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Vicki Schmidt

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Walden University
2021

Abstract

The Underutilization of Hospice Services for African Americans

by

Vicki L. Schmidt

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

November 2021

Abstract

The focus of this doctoral project was increasing knowledge of underutilization of hospice services for African Americans (AAs) and the need to increase cultural competence among nurses regarding this issue. The identified gap in practice was nurses' lack of cultural competence and knowledge regarding the underutilization of hospice specific to AAs. The practice-focused question focused on whether a staff educational intervention increased nurses' knowledge of the cultural implications regarding the introduction of hospice services for AAs. The education was guided by the Purnell model for culturally competent health care, Healthy People 2030, and the National Hospice and Palliative Care Organizations AA Outreach Guide. Ten nurses in the southwest received an educational intervention and answered pre and posttest data on cultural competence and understanding of hospice services. Descriptive statistics of the pre and posttest scores resulted in a 47.6% increase in nurses' knowledge of underutilization of hospice services by AAs and their understanding of the cultural implications of patient education. Additional evaluations with larger populations and in other geographic areas is needed. Further research should be conducted on the impact of the educational intervention on quality of care provided by the nurses as evidence of practice change. The potential positive social change of this project is the increased nursing ability to provide care for ethnically diverse patients who would benefit from earlier and improved access to hospice care at the end of life.

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Section 1: Nature of the Project

Introduction of Problem and Project for Positive Social Change

Underutilization of hospice care by African Americans (AAs) is significantly related to health disparities (National Hospice and Palliative Care Organization [NHPCO], 2019). The latest numbers from NHPCO show only 8.2% of AAs utilize hospice services compared to 82.5% of White Americans (NHPCO, 2019). Those statistics are surprising, given the fact that AAs have the highest mortality rate for most cancers in the U.S (American Cancer Society, 2020). For example, AA female deaths from breast cancer are 3.1% compared to White females of 2.6%; and AA male prostate cancer death rate is 4.0% compared to White at 2.2% (American Cancer Society, 2020).

Certain ethnic or racial populations, such as AAs, have greater difficulty accessing medical services due to barriers such as mistrust of healthcare workers and the healthcare system in general. This leads to further health disparities for this population. The increasing amount of literature on health disparities continues to provide undeniable evidence for the need of nurses and other health care workers to provide culturally competent care (Purnell, 2014).

The aim for this Doctor of Nursing Practice (DNP) staff education project was to increase knowledge of underuse of hospice services for AAs, related to health disparities, and the need for cultural competence among nurses. This project has potential for positive social change by supporting one of the objectives for the new Healthy People 2030 Social Determinants of Health, and one of its five subcategories: health care access and quality (Office of Disease Prevention and Health Promotion [ODPHP], n.d -c.). This

subcategory focuses on social determinants and interventions for increasing access to better quality medical services (ODPHP, n.d.-c).

Section 1 will discuss (a) underutilization of hospice services related to health disparities for AAs, and the need for cultural competence among nurses, (b) the purpose and nature of this DNP project, and (c) the significance to nursing practice. A summary will provide the main points from Section 1.

Problem Statement

The nursing practice problem this doctoral project focused on was increasing knowledge of underuse of hospice services for AAs, related to health disparities, and the need for cultural competence among nurses (NHPCO, 2008). This population is known to use hospice services significantly less than Whites (Fosler et al., 2015). Dillon and Basu (2016) identified underuse of hospice among AAs at a large hospice organization with a census of 7,400 hospice patients. Of those 7,400 patients, 9.8% were AA, and 73% were White. Underutilization of hospice increases further for AA Medicare recipients during the final year of life, who comprise 22% of hospice patients compared to 29% of their White counterparts (NHPCO, 2008).

Statistics in Nevada align with the numbers reported nationally. The most up-to-date statistics from NHPCO identified 47.1% of Nevada Medicare recipients were enrolled in hospice at the time of death (NHPCO, 2019). In Southern Nevada, a hospice organization administrator discussed census information which identified underutilization of hospice services for AAs. In December 2019, the hospice census report showed 8% of patients were AA compared to 78% who were White (personal communication,

December 2019). Likewise, in September 2020, 9% of hospice patients were AA compared to 77% who were White (personal communication, September 2020). Another hospice in Southern Nevada reported similar numbers. According to the administrator at the study site for this project, in July 2020, there were 11% AA patients compared to 54% White (Personal communication, July 21, 2020). These figures show significant differences in the use of hospice and are particularly concerning with the aging AA population because more individuals will be dying in pain and in hospitals receiving prolonged ineffective treatments (Dillon & Basu, 2016).

In one study, interviews with patients and caregivers revealed hospice underutilization due to mistrust and lack of healthcare workers' cultural knowledge. One patient in the study said, “I think you have a lot of Black folks who wouldn’t have a doctor they trusted enough to allow that person to put them in hospice” (Dillon & Basu, 2016, p. 224). Improving communication, between patients and nurses, can help achieve a higher quality of medical care for the patients by working together to make decisions regarding the patients’ health (ODPHP, n.d.-a). An interview with an AA caregiver revealed that the reason hospice was not chosen was due to lack of understanding by physicians and hospice representatives regarding difficulties specifically for AAs and choosing a hospice. Difficulties mentioned included personal fears and beliefs and the opinion of others. Also, the perception that hospice representatives are not interested in AA issues with hospice and not interested in listening to AA patient’s and caregiver’s struggle with deciding. As one participant in the study noted, “Like I said, we’re second-class patients with everything else, why would it be any different when you are

discussing hospice with them? They don't know our culture or our experiences, and most don't care" (Dillon & Basu, 2016, p. 225). Increasing knowledge of cultural differences can increase nurses' ability to provide care for diverse patients such as AAs (ODPHP, n.d.-a).

Healthcare disparities for AAs also lead to undermanagement of pain. Ninety-six physicians, comprised of oncologists and primary care, participated in a randomized field study on managing lung cancer pain. The study was guided by the American Association of Hospice and Palliative Medicine guidelines and found AA standardized patients were 95% less likely to receive opioids for lung cancer pain from oncologists than Whites (Shields et al., 2019). Compared to Whites, AA pain is under rated twice as much (Aronowitz et al., 2019). Audited patient charts at 12 federal health centers, where pain assessments are a requirement, found AAs were assessed less for pain than Whites (Aronowitz et al., 2019). The same study concluded both nursing students and nurses' assessment of pain determined AA's have less compared to Whites after the same type of injuries (Aronowitz et al., 2019).

A Nevada healthcare worker participated in an interview for the NPHCO AA Outreach Guideline. She discussed how religion and spirituality also play a role in the underutilization of hospice by AAs. She discussed the need for hospice education, so culturally competent discussions could take place regarding spirituality in the AA population (NHPCO, 2008).

The doctoral staff education project holds significance in nursing for several reasons. It is in alignment with the NHPCO focus on increasing AAs' use of hospice

services by educating nurses to increase knowledge of health disparities (NHPCO, 2008). In the United States, AAs are the second largest population of minorities, with a life expectancy of 76.1 years (Office of Minority Health, n.d.). Nurses need to gain certain knowledge of the populations they care for to deliver culturally competent care (Purnell, 2014). Knowledge of barriers to healthcare can be increased through education and used to observe the cultural effects on disease, self-care insufficiencies, and health; thus, allowing nurses to consider the effects of cultural variables on health. This knowledge may increase health services, improve the quality of care, and decrease health disparities (Yilmaz & Toksoy, n.d.).

This project supports one of the new Healthy People 2030 (HP2030) objectives to eliminate health disparities (Healthy People, 2020). HP2030 recommends interventions such as educating nurses to develop patient relationships to help achieve better patient outcomes (ODPHP, n.d.-c). Even though there are national recommendations and available nursing models, Southern Nevada hospice administrators reveal there are no specific trainings provided at their facilities for nurses regarding cultural competence (personal communication, July 21, 2020; personal communication, September 2020). The practice-focused question focused on a staff educational intervention to increase nurse's knowledge of underutilization of hospice services for AAs, related to health disparities.

Purpose Statement

The purpose of this project was to increase knowledge of underutilization of hospice services for AAs related to health disparities, and the need for cultural competence among nurses. Many factors contribute to health disparities, including

nurses' lack of cultural competence (NHPCO, 2008). This educational intervention to increase cultural competence and understand health disparities helped nurses improve their understanding of complex individuals and issues which influence health. The educational intervention also prepared nurses with the necessary knowledge for fostering culturally competent care (Douglas et al., 2014). Understanding factors such as cultural barriers raised awareness of difficulties in accessing medical services.

Additionally, increasing accessibility to medical services will help decrease health disparities (ODPHP, n.d.-a). Issues specific to AAs, such as mistrust of nurses, create barriers to accessing medical care (Purnell, 2014).The gap in practice is nurses' lack of cultural competence and knowledge of the underuse of hospice related to health disparities specific to the AA population (NHPCO, 2008).

The project revealed a staff educational intervention can increase nurse's knowledge of underutilization of hospice services for AAs, related to health disparities. This project has the potential to address the gap in practice by educating nurses on cultural competence and underuse of hospice related to health disparities specific to the AA population (NHPCO, 2008). Reasons for lack of use include cultural practices, treatment preferences, spiritual views, and insufficient information of hospice services. There is also a stigma attached to the use of hospice with some in the AA community, and people are judged poorly for using these services (Dillon & Roscoe, 2015). Lack of hospice knowledge has been found to be greater in the AA population compared to the White population (Townsend et al., 2015). Other factors include a deep mistrust of the healthcare system by the AA population due to lack of cultural awareness and a history of

racism and suffering stemming from slavery and discrimination in America (NHPCO, 2008).

Nature of the Doctoral Project

There were many sources of evidence gathered to meet the purpose of this doctoral project. The NHPCO AA Outreach Guide was utilized as a guide for this staff education. This guideline from NHPCO was written in 2008; however, it continues to be recommended for hospice use with this population from the NHPCO (NHPCO, 2008). The ODPHP and HP2030 were other sources of information utilized (ODPHP, n.d.-a). One of the new HP2030 objectives to address health disparities is improving access to health care (ODPHP, n.d.-c). Additionally, the Purnell model for culturally competent health care, which can be integrated into any health care setting, served as a guide for this project. According to Purnell, health care professionals, including nurses, need knowledge of cultural diversity to provide higher quality and culturally competent care (Purnell, 2014).

The Walden library provided many evidence-based, peer-reviewed articles, models, and frameworks as evidence for this project. Search terms, combined with Boolean phrases were used, such as *hospice, underutilization, African American (AA)* or *Black, nursing, cultural competence, inequalities, disparities,* and *healthcare*, produced journal articles from CINAHL, MEDLINE, Academic Search Complete, OVID journals, Complementary Index, and others with additional evidence-based literature.

These sources of evidence were obtained using Walden University library resources, which are provided for all Walden University students. Statistics and

information were also obtained from the local health department, Centers for Disease Control, and the World Health Organization. Walden Librarian services were available but not necessary to complete this project. The Manual for Staff Education, available on the Walden University website, was utilized as a guide for completing this DNP project.

The staff education intervention was presented to nurses at the project site who voluntarily participated. The goal was to have at least eight hospice nurses from the project site to participate. Additionally, to increase the number of participants, 20 hospice nurses and administrators from other Southern Nevada hospice organizations were invited. Summative evaluations were used to compare answers from the pre and posttests on the information in the education intervention to determine if nurse's knowledge increased based on the presentation. A 3-member panel of experts reviewed the pre and posttests and the presentation. Permission was obtained by the project site organization after meeting with the administrator and clinical field staff supervisor to discuss the project. A second organization meeting was held with available nurses to explain the project, get feedback, and recruit volunteers to participate in the project. This project addressed the underuse of hospice services by identifying factors, which furthers health disparities among AAs due in part to the lack of cultural competence among nurses. The class portion of this project began with pretests to assess knowledge prior to the intervention. The learning objectives for the education portion were, at the conclusion of the education portion, nurses will:

- Identify factors which lead to underutilization of hospice services and further health disparities for AAs.

- Discuss approaches to identify and implement evidence-based practice guidelines and the Purnell model to increase cultural competence in providing care for AAs.

The main topics were presented with a PowerPoint presentation, then participants were given posttests. Due to the current pandemic, the educational class was offered both in person and via Zoom; and completed within a 1-hour timeframe.

Significance

The following Essentials of Doctoral Education for Advanced Nursing Practice (DNP Essentials) are supported by this DNP project:

- "Essential III: Clinical Scholarship and Analytical Methods for Evidence-Based Practice: 1. Disseminate findings from evidence-based practice and research to improve healthcare outcomes" (Rrosseter, 2018, p. 12).
- "Essential V: Health Care Policy for Advocacy in Health Care: 1. Advocate for social justice, equity, and ethical policies within all healthcare Arenas" (Rrosseter, 2018, p. 14).
- "Essentials VII: Clinical Prevention and Populations Health for Improving the Nation's Health: 1. Analyze epidemiological, biostatical, environmental, and other appropriate scientific data related to individual, aggregate, and population health. 2. Synthesize concepts, including psychosocial dimensions and cultural diversity, related to clinical prevention and population health in developing implementing, and evaluating interventions to address health promotion/disease prevention efforts, improve health status/access patterns,

and/or address gaps in care of individuals, aggregates, or populations. 3. Evaluate care delivery models and/or strategies using concepts related to community, environmental and occupational health, and cultural and socioeconomic dimensions of health" (Rrosseter, 2018, p. 16).

- "Essentials VIII: Advanced Nursing Practice:1. Conduct a comprehensive and systematic assessment of health and illness parameters in complex situations, incorporating diverse and culturally sensitive approaches. 2. Design, implement, and evaluate therapeutic interventions based on nursing science and other sciences. 3. Develop and sustain therapeutic relationships and partnerships with patients (individual, family, or group) and other professionals to facilitate optimal care and patient outcomes. Demonstrate advanced levels of clinical judgment, systems thinking, and accountability in designing, delivering, and evaluating evidence-based care to improve patient outcomes. 4. Guide, mentor, and support other nurses to achieve excellence in nursing practice. 5. Educate and guide individuals and groups through complex health and situational transitions (Rrosseter, 2018, p. 16-17)."

According to the NHPCO AA Outreach Guide, all hospice staff should receive cultural diversity training to provide the greatest possible care to the AA community (NHPCO, 2008). This project had a positive impact on project site nursing staff and will potentially have a positive impact on the AA population in the community. Nurses gained knowledge of end-of-life issues explicit to AAs, which enhance their ability to provide care for this diverse population (NHPCO, 2008). Cultural competence is the ongoing

ability of health care professionals, organizations, and health care systems to afford high-quality care for diverse populations. The potential contributions of this doctoral project to nursing practice are culturally competent nurses who integrate cultural beliefs into the care of patients, which bring about positive social change by reducing health disparities for this vulnerable population (Douglas et al., 2014).

According to Walden University's position on Social Change, positive change comes with uplifting of cultures, communities, and individuals by actions taken by others to inspire, create, and plan activities, which lead to improvement of social and human circumstances (Walden University, 2019). This project supported Walden University's social change mission by implementing a project which may lead to overall improved human and social circumstances for an at-risk population. Social determinants of health, such as access to health care, are important for nurses to comprehend because they influence individual's health and all-around quality of life. This DNP project supports one of HP2030 goals to increase access to better quality medical services (ODPHP, n.d.-c).

This project also focused on social change for the AA population and the importance of building relationships, and ultimately increase the use of hospice (NHPCO, 2008). Building relationships may lead to increased decision making with individuals and their health care provider, and better medical outcomes for these individuals (ODPHP, n.d.-d). The use of hospice will improve symptoms at the end of life, such as fatigue, depression, insomnia, and pain (Lee et al., 2020). These are complications from delayed medical care which HP2030 strives to decrease (ODPHP, n.d.-e). This doctoral project

has potential transferability to other areas for AAs such as breast cancer and maternal mortality rates because the objectives under "Health Care Access and Quality" are applicable to these areas as well. The focus for these areas would still be to improve access to prevention and treatment services to improve the overall health of individuals living in the U.S. (ODPHP, n.d.-c).

Summary

Section 1 discussed the lack of knowledge nurses possess on the underuse of hospice services by AAs regarding health disparities, the context of a staff education project, contributions to nursing, and positive social change. The project addressed the need to increase nurses' knowledge of underutilization of hospice services for AAs, related to health disparities. The NHPCO AA Outreach Guide, as well as the Purnell model, were utilized to guide this project. Section 2 discusses project evidence and its purpose, relevance to nursing practice, concepts and theories, institutional settings, and role of the DNP student.

Section 2: Background and Context

Introduction

Evidence shows underutilization of hospice services is linked to health disparities for the AA population (NHPCO, 2019). Increased health disparities are associated with a lack of cultural competence in healthcare, particularly by nurses (Reese et al., 2015). To provide culturally competent care, nurses must be conversant with various cultures, as well as knowledgeable about health disparities and end-of-life issues specific to the AA population. Currently, only 8.2% of AAs utilize hospice services compared to 82.5% of Whites, which necessitates the implementation of effective interventions to address this issue and prevent further disparities (NHPCO, 2019).

The purpose of this DNP project was to educate nurses providing hospice services to the AA population, to improve their knowledge and understanding of health disparities, and to show how these relate to AAs underutilization of hospice. The educational intervention resulted in increased knowledge of health disparities among the nurses, which can lead to a higher utilization of hospice for the AA population. With the educational intervention in place, nurses may become increasingly culturally competent and well acquainted with the knowledge to effectively serve the AA population. The practice-focused question focused on whether a staff educational intervention increased nurses' knowledge of the cultural implications regarding the introduction of hospice services for AAs.

Section 2 focuses on the background and contextual information related to the project. Among the subsections that will form the basis of discussion in this next section

include (a) concepts, and models (b) the relevance to nursing practice, (c) local background and context, and (d) the role of the DNP student for this project. A summary of the section with key concepts covered will also be provided.

Concepts, Models, and Theories

The NHPCO AA Outreach Guide, HP2030, Purnell's model for cultural competence, and the ADDIE model guided the development of this project. Although the NHPCO AA Outreach Guide from NHPCO was written in 2008, it was useful in developing this project because it continues to be the most current guideline suggested for hospice use with the AA population on the NHPCO website (NHPCO, 2008). The guideline provided information on how to educate hospice staff, including nurses, on becoming more knowledgeable on health disparities and end-of-life issues specific to the AA population and how these disparities lead to the underuse of hospice services. It briefly discusses the history of AAs mistrust of healthcare due to a history of health experiments on AAs, which is just one contributing cause of health disparities. One example the guide discusses is the Tuskegee syphilis experiment, which ended less than 50 years ago (NHPCO, 2008). During the experiment the cure for syphilis was discovered yet withheld from AA patients in the study, to study the disease process. Therefore, many AA people died painful deaths before it finally ended in 1972 (Park, 2017). The guide also discusses examples of AA mistrust, such as the belief the American government attempted to annihilate the AA population with HIV/AIDS (NHPCO, 2008). More recent literature discusses how HIV continues to affect the AA population greater than other populations and the substantial number of AAs who

continue to believe HIV was created purposefully by the government and treatment is being withheld (Bogart et al., 2019).

HP2030 also helped in the development of this project. According to HP2030, multiple elements contribute to health disparities including social determinants of health. Social determinants of health include factors such as discrimination, racism, environment, socioeconomic status and more which can greatly impact individual's quality of life and overall health (ODPHP, n.d.). One of the 5 subcategory areas for social determinants of health is health care access and quality. The overall goal for health care access and quality is to increase access to better quality medical services because in the United States, numerous people are unable to obtain the medical services they need (ODPHP, n.d.). To address these issues, HP2030 set objectives toward which to work. One objective is to improve collaborative health care decisions between health care workers, such as nurses, and patients (ODPHP, n.d. - c.). Another objective is to improve communication between patients and health care professionals, including nurses. Talking to a health care professionals can be difficult for some, for various reasons, which can hinder care of patients (ODPHP, n.d.-a). Additionally, an objective from HP2030 is to increase access to timely, better quality medical services. Delayed services can lead to stress, anxiety, and preventable hospitalizations (ODPHP, n.d.-b).

HP2030 recommends interventions such as educating health care workers, including nurses, to develop patient relationships to help achieve better patient outcomes (ODPHP], n.d.- c).

Purnell's model for cultural competence was an additional guide in developing this project because it focuses on educating health care professionals, such as nurses, on the importance of increasing cultural diversity knowledge. Increased knowledge may lead to higher quality and culturally competent care (Purnell, 2014). This model also contains a section specific to AAs which discusses more specific details such as varying terms for this population. For example, some refer to themselves as AA, where some refer to themselves as Black (Purnell, 2014, Chapter 4).There are 20 major assumptions in Purnell's model, for this project, the following assumptions guided the project:

1. "If patients are coparticipants in their care and have a choice in health- related goals, plans, and interventions, their compliance and health outcomes will be improved" (Purnell, 2019, p. 8).
2. Culture has a powerful influence on one's interpretation of and responses to health care" (Purnell, 2019, p. 8).
3. "Caregivers who can assess, plan, intervene, and evaluate in a culturally competent manner will improve the care of patients for whom they care" (Purnell, 2019, p. 9).
4. "To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and worldview of diverse populations and individual acculturation patterns" (Purnell, 2019, p. 9).
5. "To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and worldview of diverse populations and individual acculturation patterns" (Purnell, 2019, p. 9).

This model can be integrated into any health care setting (Purnell, 2014).

Walden University criteria for a staff education project includes utilization of "The Staff Educator's Guide to Professional Development." This book details the utilization of a framework to Analyze, Design, Develop, Implement, and Evaluate aka the ADDIE Model to use in developing professional education. The ADDIE model is a framework similar to the nursing process and was helpful in developing educational activities (Jeffery et al., 2016). The ADDIE model steps are:

1. Analysis: assessing for a problem/gap in skill, knowledge, and identify stakeholders.
2. Design: during this stage, design activities for learning such as developing objective, and asking questions.
3. Development: consider use of technology to reinforce education suchas a power point presentation.
4. Implementation: final tasks and presentation are completed.
5. Evaluation: this portion will answer questions such as the results of the activity; or if there was learned behavior (Jeffery et al., 2016).

The following terms are defined as they were used in this project:

Cultural competence relates to the ability of healthcare professionals to provide care to diverse populations with different beliefs and values.

Health disparity includes the burden of a disease experienced by a specific group of individuals, often due to economic, social, or environmental disadvantages (NHPCO, 2008).

Underutilization, also referred to as underuse, refers to the state of not using something to its full potential.

Hospice care relates to care provided to individuals in their end-of-life stage, with the aim of making them feel comfortable by meeting their emotional and spiritual needs (Parajuli et al., 2020).

Relevance to Nursing Practice

Health disparities negatively affect certain populations who have faced barriers to health care due to socioeconomic status, geographic locations, ethnicity, and other factors (ODPHP, n.d.-a). Health disparities are also reflected in hospice care among AA patients who underutilize hospice services (NHPCO, 2008). In the context of this project, underutilization of hospice services for the AA population is mainly attributed to nurses' lack of knowledge on health disparities for this population and their lack of cultural competence. According to discussions with hospice administrators, there is no specific training on cultural competence provided for hospice nurses (personal communication, July 21, 2020; personal communication, September 2020). Hence, the nursing practice problem this doctoral project focused on was the need for nurses to increase their knowledge of health disparities, and the importance of culturally competent care, to provide culturally competent care to the AA population. Subsequently, the goal was prevention of further disparities and underuse of hospice services (NHPCO, 2008).

Common barriers to hospice service access include healthcare disparities, incompatibility between the AA cultural, spiritual, and religious beliefs and the hospice philosophy, physician influence, the hospice admission criteria, and mistrust of the

medical establishment (NHPCO, 2008). Currently there are various relevant nursing practice approaches for preventing underutilization of hospice services among the AA population. However, there are no specific methods currently in practice, in turn, contributing further to underutilization of hospice services among the AA population (Loftin et al., 2013; NHPCO, 2008). Providers, including nurse practitioners, are less likely to have a conversation about hospice care with AA patients, which contributes to underutilization of hospice care (Rizzuto & Aldridge, 2017). Research shows nurses often underassess or inaccurately assess pain in AAs which leads to undertreatment of pain (Booker, 2015). Other research shows AAs rating of pain was rated lower than Whites by both nurses and nursing students which also furthers health disparities for AAs (Aronowitz et al., 2019).

Local Background and Context

This doctoral project addressed the practice problem by implementation of a staff educational intervention. The educational intervention was implemented at a hospice in Southern Nevada. The target facility offers hospice care to terminally ill, end-of-life patients. The organization is comprised of hospice nurses, clinical supervisors who are also RNs, and other hospice staff, such as social workers. The educational intervention target was hospice nurses at the facility. Pre and posttests, composed of multiple-choice questions, were completed by the nurses to determine the effectiveness of the educational intervention (Appendix B). Results of pre and posttesting showed this project increased nurses' knowledge of health disparities and cultural competence specific to the AA population, and the issue of hospice underutilization.

The locally used terms in the project, previously defined, include cultural competence, health disparity, underutilization, also referred to as underuse, and hospice care. Census information identified underutilization of hospice services by AAs at the local site. One Southern Nevada hospice census report showed 8% AA compared to 78% Whites in December 2019 (personal communication, December 2019). More recent figures for the September 2020 census show 9% AAs compared to 77% White patients (personal communication, September 2020). Another hospice facility in Southern Nevada identified a similar census report. According to the administrator at the facility in which this project was conducted, there were 11% AAs compared to 54% White patients on the July 2020 census report (personal communication, July 21, 2020).

Role of the DNP Student

As a DNP student, my key role in the project entailed development of the staff educational intervention designed to address the issue of underutilization of hospice by the AA population in the target facility. I designed a staff educational intervention using evidence-based approaches. I also developed the summative evaluations, (i.e., pre and posttests) used to evaluate the knowledge gained during the presentation. My main motivation for this doctoral project was a staff educational intervention. The intervention was a 1-hour presentation based on integration of the NHPCO AA Outreach guideline, HP2030, the Purnell model for cultural competence, and the ADDIE model. The class portion of this project began with pretests to assess knowledge prior to the intervention. After the main topics were presented with a PowerPoint presentation, posttests were

completed by participants. The class was completed both online and via Zoom within a 1-hour timeframe. An outline for the presentation is in Appendix A.

I am confident the project intervention was effective. The perspective which could affect the choices made about my motivation entails the previously outlined integration of HP2030, Purnell model, and NHPCO AA guideline approach for addressing the issue of underutilization of hospice services among the AAs. During my undergraduate nursing studies, cultural differences were briefly touched on in nursing theory. I began my nursing career as a hospice nurse and worked in this specialty for 11 years. I did not receive any specific training on cultural competence or health disparities during my years in hospice. I do not possess any biases which may affect the project's outcome.

Summary

Underutilization of hospice services among the AA population is prevalent, despite increased mortality rates among this ethnic group due to various chronic illnesses, including cancer and other issues such as maternal mortality rates. Various factors contribute to the underuse of these services by AAs, including nurse's lack of knowledge related to health disparities for AAs, mistrust of the healthcare system by AAs, healthcare disparities, and differences between the African American cultural, spiritual, and religious beliefs and the hospice philosophy (NHPCO, 2008). This project aimed to address the gap in practice based on nurse's lack of cultural competence and knowledge of underuse of hospice related to health disparities specific to the AA population with a staff educational intervention.

The project specifically focused on determining if a staff educational intervention could increase nurse's knowledge related to health disparities specific to the AA population and underutilization of hospice. Use of the staff educational intervention increased the nurse's knowledge of health disparities, and the need for cultural competence, ultimately enabling them to provide culturally competent care to the AA population to prevent further disparities and underuse of hospice services. Section 3 focuses on the collection and analysis of evidence-based regarding the identified gap-in-practice. The main areas covered include (a) the practice-focused question, (b) sources of evidence, and (c) analysis and synthesis of the findings.

Section 3: Collection and Analysis of Evidence

Introduction

The mortality rate for AAs decreased by 25% from 1999 to 2015 (Centers for Disease Control and Prevention [CDC], 2017). Conversely, there still exist discrepancies in death rates between Whites and AAs. Specifically, as of 2018, the prevalence of deaths per 100,000 AAs and White individuals in the United States was 852.9 and 725.4, respectively. In Nevada, the death rate was 871.6 for AAs compared to 761.6 among Whites (Kaiser Family Foundation, 2018). Similarly, the prevalence of terminal illnesses, such as cancer, are higher among AAs (Byhoff et al., 2016). Despite the death rates and prevalence of life-limiting illnesses among this population, AAs significantly underutilize life-sustaining strategies that are provided through hospice services. Paredes et al. (2020) used data from Medicare claims to assess racial and ethnic trends in the utilization of hospice services among 14,495 individuals who underwent pancreatectomy. Out of 14,495 patients, 6,859 (47%) died. Among the patients who died, three-fourths of the individuals (n = 4,978, 72.6%) used hospice. Paredes et al. (2020) found that individuals from racial/ethnic minorities were 22% less likely than their White counterparts to enroll for hospice services.

The underutilization of hospice services among AAs can be associated in-part by the referral patterns, hospital-based systems, underinsurance, inadequate awareness among the population, and the lack of cultural knowledge among healthcare workers, which result in the disparity (Dillon & Basu, 2016; Haines et al., 2018). The problem this project focused on was the need for nurses to increase their knowledge of health

disparities to provide culturally competent care for the AA population, which can prevent further discrepancies and underuse of hospice services. The underuse of hospice services results in adverse outcomes such as lack of compassionate care and increased healthcare costs. Approximately one-quarter of Medicare expenditures occur during the last year of a patient's life (Byhoff et al., 2016). Medicare costs among AAs exceeds those for White individuals by 20%. The prevalent Medicare cost can be associated with the minimal hospice utilization rates among AAs, which results in a disparity of care (Hughes & Vernon, 2019).

Consequently, AAs received fewer hospice-related advantages, such as improved quality of life, lower costs, and lesser symptoms (Byhoff et al., 2016). The purpose of the project was to increase understanding of health disparities and the need for cultural competence among nurses, specific to AAs, the lack of which results in the underuse of hospice services for this population. This section contains a discussion of the collection and analysis of evidence. The section's components include a (a) practice-focused question, (b) sources of evidence, (c) analysis and synthesis, and (d) summary.

Practice-Focused Question(s)

At the practicum site, it was identified there is an underutilization of hospice services among minority groups, including AAs. Specifically, in July 2020, AAs were significantly less likely to utilize hospice care than White patients with terminal illnesses (11% vs. 54%; personal communication, July 21, 2020). The gap in practice is nurses' lack of cultural competence and knowledge of underutilization of hospice related to health disparities specific to the AA population (NHPCO, 2008). The underutilization of

hospice services among AAs hinders the populations' access to compassionate care provided to decrease the burden of terminal illnesses symptoms and enhance the quality of life (Haines et al., 2018; Paredes et al., 2020).

A staff educational intervention increased nurses' knowledge of underutilization of hospice services by AAs, related to health disparities. The purpose of the project was to increase understanding of health disparities and the need for cultural competence among nurses, for AAs, the lack of which results in the underuse of hospice services for this population. The purpose of the project is congruent with the practice-focused question because it entails educating the nurses, who provide care at the target facility, to increase their cultural competence and understanding of the underutilization of hospice services, related to health disparities, among AAs.

The three key aspects of this project were cultural competence, AAs, and health disparities. In this proposal, the term *cultural competence* relates to the ability of healthcare professionals to provide care to diverse populations with different beliefs and values (NHPCO, 2008). AAs are a minority group in the United States, but the term in this study refers to individuals of the population with terminal illnesses. The term *health disparities* include the burden of a disease experienced by a specific group of individuals, often due to economic, social, or environmental disadvantages (NHPCO, 2008).

Sources of Evidence

The practice-focused clinical question was answered by collecting pre and posttest data on cultural competence and understanding of underutilization of hospice services from the participants. A 3-member expert panel reviewed the presentation and

pre/posttests. The literature included five electronic databases: CINAHL, MEDLINE, Academic Search Complete, OVID journals, and Complementary Index. The keywords used included *hospice, disparity, utilization, AA nurses*. The keywords were combined using a Boolean operator AND to develop search terms. The search terms included *hospice nurses* AND *understanding disparity, underutilization* AND *hospice services*, and *nurses* AND *understanding* AND *underutilization* AND *hospice services*. The most up to date literature was retrieved by setting the years of the terms searched within a 5-year timeframe.

Collecting the baseline and end-line data on the nurses' cultural competence and understanding of disparity helped achieve the project's purpose. Similarly, the collection and analysis of the pre and posttests helped determine whether staff education effectively increased the nurses' knowledge related to health disparities experienced by AAs which result in the underutilization of hospice services. Thus, the purpose, practice- focused question, and the pre/posttest results collected are congruent to each other.

Procedures

The data collected were pre and posttests used to assess the participants' understanding of the underutilization of hospice services among AAs. The intervention presentation was based on integration of the NHPCO AA guideline, HP2030, the Purnell model for cultural competence, and the ADDIE model. The class portion of this project began with pretests to assess knowledge prior to the intervention. The main topics were presented using PowerPoint, then posttests were completed by participants. The class was

completed both online and via Zoom within a 1-hour timeframe. The outline for the presentation is in Appendix A.

Protections

The participants indicated their willingness to be part of the project and understanding of the intervention by their participation. The staff education was conducted after receiving Walden's University Institutional Review Board (IRB) approval. The participants' confidentiality was supported by not collecting information such as names that can be used to identify them. My password protected computer was utilized for storage of project materials. No one else has access to my computer or password.

Analysis and Synthesis

The results of the pre and posttests were recorded on a Microsoft Excel sheet to help organize it. Recording of data on the Microsoft Excel sheet also helped systematically categorize the data. The accuracy of the recorded data was crosschecked and reviewed for missing values. The pre and posttests, (i.e., summative evaluations) were analyzed using descriptive statistics using percentages and means.

Summary

This DNP project focused on the issues of lack of cultural competence among nurses and the underutilization of hospice services related to health disparities among AAs. It is well documented that although AAs are disproportionately affected by chronic illnesses and have higher death rates than their White counterparts, the population is less likely by approximately 20% to use hospice services. The limited use of hospice services

hinders the AA access to compassionate care and burdens the population with terminal illness symptoms, which affect their quality of life and increase the cost of Medicare. The staff educational intervention helped increase nurses' cultural competence and understanding of the underutilization of hospice services among AAs. The baseline and end-line data were collected using pre and posttests. Microsoft Excel was used to compare the pre and posttest results and determine if the staff education had a statistical impact on the nurses' knowledge.

Section 4: Findings and Recommendations

Introduction

The underutilization of hospice services for AAs related to health disparities remains a problem in Southern Nevada. The gap in practice, identified at a Southern Nevada Hospice organization, is nurses' lack of cultural competence and knowledge of the underuse of hospice related to health disparities specific to AA population (NHPCO, 2008). A staff educational intervention increased nurses' knowledge of underutilization of hospice services by AAs, related to health disparities. The purpose of this DNP project was an educational intervention for nurses providing hospice services to the AA population, to improve their knowledge and understanding of health disparities and how these relate to AAs underutilization of hospice.

The project was implemented by following these steps. First, the IRB at Walden University approved the staff education project (IRB #05-17-21-1012790). Next, a meeting took place with the project organization for finalization of the project presentation. The project was presented on July 21st, 2021. All eight nurses in the organization were invited, along with 20 other nurses and nursing administrators from other hospice organizations in Southern Nevada. The presentation was offered both in person and via Zoom. It was explained to the organizations' nurses that participation was voluntary and their willingness to partake in the project would be indicated by their participation. After 10 nurses, including all eight of the project's site nurses, verbalized understanding, data was collected by means of pretests. Each participant received a pretest which was randomly numbered 1–10 and placed in individual identical folders.

The folders were distributed randomly to the participants. After completion, participants then placed their completed tests into a manilla envelope.

Next, the main topics were presented using a PowerPoint. After a brief question and answer session, participants were given a posttest. Participants were instructed to write the same number on their posttest as was on their pretest. After posttests were completed, participants placed their tests into the same manilla envelope. There was one Zoom participant who was emailed the pre and posttests with instructions on how to complete the process. The completed tests were then collected in person and placed in the manilla envelope. The tests were used to assess participants' understanding of the underutilization of hospice services among AAs and to assess knowledge before and after the educational intervention.

Findings and Implications

Descriptive statistics were used to determine if the staff educational intervention increased each nurse's knowledge of underutilization of hospice services by AAs, related to health disparities. The baseline and final data were collected using pre and posttests. A Microsoft Excel sheet was used to organize data and compare the pre and posttests results to establish if the staff education had an impact on nurses' knowledge. Criteria for analysis was each pre and posttest had to have a number at the top of the page and every question had to be answered. Also, each pretest had to have a matching numbered posttest. The posttests showed increased scores. Appendix C shows results of the posttest scores, which identified improvement from the sum of the pretest scores. After the educational intervention, a 47.6% increase in overall knowledge was identified by the test

results. These numbers are important because they reflect how much this small group of nurses learned in such a small amount of time. The scores were as follows (see Appendix C):

- Pretest = 57.1
- Posttest = 84.3

Scores were recorded on a Microsoft Excel sheet which helped organize and systematically categorize the data. The accuracy of the recorded data was crosschecked and reviewed for missing values. The summative evaluation (i.e., pre and posttests) were analyzed using descriptive statistics (Appendix D).

The 3-member expert panel reviewed the pre and posttests and educational presentation to determine content validity (Lawshe, 1975). Each panelist independently rated each question and the educational presentation answering, “Is the skill (or knowledge) measured by this item (a) essential, (b) useful but not essential, or (c) not necessary to the performance of the job” (Lawshe, 1975, p.567). All panelists rated each question and the educational presentation as “essential” (Lawshe, 1975, p.567).

One unanticipated limitation was Question 5, on both the pre and posttests, had to be dropped due to participant confusion caused by miswording. The question was supposed to read “Which of the following is not an adverse outcome of the underutilization of hospice services?” The word “not” was missing; therefore, participants were confused about the answer options. Thus, the analysis was completed on the remaining seven questions instead of eight. The impact this has on the findings is unknown. It is unknown how participants would have scored on Question 5. Findings

could have either increased or decreased participant scores leaving the results unknown if there was further increase in knowledge. However, considering the expert panel scoring of the presentation material, I believe the scores of this group are significant.

It can be concluded, from the project results, there was an increase in some nurses' knowledge of underutilization of hospice services by AAs, related to health disparities and lack of cultural awareness. The implications resulting from this project and the increase in knowledge may lead to higher quality and culturally competent care (Purnell, 2014). The potential positive social change this project holds is increased nurses' ability to provide care for ethnically diverse patients such as AAs (ODPHP, n.d.-a). This positive social change aligns with one of the objectives for the new HP2030 Social Determinants of Health and one of its five subcategories, "Health Care Access and Quality" (ODPHP, n.d.).

Recommendations

Recommendations for future studies include evaluating beyond increased nurse's knowledge. Further evaluation of the educational intervention should be of the effectiveness on quality of care provided by the nurses. Specifically, evaluate if an organizations current AA hospice patients are receiving better quality of care. One way to carry through with this is by organization instructors' observing nursing care (Boucher & Johnson, 2020a). Other HP2030 recommendations include interventions such as increasing understanding of developing patient relationships to help increase patient satisfaction and outcomes (Office of Disease Prevention and Health Promotion [ODPHP], n.d.).

Strengths and Limitations of the Project

A strength of this project was the content validity process used. As mentioned previously, all the panelist rated all content as "essential." Content validity increases when greater than 50% of panelists determine the content is essential (Lawshe, 1975, p.567). Another strength is cultural competency education is now more than just recommended; it is now a requirement of the Nevada State Board of Nursing.

Implementation of cultural competency education is now mandatory due to recent changes during the Nevada Legislative 2021session (LegiScan, n.d., 2 section). What also strengthens this project is it is based on current recommendations, by the United States government, to improve health care access and quality by increasing access to better quality medical services as outlined in HP2030 (ODPHP, n.d -c.). Additionally, a strength of this project is it addresses national priorities as it follows recommendations of the NHPCO to educate nurses on becoming more knowledgeable on health disparities and end-of-life issues specific to the AA population; and how these disparities lead to the underutilization of hospice services (NHPCO, 2008).

The possibility of this kind of training with other underserved populations, such as Hispanic, is another strength for this project. The Hispanic population have similar issues as AAs regarding end-of-life care such as health disparities, lack of cultural competence within healthcare, and access issues (McCleskey & Cain, 2019). A limitation of this project was the small number of participants. Of the 20 invited participants, only 10 nurses were present. Another limitation was the number of hospices willing to share their census information. According to Hospice Analytics, Inc., there are 31 hospices

listed in the state of Nevada but only 3 total censuses were obtained from hospices willing to participate in this project. Recommendations for future projects addressing similar topics and using similar methods include increase the expert panel size to an even number of experts. According to Lawshe (1975), the best results have been found with an even number of panelists. The greater the number of panelists who determine the tests information is essential, the higher the level of validity (Lawshe, 1975, p.567).

Section 5: Dissemination Plan

My plan to disseminate project findings include submitting a manuscript to the Journal of Chi Eta Phi Sorority (JOCEPS; Chi Eta Phi Sorority Incorporated, 2021). Chi Eta Phi Sorority Incorporated is a national professional nursing organization founded in 1932. This organization has several areas of focus including health promotion and disease prevention and advocating for social change by strengthening and inspiring nurses and student nurses (Chi Eta Phi Sorority Incorporated, n.d.). JOCEPS is a peer-reviewed journal focused on disseminating the contributions of nursing professionals to underserved populations around the world (Chi Eta Phi Sorority Incorporated, 2021). I also plan to disseminate project findings by meeting with project site administrators and clinical managers to discuss the project results. Additionally, I plan to submit my abstract for consideration of a podium presentation for the 2022 Chi Eta Phi Sorority Incorporation Southwest Regional Education Conference. I have also been asked by two medical organizations in Nevada to do a presentation for them after graduation. After graduation I would like to become a continuing education provider and offer this education. Providing continuing education in Nevada will help meet the new requirements of Assembly Bill 327 which requires completion of two hours of cultural competency and diversity, equity and inclusion continuing education. On May 31, 2021, NRS 632.343 was amended to require this mandatory education to be completed every 2 years and must address a diverse range of cultural backgrounds including age; race; ethnicity; sexual preference; religion; physical, intellectual, and developmentally disabled; and others (LegiScan, n.d.,2 section).

Analysis of Self

My view on cultural competence has expanded during this process. I view cultural competence not only as relevant knowledge but as a fundamental skill nurses' need to develop just like any other skill essential for quality care. This knowledge can affect a patient's health outcome. Increased cultural competence helps patients gain respect and trust, which leads to improved patient care, promotes health, decreases costs in healthcare, and reduces the rate of mortality and morbidity (Sharifi et al., 2019). I have been told many times on this journey that earning my degree is not a race, so I have learned to be patient with myself and trust the process. This lesson is important going forward as a doctorate prepared nurse as I discover new problems to address during my career. I realized health disparities will be my area of focus for the duration of my career for reasons such as certain ethnic or racial populations, including AAs, have greater difficulty accessing medical services. This is due to barriers such as mistrust of healthcare and the healthcare system in general. These barriers lead to further health disparities for this populations (Purnell, 2014).

Summary

Following an educational presentation, participants test results showed evidence of increased knowledge among the nurses on underutilization of hospice care for AAs, related to health disparities (NHPCO, 2008). The project findings contribute to the literature available on health disparities which continues to provide undeniable evidence there is a need for nurses and other health care workers to provide culturally competent care (Purnell, 2014). Although culturally competent care is vital to quality care, there is

no clear method for implementing this concept (Sharifi et al., 2019). My hope is this educational project will provide direction for others on implementing culturally competent education; in turn, reducing the occurrence of underuse of hospice related to health disparities specific to the AA population (NHPCO, 2008). “Mortality is universal; there is no color line in death and there should not be one in life either” (NHPCO, 2008, p.3).

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Appendix A: Project Outline

Learning objectives:

(1) Identify factors which lead to underutilization of hospice services and further health disparities for AAs.

- Lack of nurse's cultural competence.
- Mistrust and fear of the health care system.
- Difficulty accessing health care services.

(2) Discuss approaches to identify and implement evidence-based practiceguidelines to increase cultural competence for providing care to AA's.

- NHPCO AA Guideline:
  - Educate hospice staff on health disparities
  - End of life issues specific to AA's
- Purnell Guide to Cultural Competence:
  - Educate nurses to be familiar with population caring for.
  - Increase cultural diversity knowledge (Purnell, 2014, Chapter 4).
- Healthy People 2030:
  - Develop patient relationships to help achieve better patientoutcomes.
  - Access to timely, better quality medical services
  - Improve communication between patients and nurses (Officeof Disease Prevention and Health Promotion [ODPHP], n.d.-c).

The main topics for these objectives will be presented, using PowerPoint, time will be allotted for Q & A, then participants will be given posttests. Due to the current pandemic, this class will be completed online via Zoom within 1- hour timeframe.

Appendix B: Pre and Posttest

General Purpose: Assess the hospice nurse's understanding of AA’s underutilization of hospice services. Please select an answer.

1. African Americans are less likely than Whites to seek hospice care services
□ True
□ False

2. How can the number of African Americans in hospice care be increased?
□ Educating African Americans about hospice services
□ Providing free hospice services
□ Having multicultural healthcare professionals
□ Supporting cultural diversity in hospice through education

3. What is a prevalent cause of the limited utilization of hospice services among the African American minority group?
□ Geographical location
□ Social support
□ Social-economic status
□ Lack of nurses’ cultural competence

4. How can nurses decrease the underutilization of hospice services?
□ Being culturally sensitive
□ Appreciating other’s beliefs
□ Being aware of other’s differences.
□ Having an attitude of humility and success

5. Which of the following is an adverse outcome of the underutilization of hospice services? **This question was eliminated from the results process. It should have read “Which of the following in NOT an adverse outcome of the underutilizationof hospice services?”**
□ Increased burden of terminal illness symptoms
□ Decreased Medicare cost
□ Decreased quality of life
□ Increased Medicare cost

6. Nurses can provide culturally competent care by:
□ Admitting to one’s own prejudices
□ Agreeing with viewpoint of other cultures
□ Not being racist
□ Knowledge of various cultures

7. African Americans have greater difficulty accessing medical services due to?

□ Less interest in their health
□ Mistrust of healthcare workers
□ Insurance issues
□ Language barrier

8. Reasons AA do not choose hospice include all **except**?

□ Hospice representatives lack of interest
□ Difficulty making decision
□ Personal fears
□ Beliefs and opinions of others

Appendix C: Pre and Posttest Scores as Percentages

Participants	Pre-test	Post-test
1	57	86
2	71	71
3	43	86
4	14	100
5	86	86
6	86	86
7	29	71
8	57	71
9	71	100
10	57	86
Percent Total	**57.1**	**84.3**

Appendix D: Pre and Posttest Results Bar Graph