishing the concept of 'early' hospice referral. Last, additional studies are needed to examine the practice of PCPs to further identify strategies that enhance timely hospice referral (Carey et al., 2019; Thoonsen et al., 2016).

Strength and Limitations of the Project

The strength of this project is the expanded information that answered the practice-focused question on strategies used not only by PCPs but also by nurses that enhance timely hospice referrals. The information answering the original practice-focused question was based on findings generated from systematic reviews of quantitative data and randomized controlled trials, which are the top two levels in the hierarchy of evidence (Ackley et al., 2008; Fineout-Overholt et al., 2010; JBI, 2018). Also, expanded research on nursing strategies was a cohort study for over 5 years, the fourth in the hierarchy of evidence (Stillwell et al., 2010). Additionally, SQUIRE guidelines (Davies, Batalden, Davidoff, Stevens, & Ogrinc, 2015) were used to ensure that the final report was written with sufficient details for readers to understand the problem, methodology, and findings generated from the project. The limitation of this study was that it was not solely focused in one health science discipline. As previously mentioned, there were limited resources detailing strategies used by PCPs for early hospice referrals. Therefore, the literature search was expanded to include strategies used in nursing practice to enhance early hospice referral. With many PCPs providing patient care across the life span, it is recommended that additional research be undertaken to explore the PCPs' practices that enhance timely hospice referral.

Summary

In summary, section 4 provided findings from a systematic literature review carried out to answer the practice-focus question, step-by-step methodology of a literature search strategy using the PRISMA flow diagram and several critical appraisal tools for systematic reviews, and the analysis and synthesis of all the resources that met criteria for study selection. Findings indicate medical providers and healthcare staff education and training, nurse-led interventions, patient and family teaching, inclusion of hospice and palliative care in academic education of healthcare workers, and early palliative care referrals enhances early hospice referral (Carey et al., 2019; Kirk et al., 2019; Mulville et al., 2019; Pattison et al., 2015; Riggs et al., 2017; Rochon & Emard, 2019; Schnieter et al., 2018; Thoonsen et al., 2016). Collectively, these strategies affect nursing practice and promote social change. The healthcare providers' improved knowledge and skills regarding EOL issues, prognostication, and GOC discussions promotes confidence and increased competency. Furthermore, the patients and family's awareness and understanding of terminal diagnosis minimizes unrealistic expectations, therefore, avoiding unnecessary medical treatments at EOL and promoting early hospice referral. The strength of this project was the expanded information that answered the practice-focused question on strategies used not only by PCPs but also by nurses that enhance timely hospice referral. The limitation of the study was that it was not focused on one discipline. In Section 5, I address my plans for disseminating findings from project.

Section 5: Dissemination Plan

Introduction

Through this DNP project, I aimed to find the best evidence-based strategies used by PCPs to enhance timely hospice referrals. I focused on answering the practice-focused question: What are the best strategies used by PCPs for initiating timely hospice referrals? In Section 5 of the project, I will discuss plans for dissemination of the findings. This section ends with a reflective analysis of my growth as a scholar-practitioner during development of this project.

The plans for dissemination of the findings of this study include submitting to ProQuest as part of the requirements for completion of the Doctor of Nursing Practice at Walden University. Additionally, I plan to reach out to professional organizations where I have active membership such as the Philippine Nurses Association of America (PNAA) and the Central Texas Nurse Practitioners to disseminate this project's findings through a poster or podium presentation. As a federal employee and active member of the PNAA, I plan to reach out to peer-reviewed journals such as *Federal Practitioner* and *Philippine Nurses Association of America Journal of Nursing Practice Applications and Reviews of Research* in order to reach a broader audience and to share my work with my peers. Finally, I will also reach out to the clinical education and system redesign department at my place of employment for guidance on procedures for disseminating the results of my project with hopes that these findings will be used to improve practice in the primary care setting or the geriatric clinic.

Analysis of Self

The process of completing this project has been a worthwhile journey. First, it afforded me the opportunity to put into practice the methods and principles learned throughout my time at Walden University. This experience has made me realize the value of a doctorate-prepared nurse not only for myself but more importantly, to the profession and the patients we serve. The completion of this project required many hours of research, studying, and writing. It was not an easy undertaking. As the saying goes, “if it was easy, everyone would be doing it!” With that, I realize that my work and those who came before me will shape the future of the profession and patient care, and that the more diligent we are, the better off our patients are. Furthermore, the challenges in the completion of this project has reinforced my personal make up as it required tenacity and flexibility. Finally, I realize that I did not get here on my own. I have my family, friends, colleagues, mentors, and teachers to give credit for helping shape me professionally. With that being said, I understand that I too, have a moral obligation to mentor and teach those who come behind me.

Summary

With this systematic literature review I analyzed, synthesized, and presented the current evidence on the strategies used by PCPs that enhance timely hospice referrals. This search was expanded to nursing strategies as there were limited resources available to answer the original practice-focused question. It is clear that there is work that needs to be done to educate and train healthcare workers. This can be achieved by redesigning the academic education and training of physicians and nurses to address hospice and palliative care academically. Healthcare organizations should prioritize educating their staff who are involved in caring for terminally ill patients on EOL issues such as advance care planning, goal clarification, disease process and symptom management, identification of eligible patients, and creating processes that promote a collaborative approach among the healthcare team. This study contributes to evidence-based practice by providing information that will guide practice in improving the quality of EOL for patients with terminal illness. Further studies are needed to examine practice of PCPs in the primary care setting in order to identify additional strategies that enhance timely hospice referrals.

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Appendix A: Literature Review Matrix

Author / Title	Purpose	Methodology	Major Findings	Level of Evidence
Carey, Zucca, Freund, Bryant, Herrmann, & Roberts (2019). Systematic review of barriers and enablers to the delivery of palliative care by primary care practitioners	To explore the type and prevalence of barriers and enablers to palliative care provision reported by primary care practitioners	Systematic review of quantitative data-based articles	• More than 50% of articles reviewed reported lack of confidence in general, or in relation to specific tasks with palliative care, as barriers to provision of care. The lack of confidence spread across many care areas including treatments, symptom management, and psychological and communication issues, reflecting the holistic nature of palliative care. • Most common barriers: bureaucratic procedures, communication between healthcare professionals, primary care provider's personal commitments, and their skills or confidence. • Enablers: education, nurses and trained respite staff to assist with care delivery, better communication between professionals, and templates to facilitate referral to out-of-hours services • Other reported enablers included diversifying the palliative care workforce with more nurses available to provide out-of-hours care, and more	Level I

			respite workers trained in palliative care, as well as increasing access to multidisciplinary support and out-of-hours telephone support.	

Kirk, et al (2019). Pilot test of an adapted intervention to improve timeliness of referrals to hospice and palliative care for eligible home health patients	To assess the feasibility, acceptability, and patient outcomes of the adapted intervention	Observational pilot study	• Feasibility – 29 eligible patients were approached with 96.6% were enrolled and screened
			• Fidelity to intervention protocol in that all screening questions were asked of eligible patients. Patients appropriate were asked to authorize follow up with their PCP regarding hospice/palliative care.
			• Attrition rates – 100% of enrolled patients responded to screening questions and did not withdraw
			• Staff Experience with intervention
			  • Staff stated it facilitated EOL conversation with patients
			  • Helped structure conversations especially for patients uncomfortable with topic
			  • It yielded structured information on the patient care goals, needs, and preference
				Level IV

Mulville, et al. (2019). Timely referral to hospice care for oncology patients: A	• To evaluate and identify barriers that exist for timely referral of hospice care	Retrospective study	• 44% enrolled in hospice (n=161) • Length of stay in hospice – average 38 days, median 10 days; Non-hospice 56%	Level IV

retrospective review	referral for oncologic patients near EOL		- Treatment received by both groups showed that greatest proportion of hospice patients received radiation and chemotherapy (26%) or a combination of radiation, chemotherapy, or surgery - Majority of non-hospice patients received only chemotherapy followed by a combination of treatment modality with 18% receiving chemotherapy, radiation, and surgery. - Proportion of patients who received only chemotherapy were not significantly greater than non-hospice patients receiving chemotherapy - Significant proportion of hospice patients received radiation plus chemotherapy than non-hospice patients. - Most patients (71.4%) spent less than 30 days in hospice and 83 of those spent 10 days or less in hospice. Median number of days spent in hospice was 10 days 56% of hospice patients died in the hospital	
Pattison, O'Gara, & Wigmore (2015). Negotiating transitions:	- Establish how much time critical outreach teams spend	Retrospective study with Qualitative analysis	Referrals were predominantly initiated by nurses (66.7%). 32.4% were by junior physicians and fellows,	Level IV

Involvement of critical care outreach teams (CCOT) in EOL decision making	with patients who are subsequently subject to limitations of medical treatment (LMOT) at EOL decisions and how much influence teams have on those decisions		and 0.9% by a consultant. Time spent for patients (in minutes) with LMOT or EOL transition was substantially longer than the mean time for the 890 patients referred to outreach (mean 45; SD 84.4 min). The mean duration for all CCOT episodes for 108 patients was 135 minutes (SD 99.1 min, median 90 min, interquartile range 165-250 mins), with a total time expenditure of 848 hours (50880 min) out of the total time for all 890 referrals of 236295 minutes or 21.5% of all clinical contact time. 51.9% (56/108) of patients with LMOT had a clear EOL plan made by the CCOT and the treating team following a CCOT referral.	
Rochon & Emard (2019). End-of-life care: Redesigning access through leveraging the institute of medicine future of nursing recommendations	• Improve home health nurses' skills in caring for patients with advanced illness • Engage patients in discussion of advance directives and communicating the patients' decisions to the entire healthcare team • To provide care through an NP home visit	Observational study/System redesign	After 5 years, • Hospice census increased 31 to 92 average per patient day (300%) • Average length of stay increased 230% • Nurses knowledge of patient preferences for EOL care and documenting in the electronic health records increased from 8% to 78% • The number of advanced illness case conferences with nurses increased to 5% of the weekly VNA census	Level IV

			• Community referrals are higher than hospital referrals – influenced by nursing recognition of plan of care and contacting the PCP • Median length of stay from community referral (37) is higher than referrals from hospital (6)	
Riggs, Breuer, Dhingra, Chen, Portenoy, Knotkova (2017). Hospice enrollment after referral to community-based, specialist palliative care: Impact of telephonic outreach	To evaluate the incidence and predictors of hospice enrollment following telephonic outreach by a nurse after referral to community-based specialist care program •	Retrospective cohort study	706- referred • 42.3% – enrolled to hospice during the study period • 59.2% – enrolled to hospice after telephone contact and before a home visit was completed • 40.8% – enrolled after home visit by palliative care team • Hospice enrollment occurred after a mean of 4.5 calls (median =3), mean of 14 days (median = 10 days) • 50% of patients of patients were enrolled in hospice between 4-7 days after referral to the palliative care program. • Mean length of stay in hospice for patients who enrolled after	Level IV

			telephonic outreach alone was 100 days (median = 25 days) • Patients who enrolled in hospice after telephonic outreach alone were more likely to be unmarried, not live alone, be referred to palliative care from the community, have Medicare, and have a PPS between 10-40.	
Schneiter, Karlekar, Crispens, Prescott, & Brown (2018). The earlier the better: The role of palliative care consultation on aggressive EOL care, hospice utilization, and advance care planning documentation among GYN oncology patients	• To evaluate the role of specialty palliative care consultation (PCC) on EOLC outcomes among terminally ill gynocology patients	Retrospective study	• n=204 subjects • 83 (40.7%) had at least one form of aggressive medical care EOLC • 6 (2.9%) had chemo in the final 14 days of life • 19 (9.3%) visited ED more than once • 26 (12.7%) had more than 1 hospital admission • 21 (10.3%) spent more than 14 days in the hospital in the last 30 days of life • 31 (15.2%) admitted in ICU in the last 30 days of life • 43 (21.1%) died in hospital	Level IV

			• 15 (7.4%) admitted to hospice less than 3 days prior to death • 46 (22.5%) died in inpatient hospice • 100 (49%) died at home • 107(52.5%) had PCC prior to death 88.8% were inpatient and 11.2% were outpatient **Inpatient PCC** • (44%) – aggressive medical care at EOL • (82%) – enrolled in hospice before death • Outpatient PCC (25%) aggressive medical care • (91.7) – enrolled in hospice before death **Probability** • Patients with PCC are 6.8 times more likely to have advance care planning • Patients with PCC are 2.55 times more likely to enroll in hospice	
Thoonsen, Groot, Verhagen, Weel, Vissers, & Engels (2016). Timely identification of palliative patients and anticipatory care planning by	• Evaluate of a training program	Randomized controlled trial with qualitative study	• Most GPs mentioned small changes in attitude and their way of thinking about palliative care and how to provide it • It widened their view on palliative care and realized that other	Level II

GPs: Practical application of tools and a training programme			patients with chronic diseases may also benefit for its timely initiation. • Although RADPAC indicators that might help GPs become aware when patients may benefit from palliative care were considered clear, GPs did not continue to use. However, some GPs integrated the indicators in their daily practice • GPs continued to find it difficult to identify patients with organ failure who may benefit from palliative care • Patients reported clinicians rarely discussed life-sustaining treatment preferences, prognoses, dying processes, or spiritual issues with them • GPs would appreciate a digital RADPAC tool fully integrated with electronic health record which was proven to be successful in timely identifying in another setting (Scotland) • Some GPs still considered it difficult to start a conversation on anticipatory care with their patients with COPD and CHF • Most GPs stated that the problem square was valuable in structuring the inventory of actual and possible future problems, needs, and	

			wishes • Consultants expressed that although they considered themselves capable to partner with the GPs in proactive palliative care planning, they were not able to answer all questions. They stated that they needed to know where to retrieve the knowledge themselves if in doubt; or when they lacked expertise. They also admitted to needing the extra training themselves with regard to proactive palliative care training for patients with COPD and CHF Consultants were positive about GP preparation prior to consultation… although did not always address spiritual and psychological problems	

Appendix B: Identified Themes and Strategies that Enhance Timely Hospice Care Referrals

Theme	Strategies
Provider training and healthcare staff education	• GP education on training program identifying palliative care patients using RADPAC and Problems Square (Thoonsen et al, 2016) • Education of medical providers on prognostication (Mulville, et al., 2019) • Comprehensive training of PCPs to address lack of confidence, to include training at the undergraduate level and ongoing professional development (Carey et al., 2019)
Nurse-led interventions	• Nurses screen *high risk* or *frail* patients utilizing established criteria. RNs administered screening questions to patients. • RNs referred patient to physician following consent. RNs initiated referral to palliative care, if authorized (Kirk et al., 2019) • Utilization of nurse navigators (Mulville et al., 2019) • NP collaborated with home healthcare staff through weekly case conference focusing on patients with palliative care needs. Another NP assigned for home visits and receiving referral for palliative care from home health nurses, patients/families, acute care, primary care, and other specialties (Rochon & Emard, 2019) • Allowing nurses to initiate referral of patients to critical outreach care team (Pattison et al., 2015). • Telephone outreach by a nurse following a community-based specialist care program (Riggs, et al., 2017)
Patient and family teaching	• Patient and family training on EOL issues, goals of care, and disease process and treatment options (Mulville, et al., 2019; Schnieter et al., 2018)
Academic education and research	• Comprehensive training for medical providers to address lack of knowledge and confidence in identifying organ failure and initiating palliative care either at the undergraduate level or ongoing professional development (Thoonsen et al., 2016)

	- Development and evaluation of robust training program addressing confidence in initiating and transitioning to EOL care (Thoonsen et al., 2016)
Specialist support	- PCPs direct access to palliative care specialists (Carey et al., 2019) - Initiation of palliative care referral early in the diagnosis and/or treatment (Mulville et al., 2019; Schnieter et al., 2018)