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End-of-Life Care for African Americans: A Staff Education Project

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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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Project Submitted in Partial Fulfillment

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Abstract

Increased knowledge is needed among long-term care facility staff members regarding end-of-life care services. There is a gap in staff knowledge regarding how to initiate education about these care services with patients and family members and how these services impact patient care and health outcomes, especially among the African American residents in long-term care facilities. The practice-focused question addressed in this project was whether staff education increased the staff members' knowledge about end-of-life care and how to initiate conversations with African American patients and families on available services. The development of this staff education project used Roger's diffusion of innovation theory followed by the application of the analysis, design, development, implementation, and evaluation (ADDIE) model to facilitate translation of the evidence into practice. A total of 16 staff members, representing all three shifts at the facility, attended the education in-service. The education included a PowerPoint presentation followed by a short question-and-answer session. A pretest and posttest were used to collect knowledge data before and after the staff education. Descriptive statistics in the form of number of correct answers were used to analyze findings. The change in mean test scores from pretest (58.75) to posttest (88.75) suggested that the education was effective in increasing staff knowledge. The potential positive social change resulting from this project is the increased use of end-of-life care services among African American patients in the long-term care facility and the easing of pain and suffering at end-of-life.

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Dedication

To my mom, Enid Rigby, husband Marlon Britton, and my three wonderful children Montell, Brianna, and Tyler. Your love, support, and encouragement give me the room and freedom to dream and the confidence to make those dreams a reality.

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Thank you, Dr. Sue Bell, for your guidance, understanding, and support during this journey. Dr. Edna Hull your input and critique has been invaluable in making this journey a reality and will carry forth throughout my professional journey. Valarie Gaston, my fellow classmate and now friend, thank you for all your prayers, support and encouragement when feeling discouraged.

To my family, Marlon, Montell, Brianna, Tyler, brother Junior, and mom Enid, I could not have done this without your support and encouragement. Thank you all for your listening ears and sacrifices made throughout these years and for helping make my dreams a reality.

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Section 1: Nature of the Project

The number of Americans ages 65 and older is projected to nearly double from 52 million in 2018 to 95 million by 2060, and the 64-and-older age group share of the total population will rise from 16% to 23% (Estrada et al., 2021). The older population is becoming more racially and ethnically diverse. Between 2018 and 2060, the share of the older population that is non-Hispanic White is projected to drop from 77% to 55% (Estrada et al., 2021).

The aging of the baby boom generation could fuel a more than 50% increase in the number of Americans ages 65 and older requiring nursing home care, to about 1.9 million in 2030 from 1.2 million in 2017 (Estrada et al., 2021). The demand for elder care will also be driven by a steep rise in the number of Americans living with Alzheimer's disease, which could more than doubled by 2050 to 13.8 million, from 5.8 million today. The projection in the number of older adults living alone without family members willing or able to provide care will contribute to increasing demands for community-based health care services including long-term care facilities (Chong & Moon-HoHo, 2018).

End-of-life care can be described as care services provided to individuals who have a life-limiting disease and care, and comfort are their preferred treatment choice. This aspect of care is composed of two types of care: palliative and hospice care. According to Estrada et al. (2021), palliative care is specialized medical care for people living with a serious illness whose goal is to improve the quality of life for patients and families through the prevention and relief of suffering. Palliative care is meant to enhance a person's current care by focusing on quality of life, early identification of disease/illnesses and management of the physical attributes of the disease such as pain or other distressing symptoms (Estrada et al., 2021). Hospice care is described as comprehensive services provided to individuals who are diagnosed with a life-limiting illness and the emphasis and focus of the care are placed on symptom relief and pain management in the last phase of an incurable disease (Estrada et al., 2021). As in palliative care, hospice care provides comprehensive comfort interventions and support for the family, but in hospice, attempts to cure the person's illness are stopped (Estrada et al., 2021). Hospice care also includes the provision of medical, psychological, and spiritual support to patients and families, coordination of care and clarification of the patients and family's goals of care and quality of life. For this Doctor of Nursing Practice (DNP) project, I will focus on hospice care when referring to end-of-life care services.

The staff knowledge practice gap related to end-of-life care is important to address as hospice care provides patients and families with care, comfort, and improved quality of life after the diagnosis with a life-limiting disease. Racial and ethnic minority older adults who resides in the long-term care facilities tend to have poorer overall quality of care (Estrada et al., 2021). Due to the vulnerability of long-term care patients; and the growth of the racial/ethnic minority population in these long-term care facilities, it is important to address health care disparities at end-of-life care among minority patients residing in the long-term care environment.

Evidence has confirmed that nursing home quality of care disparities exists. A systematic review found that racial/ethnic minority nursing home residents had lower advance directive completion rates compared with White residents and were more likely to be hospitalized and report more discomfort at end of life. Hospice use among the residents was mixed, but a higher proportion of racial/ethnic minority residents was associated with decreased hospice use, and the end-of-life care disparities increased as the proportion of racial/ethnic minority residents increased within the nursing homes (Estrada et al., 2021). According to Estrada et al. (2021), some of the reasons for the disparity include the history of mistrust of the medical establishment among racial/ethnic minorities, feelings of discrimination and feeling valued "less" by physicians, and nursing staff that do not represent the minority group demographically. In addition, clinicians have expressed difficulty in discussing advance care planning with racial/ethnic minority patients and often have preconceived notions regarding their willingness to engage in these discussions (Estrada et al., 2021). While end-of-life services have been shown to improve quality of life and maintenance of dignity for patients, there has been underutilization especially among ethnic/racial minority populations; specifically, among African Americans, hospice care has declined since 2007 (Mazenec et al., 2012).

The purpose of this DNP project was to develop and implement a staff education in-service for the long-term care facility's staff to address the issue of underutilization of end-of-life care among African American patients. The educational in-service defined end-of-life, hospice, palliative care, disparities, and barriers to utilization. Implementation of the staff education bridged the knowledge gap, created positive social change by addressing barriers to end-of-life care utilization and improving quality of care.

Problem Statement

The problem to be addressed by this DNP project was the underutilization of end-of-life care services by African Americans in a long-term care facility. End-of-life care is described as care services provided to meet the needs of patients encountering life-limiting medical conditions. End-of-life services include palliative and hospice care that facilitate the primary goals of providing comfort, pain relief, stress reduction, and symptom relief that are associated with certain disease.

The utilization of end-of-life care services provides several benefits, including enhanced patient care outcomes, increased patient and family care satisfaction, improved quality of life, and lower medical costs during the last days of life (Dillon & Basu, 2016). Although hospice and palliative care services may be readily utilized and accepted among some patient populations and cultures, the concept can be met with anger, hostility, evasiveness, and lack of understanding among the African American population (Dillon & Basu, 2016). The lack of hospice utilization and end-of-life care among African Americans is disheartening because the omission of these services leads to greater numbers of African Americans dying in hospitals, experiencing long periods of uncontrolled pain, futile treatment, and increased expenses (Dillon & Basu, 2016).

According to Dillon and Basu (2016), African Americans comprise approximately 12.6% of the U.S population, yet this population group accounted for only 8.5% of hospice patients in 2012. There is emerging evidence describing factors leading to the disparity between African Americans and Caucasians utilizing end-of-life care. Numerous studies have identified factors associated with the underutilization of end-of-life care among African Americans including spiritual beliefs, financial concerns, cultural caregiving practices, mistrust of the healthcare system and preferences for aggressive treatment, but the most noticeable and concerning factor is poor communication and education from health care providers who have insufficient knowledge on end-of-life care (Dillon & Basu, 2016).

According to Dillon and Basu (2016), in recent years, health researchers and practitioners have demonstrated an increased interest in and attention to disparities in end-of-life medical care and are investigating the reasons behind identifies disparities in the care of older African American adults nearing end of life. Recent research has shown that care provided to terminally ill African Americans is generally more expensive and of lower quality than care provided to White patients due to the use of expensive and futile life-sustaining treatments (Dillon & Basu, 2016). It has long been established that African Americans are not trusting of the health care system and the services it provides, which stems from blatant mistreatment and unethical research practices in the past (Dillon & Basu, 2016). One of the most unethical studies leading to this mistrust is the Tuskegee Syphilis Study/Experiment. This experiment was conducted between 1932 and 1972 among impoverished African American sharecroppers who were enrolled as research subjects under the false pretense that they were obtaining treatment for syphilis in exchange for free medical care (Morris, 2016). It was later exposed that these men were never informed of their diagnosis and were subjected to disguised placebo, an ineffective treatment regimen and procedure, and never given the proven treatment of penicillin even though by 1947, the antibiotic was widely available, and had become the standard treatment for syphilis (Morris, 2016). The study is believed to have contributed to a general mistrust of the medical community among the African American community.

Spiritual and religious beliefs are additional factors that have had a significant impact on the utilization of end-of-life care services by the African American population. Religion and the refuge it offers goes back to the days of slavery when religion and the church became the most important social institutions in the African American culture. According to Townsend et al. (2017), African Americans believe in the omnipotence of God, and illness and death are viewed as God's will. God is benevolent and has miraculous powers where he can cause recovery resulting in good health outcomes. Many African Americans consider themselves religious, seek health care advice from their pastors, and use religion as a coping strategy.

The third factor that has a significant influence on the use of end-of-life care services is the financial disparity that exists among African Americans. According to Dillon and Basu (2016), African Americans are twice as likely to be uninsured than non-Hispanic Whites causing greater difficulties in gaining access to health care services and quality medical care. As a direct result, when African Americans do access health care services, they often receive lower quality care than Caucasians and are often faced with racial bias and discrimination within the health care system (Dillon & Basu, 2016).

A fourth factor that has a significant influence on the utilization of end-of-life care services is the lack of culturally competent care. Culture has a direct impact on how individuals view health, illness, death, and dying, and providing care that is sensitive and congruent to their cultural beliefs is important. Misconceptions associated with lack of cultural sensitivity and skills lead to unwanted treatments and inappropriate health care outcomes as well as poor interactions with patients and families at a critical point in care (Dillon & Basu 2016). The task of educating this patient population lies with health care providers including nurses and ancillary staff across all health care delivery settings. Increasing the knowledge of a long-term care facility's staff about end-of-life care services and options will be a way to increase staff ability to educate patients resulting in use of end-of-life care services among African American patients and families.

Although hospice care service is viewed as the gold standard for end-of-life care, there is a significant difference in enrollment and utilization of hospice care among racial and ethnic groups (Collins et al., 2018). According to Mazanec et al. (2012), the use of hospice services by African Americans compared with the general population is significantly less than that of Caucasians, even after controlling for added factors such as education and income. Underutilization of these care services among African Americans continues today, even though tremendous advancements in end-of-life care and practices have been made (Collins et al., 2018).

The practice gap identified in this clinical setting was the lack of knowledge on the part of staff, patients, and families of what comprises end-of-life care programs and services. More specifically, what has been observed was a staff knowledge deficit regarding how to educate African American patients and families about end-of-life care. The unit manager and administrator at the project site reported that despite hospice and palliative care services being offered within the facility, nurses and other healthcare staff were uncomfortable discussing death and dying with patients and families due to lack of knowledge and competence on end-of-life care. According to White and Coyne (2011), nurses and other healthcare professionals are the frontline caregivers for patients with life-limiting diseases, but a significant gap exists in nursing undergraduate, graduate, and continuing education programs on end-of-life care. As a result of this gap, nurses, and other healthcare professionals lack the knowledge and skills needed to educate patients and families on end-of-life care services (White & Coyne, 2011).

Because nursing staff provide patient education, increasing staff knowledge about end-of-life care can equip the staff with the knowledge and information to successfully provide and meet the educational needs of the African American patient population in the facility. The staff education program provided education for nurses, social service professionals, and admission personnel on end-of-life care that can improve the education and assistance to African Americans patients and family members in utilizing these services. Educating staff on end-of-life services have both short-term and long-term benefits. Short-term benefits include increasing the staff knowledge and competency about end-of-life care options, program purpose, how to offer the care to patients and families, and how to implement the services. The long-term benefits are appropriate end-of-life care education and increased program utilization

Purpose Statement

The primary purpose of this DNP project was to develop and implement an educational in-service for facility staff to address the underutilization of end-of-life care services among African American patients and families. Providing a targeted intervention to enhance staff knowledge related to end-of-life care services may ultimately result in improved knowledge transmission to patients and families and increased utilization of end-of-life care services. The educational in-service was constructed to address the following practice-focused question: “Will an educational in-service increase the knowledge of staff in the long-term care facility on hospice care introduction and delivery to African American patients and families?” As staff members continue to encounter the progression of illnesses and health decline, an educational in-service to educate staff members on the program and services that are offered in end-of-life care can be beneficial to staff, patients, and families. Implementation of the education can increase staff knowledge and ability to educate African American patients and families on end-of-life care and services. This educational in-service can potentially result in increased utilization of end-of-life care services.

Nature of the Doctoral Project

For this DNP project, a staff education in-service was implemented and delivered over 4 weeks in a long-term care facility. This timeframe was selected to ensure that staff working on all shifts can participate in the education program. The Walden University’s library resources were accessed to obtain best practices for end-of-life care among African Americans and the utilization of these services among the African American population residing in long-term care facilities. Additionally, a search of the literature was conducted to assess barriers that exist among African American patients and families in the long-term care setting and the knowledge deficit that exist among long-term care facility staff on end-of-life care. Databases that were accessed for this DNP project include PubMed, CINAHL and Google Scholar. In addition, I have accessed some organization websites and research information from organization websites such as the National Coalition for Hospice and Palliative Care, the Association of Death Education and Counseling, and the American Academy of Hospice and Palliative Medicine. I developed a staff education program utilizing the best evidence in the literature to increase facility staff knowledge on end-of-life care and how to impart that knowledge to African American patients and families.

The educational program was reviewed and evaluated by the facility's administrator, director of nursing, and the nurse educator to ensure the accuracy and appropriateness of the educational program before delivery of the education program. The education program was delivered through a PowerPoint presentation and question-and-answer session. Each session lasted for approximately 1 hour and included two sessions on multiple days and time to capture staff members on the various shifts. The in-service was held at 8:00 a.m. to be convenient for the outgoing night shift staff and the incoming day shift staff, and in the afternoon at 4:00 p.m. to ensure opportunity to attend for the incoming evening shift and out-going day shift staff members. Staff members were only required to attend one in-service session. At the educational in-service, staff participants took part in a pretest to assess their current level of knowledge on end-of-life care to facilitate educating patients and families about these care services. As staff participants entered the in-service conference room, they found a copy of the written pretest and a pen or/pencil on the desk where they were asked to complete the knowledge pretest. When all participants had completed the pretest, the PowerPoint presentation was delivered. A posttest was administered after delivery of the education PowerPoint presentation to assess whether knowledge about end-of-life care increased after the education. Staff members were also asked to indicate their likelihood to engage patients and family members in education on end-of-life care. Data obtained from the pretest and posttest were compared using simple descriptive statistics (counts and percentages) to measure differences in knowledge. Assessment of the effectiveness of the education in-service was obtained through a summative evaluation. The summative evaluation was completed by the staff participants at the very end of the in-service after completing the posttest. The summative evaluation was used to evaluate and give feedback on the presentation and presenter's effectiveness and the participants' satisfaction with the educational in-service.

Significance

The selected project site is experiencing low numbers in hospice and palliative care enrollment, especially among the African American patient population. Although end-of-life care services have been shown to improve patients' overall quality of life, the enrollment rate remains low among African Americans in this long-term care environment. At the time of this project, in 2021, according to the facility's electronic health record, the facility patients' census currently is at a 63% occupancy with a total of 136 patients in-house and 70 empty beds. Of the 136 patients residing in the long-term care facility, three are active hospice care patients, an enrollment of less than 2.5% of the residents. Of the three patients who are enrolled, two are Caucasian and one is Hispanic. It has been identified through assessment and evaluation that another 11 patients would benefit from hospice care services based on diagnosis and current medical condition, all of whom are African American. Further assessment showed that staff personnel were reluctant to discuss end-of-life services with these patients and their families, which may have further contributed to the existing problem. According to Dillon and Basu (2016), there are multiple reasons why end-of-life care services are not chosen by African Americans with lack of knowledge and understanding of these services considered the primary reason for the low enrollment.

The project is significant as it addressed the practice-focused problem of staff knowledge deficit about end-of-life care services. Evidence collected to support this project provided information to develop the educational in-service about end-of-life care. The educational in-service contributed to the field of nursing by empowering nurses and health care staff who are educated in the end-of-life services to feel competent to discuss services with patients and families. Through the knowledge obtained from the education program, nurses can educate patients and families, which can result in increased use of end-of-life care services. These services contribute to the field of nursing as one of the primary goals for nursing practice is to provide patients with comprehensive care that addresses their social, emotional, and physical needs. The demand for evidence-based interventions to improve patient outcomes is critical in the evolving healthcare environment. Patients and families will benefit from hospice services through the provision of a variety of support services such as education, and emotional and spiritual support.

Summary

The gap in practice identified for this staff education project was the underutilization of end-of-life care services among African American patients and families residing in a long-term care facility. It has been identified that the lack of education among long-term care staff has a direct impact on patients and families being educated to make informed decisions about accepting end-of-life care services, thereby contributing to underutilization of these services. This practice gap was addressed through answering the practice-focused question: “Will an educational in-service increase the knowledge of staff in a long-term care facility about hospice care introduction and delivery to African American patients and families?” Section 2 of this DNP project includes in depth discussion of the theoretical underpinnings used to develop this project, the relevance of the project to nursing practice, and the role of the DNP student in the implementation of the project.

Section 2: Background and Context

The practice problem addressed in this staff education project was the underutilization by African Americans of end-of-life services in a long-term care facility. End-of-life care has been shown to relieve pain and stress while providing comfort and maintaining dignity among patients faced with life-limiting health conditions (Dillon & Basu, 2016). This DNP project focused on implementing an evidence-based staff education program for staff members within the long-term care environment. The objectives of the staff education program were to educate staff on care and services provided by end-of-life care programs and how to address the needs of African American patients and families facing end-of-life decisions. This project was designed to answer the practice-focused question: “Will an educational in-service increase the knowledge of staff in a long-term care facility about hospice care introduction and delivery to African American patients and families?”

End-of-life care for long-term care residents is often a significant challenge for staff members as their levels of knowledge and their compliance with hospice and palliative care guidelines are known to be low (Part et al., 2019). By creating and implementing an education program, I hope to increase the knowledge of the long-term care staff so they can initiate educational conversations with African American patients and families about these services. Outcomes will result in more patients and families using hospice and palliative care services when faced with a life-limiting illness.

This section of the project is designed to introduce the theoretical underpinnings used to support this DNP project and include Roger’s diffusion of innovation theory and the analyze, design, develop, implement, evaluate (ADDIE) model. In addition, local context and background are discussed and used to formulate this project and the overall relevance of this project to nursing practice. Lastly, I will discuss the role of the DNP student and team members.

Concepts, Models, and Theories

The model that guided the development of this educational program was the ADDIE model. This model was first introduced in the mid-1970s and was initially developed for the (U.S.) Army (Molenda, 2015). This model was created by the Center for Educational Technology at Florida State University and was eventually disseminated to all divisions of the U.S. military (Molenda, 2015). The goal of this educational model was to demonstrate the connection between the development of instructional interventions and the development of performance improvement interventions. The ADDIE model was used within educational environments to facilitate the building of knowledge and skills during guided learning (Molenda, 2015). The model provides a systematic method of determining training needs, the design and development of training programs and materials, implementation of the program, and the evaluation of the effectiveness of the training (Allen, 2006).

The ADDIE model consists of five phases that include analysis, design, development, implementation, and evaluation (Molenda, 2015). The analysis phase assesses the barriers that exist and determines the goals of the target population. The design phase focuses on the planning and learning objectives of the target population. The development phase focuses on the instructional materials needed to address the identified needs obtained during the analysis and design phases. The implementation phase focuses on the application of concepts. It is during this phase that educational materials are presented, and modification and redesigns are addressed. The last phase is the evaluation phase, where the determination of whether learning objectives were met and where feedback is obtained from the target population. In preparing the proposal for this project, I completed the analysis, design, and development phases of the ADDIE model. The implementation and evaluation phases of the project were completed after the proposal was approved and the Walden University Institutional Review Board (IRB) gave permission to proceed.

The theoretical framework chosen for this education program was Roger's diffusion of innovation theory. The concept of diffusion was first introduced in 1903 by a French sociologist named Gabriel Tarde (Kaminski, 2011). Tarde was the first to plot the S-shaped diffusion curve. This theory, as restated for health care by Rogers as the diffusion of innovation theory, is known for being a valuable change model in directing innovations to meet the needs of the target population. The diffusion of innovation theory emphasizes the importance of communication and peer networking within the adoption process as new ideas, products, philosophies, and practices are introduced (Kaminski, 2011).

This theory distinguishes five categories of adopters of innovation: innovators, early adopters, early majority, late majority, and laggers (Kaminski, 2011). The innovators are risk-takers and change agents who are very receptive to implementing change. They are often referred to as the gatekeepers for the next group of adopters

(Kaminski, 2011). The early adopters serve as trendsetters and are viewed as role models for innovation. Early adopters make great tester subjects, act as opinion leaders and are cautious about change (Kaminski, 2011). Early adopters often have the attitude of wanting to see evidence and have the need to be convinced by others. The late majority are known as skeptics and are cautious about implementing change. Individuals defined as late majority adapt to new ideas after the average person but through peer pressure and are known to be easily influenced by laggers (Kaminski, 2011). The laggers are the last to convert and want to maintain the status quo. Laggers are suspicious of innovations and have an attitude of wanting things to remain the way it's always have been done (Kaminski, 2011). Laggers are generally the hardest group to motivate and adapt to innovation.

Roger's diffusion of innovation theory has been used successfully in the implementation of education within the health care environment (Mohammadi et al., 2018). Due to constant evidence-based implementation and a constant need for education, it is prudent to be cognizant of the various adapters in this process and design an educational program that can meet the needs and accommodate the various levels of adoption. According to Mohammadi et al. (2018), Roger's diffusion of innovation theory emphasizes that knowledge is produced when an individual is subjected to an existing innovation and acquires some understanding of its mechanism and functions. During the persuasion stage, individuals must form a view towards the innovation based on its perceived attributes. For a decision to be made, the individual must be involved in an activity that would require them to choose between implementing or dismissing the innovation (Mohammadi et al., 2018). For adoption to occur, the individual must decide that the innovation is the best available choice for moving forth (Mohammadi et al., 2018). The model and concepts were utilized in this DNP project through the collection of demographics (see Appendix A) that indicate education and years of practice, and the pretest and posttest questions (see Appendix B) related to satisfaction with the educational in-service (persuasion stage) and likelihood to implement the education by engaging in education of patients and families about use of hospice services (choice between implanting or dismissing the innovation in the adoption stage).

Relevance to Nursing Practice

End-of-life care service is an aspect of health care services that is greatly underutilized among the African American patients and families in the long-term care environment. My DNP project implementation site is currently experiencing low enrollment rate of hospice care service among African American patients. The facility currently has a total of 136 patients. Three patients are enrolled in hospice, two of them are Caucasian and one of them is of Hispanic heritage. Another 11 patients, all of whom are African American could benefit from hospice care based on their current medical condition and prognosis. This underutilization of hospice care services has created a practice gap within this long-term care facility. The underutilization of these care services within this facility has contributed to an increased patient hospitalization rate, patients being in increased anguish and pain at their end of life, and a general dissatisfaction with care at this late stage of disease. The lack of knowledge among the facility’s staff members about initiating conversations about end-of-life care services has contributed to the omission of these care services as a choice for African American patients within the long-term care facility (Johnson, 2013). Education is needed among the health care interdisciplinary team for end-of-life conversations to start and to enable communication of end-of-life wishes, thereby increasing the likelihood that patient and family needs will be met (Dillon & Basu, 2016).

Local Background and Context

This DNP educational project took place at a long-term care facility located in the southern region of the United States. This facility is a 206-bed institution in which 76% of the residents are African Americans with less than 3% of the residents being enrolled in end-of-life care and an identified 9% of additional patients who could benefit from these services immediately based on their current diagnosis and prognosis. Refusal of hospice and palliative care services at the end-of-life may result in uncomfortable, unsuccessful, futile life-sustaining efforts. In addition to the patients' reluctance to accept end-of-life care services, staff members exhibit a lack of knowledge about these services. I had multiple meetings with the director of nursing and the facility administrator both of whom identified this staff education project as an area of need for the staff. Because of the staff's lack of knowledge and the high percentage of African American patients, implementation of this project has the potential for improving care for African American as well as all patients receiving care at this facility.

Role of the DNP Student

My current role is that of a family nurse practitioner (FNP) within this long-term care environment. My experience ranges from being a charge nurse in an intensive care unit to being an FNP for 7 years, 4 years of which have been spent working with the geriatric population. As a provider within this setting, I have witnessed firsthand the disparity encountered by African American patients regarding end-of-life care services and the dilemma encountered by family members and facility staff. My role in the education project was that of project team leader whose responsibility was to develop an educational initiative and educate the facility's staff on end-of-life care for African American patients and families, the services it provides, and the options that are available. I was responsible for selecting the dates and time for the in-service offerings and putting together the materials and resources necessary for the educational in-service. In addition, I was responsible for creating the PowerPoint presentation and presenting it to the target audience, as well as developing the pretest, posttest, and summative evaluation questions.

Role of the Project Team

The project team for this educational project included me as the project team leader and educator, a DNP-prepared nurse practitioner who is my preceptor and mentor, and a hospice consultant who is a registered nurse. The hospice nurse assisted in the evaluation of the pretest and posttest and the overall educational presentation. The project team worked together to select dates and times as well as advertise the educational in-service. In addition, the project team identified needed resources, including printed educational materials, pencils, and meal selections based on the timing of the in-service.

Summary

This DNP project was initiated to address the gap in practice of patients in need of end-of-life services and the underutilization of end-of-life services of African American patients and their families in a long-term care setting. It has been identified that the lack of knowledge is one key contributor to this health disparity. Educating the staff members on end-life-care and options for African American will increase their knowledge and their competency and will enable them to educate patients and families on hospice and palliative services as an option when faced with life-limiting health conditions and decisions. In this section, I discussed the instructional model, the diffusion of innovation theory, the relevance of the project to nursing practice, the local background and setting for the project, as well as the role of the student and the project team. In Section 3, I will discuss the collection and analysis of evidence that were used to answer the practice-focused question.

Section 3: Collection and Analysis of Evidence

This staff education project addresses the underutilization of end-of-life care services among African American patients and families in a long-term care facility. One of the reasons for underutilization among this patient population regarding these care services is lack of knowledge. According to Dillon and Basu (2016), population-specific barriers that may limit African American participation in end-of-life care programs include poor communication with health care providers and insufficient knowledge. It was determined that facility staff members lack the knowledge needed to educate African American patients and families on end-of-life care. According to Malik and Chapman (2017), nursing home staff possess a significant gap in knowledge regarding end-of-life care among African Americans and the focus should be placed on communication and interaction, symptom management and goals of care. The objective of the staff education program was to develop and implement an education program to increase knowledge and provide tools for the facility's staff to educate African Americans patients and families about end-of-life care services as an option when faced with a life-limiting illness. Section 3 of the DNP project includes discussion of the practice-focused question, data collection and analysis, and the process by which evidence of staff knowledge were generated for this project.

Practice-Focused Question

The educational program was developed to address the following practice-focused question: "Will an educational in-service increase the knowledge of staff in a long-term care facility about hospice care introduction and delivery to African American patients and families?” This DNP project was implemented to address the lack of knowledge of the long-term care facility’s staff on end-of-life care and how to initiate education among African American patients. The approach of this project centered on the knowledge gap that exists among staff members in the long-term care facility. The program was designed to improve staff knowledge on end-of-life care that will be used to enhance the knowledge of African American patients and families. Increased staff knowledge related to end-of-life care services may ultimately result in increased use when appropriate of these care services by African American patients and families and help to close a gap that exists for the health care of this patient population.

Sources of Evidence

To collect evidence that supported this project, I obtained information from national and professional organizations that included the National Hospice and Palliative Care Organization, the Association of Death Education and Counseling, and the American Academy of Hospice and Palliative Medicine. In addition, databases were searched for evidence supporting this project including CINAHL, CINAHL Plus with Full Text, Medline with Full Text, and the ProQuest Nursing and Allied Health Database. Evidence within the past 5 years was collected to support relevancy of this education project and address the practice gap that exist at this long-term care facility. Additionally, the Walden University Staff Education Manual was used to guide the development of the staff education in-service.

Evidence Generated for the Doctorate Project

Participants

Participants of this project were all chosen based on their employment position held at the long-term care facility, their involvement in patient the admissions, and their participation in the care plan meetings with patients and families. The participants in this project consisted of the facility's staff who were selected because of their expertise and contribution on this subject as they have a direct role in communicating with patients and families. These individuals include the admissions personnel, a social worker, a nurse navigator, a registered nurse who is the charge nurse for the facility, and 12 licensed practical nurses (LPNs) who represented the four units of the facility on all shifts. Participation in this educational in-service was not mandatory but was encouraged.

Procedures

The goal of this project was to increase the use of end-of-life care services among African American patients and families in a long-term care facility. I have completed an assessment and conducted a thorough literature review which provides fundamental support for the education program. The staff education program included learning objectives to address the gaps in knowledge that exist consistent with the DNP Essentials. I developed and delivered a PowerPoint presentation about end-of-life care and how to initiate conversations and education specifically for African American patients and families. The teaching session was followed by an open discussion period.

I designed a flyer (see Appendix C) about the in-service and submitted it to the facility's administrator and nurse navigator for approval. After approval from the facility's personnel was granted, flyers were then distributed in various locations of the facility such as the staff lunchroom, bathrooms, nurses' stations, and clock-in stations in the facility to advertise the staff education program for the targeted audience and served as a reminder of the education in-service.

The procedure of this project involved the use a demographic questionnaire (see Appendix A) to evaluate the target audience background and level of knowledge, which may have affected their views on hospice care and hospice care use. In addition, a pretest and posttest (see Appendix B) was administered to staff who attended the educational in-service. Completion of the questionnaires was not a criterion for attendance at the educational presentation. Return of the completed demographics questionnaire and the pretest and posttest was considered informed consent to use the data. Data obtained from the demographic questionnaire and the true/false questions on the pretest and posttest were analyzed and presented using simple descriptive statistics, which included counts and percentage of participants choosing each answer. These data were used to determine whether the education program significantly improved the knowledge of the participants. A post-education summative questionnaire (see Appendix E) was administered to determine whether the educational in-service met the educational needs of the participants and increased the likelihood of use of the information to address the identified gap in practice.

Protection

I obtained a site agreement with my chosen project site and obtained Walden University's IRB approval to move forward with the implementation of the education program (IRB approval no.# 12-01-21-0391968). This education program was voluntary, and all participants names was kept anonymous. No names were used during this education program and no patients were involved, nor were data collected from patients. Participants in the project included the facility’s staff only. The demographic data questionnaire and the pretest and posttest were distributed in a paper format and measured anonymously. Collected data were analyzed and used to determined project outcomes. These data were later presented in aggregate format. An alphabetical designation based on the seating arrangement was used as a coding system to ensure that the pretest and posttest were aligned with the respective participants. There were no ethical issues presented for this educational project.

Analysis and Synthesis

For this DNP project, I used a pretest and posttest (see Appendix B) examination for data collection to answer the practice-focused question of “Will an educational in-service increase the knowledge of staff in a long-term care facility about hospice care introduction and delivery to African American patients and families?” Data collection for this DNP project included three categories: demographic data, pretest/posttest scores and summative evaluation data. Demographic data including age, gender, staff position, years of nursing experience, and prior hospice referrals made. This information was used to assess how these experiences have influenced staff knowledge and outlook related to end-of-life services.

Before the staff education, the paper pretest and a pencil were given to each participant as they entered the conference room, which was arranged in an alphabetical seating order based on the desk location. The pretest was in the form of true/false questions based on the literature and was used to assess current knowledge about end-of-life care and services. Upon completion of the education program, the posttest containing the same true/false questions as the pretest was given to each participant to evaluate knowledge gained as a result of the educational in-service. Because the coding system allowed pretest and posttest to be matched, simple descriptive statistics in the form of counts and percentages were provided for each participant. The comparison of the pretest and posttest scores helped in determining whether the educational program resulted in improved knowledge of end-of-life care by the facility's staff. The third data source was a summative evaluation to measure the effectiveness of the educational in-service in meeting the staff knowledge needs, satisfaction, and intent to use the information to improve end-of-life care in the facility (see Appendix E). The summative evaluation served to measure the target audience learning objective outcomes and education effectiveness (Billings & Halstead, 2016).

Data obtained from the participants were disseminated to the facility in written form, and the analysis and synthesis was presented in the final DNP paper in both narrative and table format. The nurse navigator who serves as the education improvement coordinator for the facility and the hospice care coordinator assisted in the evaluation of the exam scores to provide an unbiased evaluation of the educational in-service outcomes.

Although participation in this education program and completion of the questionnaires were voluntary, there was an 85% participation rate of the facility's identified staff members. At the end of the educational in-service, there was an increase in the knowledge about end-of-life care among long-term care staff members and how to educate African American patients and families on end-of-life care services. While not a goal of this DNP project, it is hoped that an increase in the use of end-of-life care services among African American patients and families will be achieved.

Summary

In summary, the selected project site is experiencing low numbers of hospice and palliative care enrollment, especially among the African American patient population. Although end-of-life care services have been shown to improve patients' overall quality of life, the enrollment rate remains low among African Americans in this facility. Further assessment has shown that staff personnel are reluctant to discuss end-of-life services with patients and families, which may further contribute to the existing problem. According to Dillon and Basu (2016), there are multiple reasons why end-of-life care services are not chosen by African Americans, but lack of knowledge about and understanding of the services provided in hospice care are the primary reasons for the decreased number of enrollments into end-of-life care services.

The practice-focused question guiding this project addressed the practice problem by educating staff about the needs of African American patients and families considering end-of-life care services. The education program was designed to increase staff knowledge, which should enhance their communication about end-of-life care services when working with African American patients and family members. Knowledge gained from this education program can enhance staff competence to provide patients and families with evidence-based information to assist in making end-of-life care decisions.

In the next section, Section 4, I will discuss the findings, implications, recommendations, and strengths and limitations of the DNP project and staff education in-service.

Section 4: Findings and Recommendations

The utilization of end-of-life care services among African Americans residing in long-term care facilities remains at a significantly low level. Racial and ethnic minority older adults who reside in long-term care facilities tend to have poorer quality of life and poor health outcomes (Estrada et al., 2021). Due to the vulnerability of long-term care patients and the growth of racial and ethnic minorities residing in these long-term care facilities, it is important to address health care disparities of end-of-life care among ethnic and minority populations residing in long-term care facilities. The gap in practice identified at the project site was the lack of knowledge by the facility's staff related to end-of-life care and the knowledge deficit regarding how to educate African American patients and families on end-of-life care programs and services. The practice-focused question that guided this DNP project was: "Will an educational in-service increase the knowledge of staff in a long-term care facility about hospice care introduction and delivery to African American patients and families?" The goal of the project was to increase the knowledge of the long-term care facility's staff who participate in the patient admission process and care coordination on end-of-life care programs and services and how to provide culturally congruent education to African American patients and families who can benefit from these care services, improving the underutilization of end-of-life care services among this patient population.

The project was implemented by following these steps. First, the IRB at Walden University approved the staff education project. Following IRB approval, a meeting was held at the project site for finalization of the project presentation. The two-member expert panel reviewed the pretest, posttest, and educational presentation to determine content validity (Lawshe, 1975). Each panelist rated the questions individually to determine whether the education presentation was (a) essential, (b) not essential for environment, or (c) useful but not necessary for the performance of the job (Lawshe, 1975). Both panel members rated the questions and educational presentation as essential for the staff members and the care environment. The project was presented on December 6, 2021, at 8: a.m. and December 7, 2021, at 4:00 p.m. The days and times were chosen to allow most staff members on all three shifts to attend. Attendance at the educational in-service included the admission liaison, the social worker, the nurse navigator, the unit charge nurse who is a registered nurse, and 12 LPNs representing all three shifts. The presentation was offered in-person in the facility's conference room. Prior to the start of the presentation, I explained to all attendees that their participation was voluntary and their willingness to attend the educational in-service and complete the demographic questionnaire, the pretest, and the posttest signified their consent for the project team to use the data collected. In addition, the Walden University Staff Education Manual consent form for anonymous questionnaires was distributed to each participant. After participants verbalized understanding, data were collected by means of the demographic questionnaire and pretest. At each seat in the conference room, a demographic questionnaire and a pretest were placed along with a writing utensil prior to the participants entering room. The questionnaires were labeled alphabetically according to the seating arrangement. After completion of the demographic questionnaire and pretest, participants were asked to place their completed documents in a collection box placed at the front of conference room.

Next, the main topics were presented using a PowerPoint presentation. Then, after a short question-and-answer session, participants were given the posttest. Posttests were distributed in the same format as the pretest, placed in alphabetical order based on the seating arrangements in the conference room. Upon completion of the posttest, participants were instructed to place the posttest in the collection box located in the front of the conference room. The project team, which included the hospice consultant, and my preceptor, arranged the pretests and posttests for paired before-and-after analysis to assess the participants' knowledge and understanding about implementing hospice and end-of-life care education to African American patients and families.

Findings and Implications

Descriptive statistics in the form of counts and percentages were used to determine if the staff education in-service increased staff knowledge on hospice care and introduction and delivery of end-of-life care to African American patients and families. A Microsoft Excel spreadsheet was used to organize the data and compare the pretest and posttest results to determine whether the staff education in-service had an impact on facility's staff knowledge. The guidelines for analysis were that each pretest and posttest had to have a letter at the top of the page and every question had to be answered. Each pretest had to have a matching letter to a posttest. The posttests showed increased scores. Appendix F shows the posttest scores, which identified improvement from the pretest scores. Posttest scores increased, following the educational in-service, by 51.1%. This number is important because it reflects the knowledge gained following education and the effectiveness of the educational in-service. The mean scores (see Appendix E) were as follows:

- pretest: 58.75
- posttest: 88.75

Scores were recorded on a Microsoft Excel spreadsheet, which was used to organize the numerical data. Data obtained were crosschecked multiple times for accuracy and missing information/values. The summative evaluation of the pretest and posttest were analyzed using descriptive statistics (see Appendix F). It can be determined from the project results that there was an increase in the facility's staff knowledge on end-of-life care and how to implement education on end-of-life care to African American patients and families. The implications resulting from this DNP project are that through the increase in knowledge gained, there will be increased education of patients and families, ultimately leading to increased utilization of end-of-life care services among African American patients and families. The significance of this DNP project to nursing practice is improved knowledge and competency of staff on end-of-life care within the long-term care facility. Significance to social change my include increased knowledge of African American patients and families served by the long-term care facility on end-of-life care and translation of that knowledge into increased uptake of evidence-based end-of-life care.

Recommendations

Recommendations for future studies include evaluating outcomes beyond increased staff knowledge about hospice and end-of-life care. Further evaluation and assessment can determine whether, as a result of increased staff knowledge, an increase in utilization of end-of-life care services among African American patients and families residing in the long-term care facility was realized. One way of evaluating this would be by monitoring and tracking the number of patients enrolling in end-of-life care services at the facility after receiving education from the facility’s staff members.

Contribution of the Doctoral Project Team

To expand staff knowledge and education on end-of-life care and implementing education for African American patients and families, I created and led an educational in-service along with a clinician known for their expertise and role in the long-term care facility. These combined efforts promoted the identified organizational goals of promoting end-of-life care education and implementing it into clinical practice. The expert panel provided guidelines and feedback on the pretest and posttest questions and the PowerPoint education presentation and assisted with the analysis and synthesis of the data to determine the outcome of the DNP project initiative.

Strengths and Limitations of the Project

Strengths

According to Lawshe (1975), content validity improves when greater than 50% of the panelists concluded that the content is essential. For this DNP project, both expert panelists determined that the content was essential and a much-needed educational initiative for this care environment. Another strength of this DNP project was addressing the myths that existed on end-of-life care by health care providers, patients, and families. These myths have contributed to the reluctance and underutilization of this care service resulting in unnecessary pain and suffering at the end of life. The third strength of this DNP project was the incorporation of cultural competence in the education initiative. Cultural competence is significant especially among patients in this health care environment as these patients feels vulnerable,and having staff members who can empathized and understand their culture can assist in bridging gaps in communication and distrust. In addition, cultural competence encourages respect and improves understanding of the individual perspective and outlook enabling providers to become better patient advocates and effectively care for patients.

Limitations

Limitations of the DNP project mainly centers around the impact of the pandemic. Quite a few of the facility's current staff members, specifically the LPNs, are agency temporary staff. Because of their new work environment and unfamiliarity with the facility's protocol and policies regarding end-of-life care, it was quite tedious to gain insight on how these nurses went about implementing care and service for patients facing an end-stage disease and the low enrollment rate among the African American patients residing in this facility. Another limitation noted in this facility lies on the 11 to 7 shift. Many of the staff working on this shift were new graduates who did not have much experience dealing with terminally ill patients or even working in long-term care facilities. Recommendations for a future project addressing similar topics and issues should include a sample of nurses across various years of clinical and work experience in this health care environment.

Section 5: Dissemination Plan

The results of the data analysis and evaluation of the DNP project were presented to the collaborative team and participants during a staff meeting. The facility's administrator, director of nursing, nurse manager, and collaborative team concluded that the DNP project education in-service was a success and they wanted to incorporate my PowerPoint presentation into their annual staff education in-service and new hire orientation. In addition, my DNP project education in-service would be appropriate to include at health care conventions, continuing education events, and national conferences as it provides a process for increasing providers' knowledge on end-of-life care and how to provide culturally congruent patient education in long-term care facilities. My plan is to submit an article to the *Journal of Hospice and Palliative Nursing*, as I believe bringing awareness to the underutilization of end-of-life care by African American patients and families in the often-overlooked long-term care environment is very important. According to Dillon and Basu (2016), despite the frequency of death in long-term care facilities, end-of-life experience has been studied less in this setting than other sites providing end-of-life care.

Analysis of Self

I embarked on the journey of becoming a DNP-prepared nurse with a purpose of identifying a practice gap within my area of practice and implementing measures to assist in filling those gaps. During the past year, I witnessed firsthand the disparity that exists within the long-term care environment in regard to end-of-life care services and their utilization, especially among African American patients and families. Due to the COVID-

19 pandemic, many patients could have benefitted tremendously from end-of-life care but opted for life sustaining medical measures that were quite often unsuccessful. This pandemic has placed a heightened awareness of this issue and disparity and the needs to address the gaps that exits.

I became passionate about this aspect of care after my mother, who was 79 years old at the time, contracted COVID-19 and I decided to enroll her into hospice care due to her health conditions and comorbidities. The care she received, and the dedication of her care team were phenomenal. It was during this time that I wished everyone facing a terminal illness or an end-of-life disease could be offered such care, comfort, peace, and dignity instead of the frequent agonizing futile life-sustaining measures often seen especially among African American patients and families. My mother ultimately survived COVID-19, was disenrolled 3 months later, and is thriving as an 80-year-old should. She confirmed that the care she received was phenomenal and would recommend end-of-life care to any individuals facing life-limiting diseases.

After this experience, I investigated why some patients choose futile life sustaining measures versus end-of-life care and found that knowledge, or lack thereof, was the determining factor in making such choices. I discovered that lack of knowledge was not only seen among patients and families but also among the care providers who are responsible for disseminating such knowledge and education to patients and families. In addition to knowledge deficit, cultural competency was lacking. Cultural competence is an important aspect in end-of-life care and should be a fundamental skill for healthcare providers. Knowledge on cultural competence can ultimately affect patients’ health care decisions and outcomes. While end-of-life care has been shown to improve quality of life, underutilization among ethnic/racial minorities has steadily increased since 2007 (Dillon & Basu, 2016). African Americans comprised approximately 12.6% of the U.S. population but accounted for only 8.5% of hospice patients in 2012 (Dillon & Basu, 2016). In addition, it has been shown that care provided to terminally ill African Americans is more expensive and of lower quality than care Caucasians receive due to the use of more expensive futile life-sustaining treatment (Dillon & Basu, 2016).

Summary

Following the educational in-service, pretest and posttest data collected showed evidence of increased knowledge among the facility's staff members on end-of-life care and how to disseminate that knowledge to educate African American patients and families. The project findings corroborate and contributes to the literature evidence that suggests there is a significant lack of knowledge among healthcare providers in the long-term care environment on end-of-life care and services. According to Park et al. (2019), nursing home staff showed high levels of need for further education in hospice care that include care of residents in their last days, spiritual care of residents among nurses, and care of the bereaved families of residents by social workers. My hope for this educational project is to provide education and direction for health care staff members in implementing culturally congruent education for patients and family members on end-of-life care and services that will in turn increase the utilization of end-of-life care among African American patients and families.

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Appendix A: Demographic Assessment Tool

1. What is your highest level of Nursing Education?
    a. Certificate (PCT/CNA)
    b. Associate
    c. Diploma
    d. Bachelor
    e. Masters
    f. Doctorate
    g. Other:
2. Which reflect your age?
    a. Less than 20 years of age
    b. 20-29 yrs
    c. 30-39 yrs
    d. 40-49 yrs
    e. 50-59 yrs
    f. 60-69 yrs
    g. > 70 yrs
3. How many years of experience do you have working in the long-term care environment?
    a. < 1 year
    b. 1-5 yrs
    c. 6-10 yrs

   d. 11-15 yrs
   e. 16-20 yrs
   f. >20 yrs

4. What is your current employment status with facility?
   a. Full-time
   b. Part-time
   c. PRN, as needed
   d. Contract
5. What is your religion?
   a. No religion
   b. Christianity
   c. Muslim
   d. Hindu
   e. Jewish
   f. Sikh
   g. Other:
6. Which of the following best describes you?
   a. Asian/Pacifica Islander
   b. Black/African American
   c. White/Caucasian
   d. Hispanic/Latino
   e. Native American/Alaskan Native

  - f. Other:

7. Gender: Male or Female
8. What is your current role at facility?
  - a. Support staff (CNA/PCT)
  - b. LPN
  - c. RN
  - d. Social service/case manager
  - e. Admission Personnel
9. Have you had a family member participate in a palliative care program?
  - a. Yes
  - b. No
10. Have you had a family member participate in hospice care program?
  - a. Yes
  - b. No
11. Have you ever referred any patients for hospice care?

___yes ___No

12. Do you know the process of referring a patient to hospice care?

___yes ___No

Appendix B: Staff Education Pretest and Posttest Questions

Please choose True or False for the following questions:

1. End-of-life care services improve the overall quality of life for patients face with life-limiting illnesses.

   ____True ____False

2. Patients who choose to enroll in end-of-life care cannot seek any other health care services and all health care treatment and services must stopped.

   ____True ____False

3. End-of-life care improve the quality of life for patients face with life-limiting medical conditions.

   ____True ____False

4. End-of-life care is comprised of both hospice and palliative care services.

   ____True ____False

5. Patients can receive palliative care at any stage of a serious illness.

   ____True ____False

6. Hospice care is usually given when a patient has a prognosis of six months or less to live.

   ____True ____False

7. End-of Life care involves a team of both medical and non-medical providers.

   ____True ____False

8. End-of-life care can only be given in a hospital setting.

   ___True ____False

9. Once end-of-life care services are started, it cannot be stopped despite the patient's wishes.

____True ____False

10. When a patient is diagnosed with a terminal illness, it is important that they be educated on end-of-life care services.

____True ____False

11. After completing the education in-service, would you now consider referring patients to hospice care?

____Yes ____No

12. After completing the education in-service, do you know the process of referring a patient to hospice care?

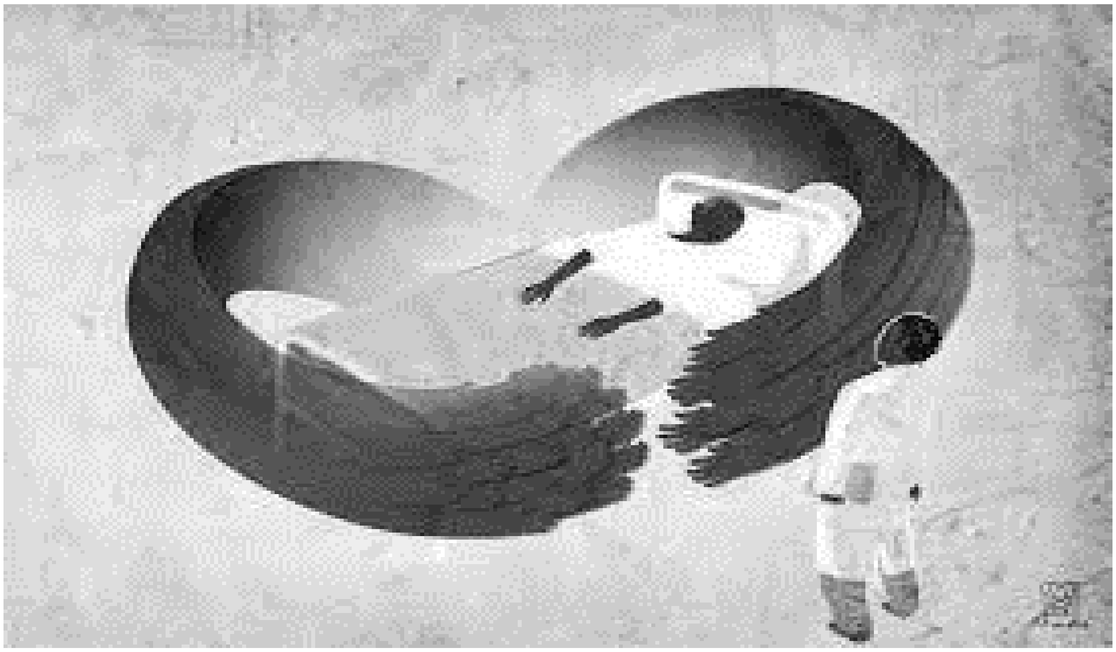
____Yes ____No

Appendix C: Staff Education Flyer

Course Offering

Quality Care at End of Life

Education In-Service to address the underutilization of end-of-life care services among African American patients and families.



Date and Time: December 6th, 2021 @ 8 am and December 7th, 2021 @ 4 pm

Location: Facility’s Conference Room

Facilitator: Oneika Rigby-Britton, MSN, FNP-C

Lunch/Breakfast/Dinner will be served

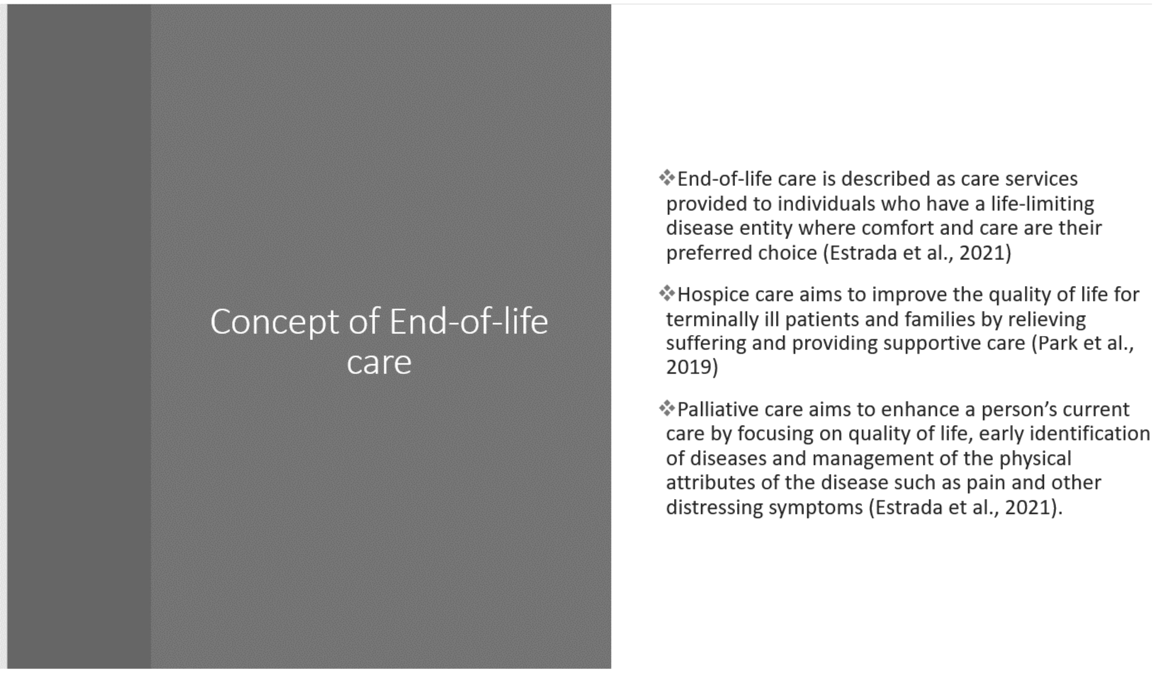
Appendix D: Staff In-service Education

Improving the Utilization of Hospice Care Services among African American patients and families

PRESENTED BY:

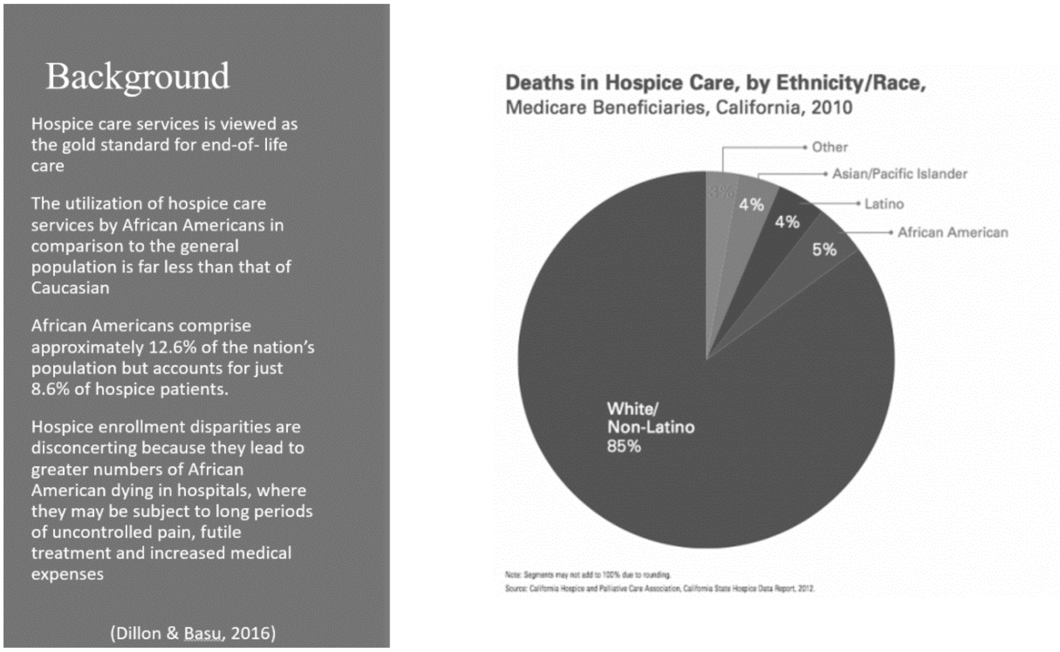
ONEIKA RIGBY-BRITTON, MSN, FNP-C

WALDEN UNIVERSITY



Concept of End-of-life care

- ❖End-of-life care is described as care services provided to individuals who have a life-limiting disease entity where comfort and care are their preferred choice (Estrada et al., 2021)
- ❖Hospice care aims to improve the quality of life for terminally ill patients and families by relieving suffering and providing supportive care (Park et al., 2019)
- ❖Palliative care aims to enhance a person's current care by focusing on quality of life, early identification of diseases and management of the physical attributes of the disease such as pain and other distressing symptoms (Estrada et al., 2021).



Background

Hospice care services is viewed as the gold standard for end-of- life care

The utilization of hospice care services by African Americans in comparison to the general population is far less than that of Caucasian

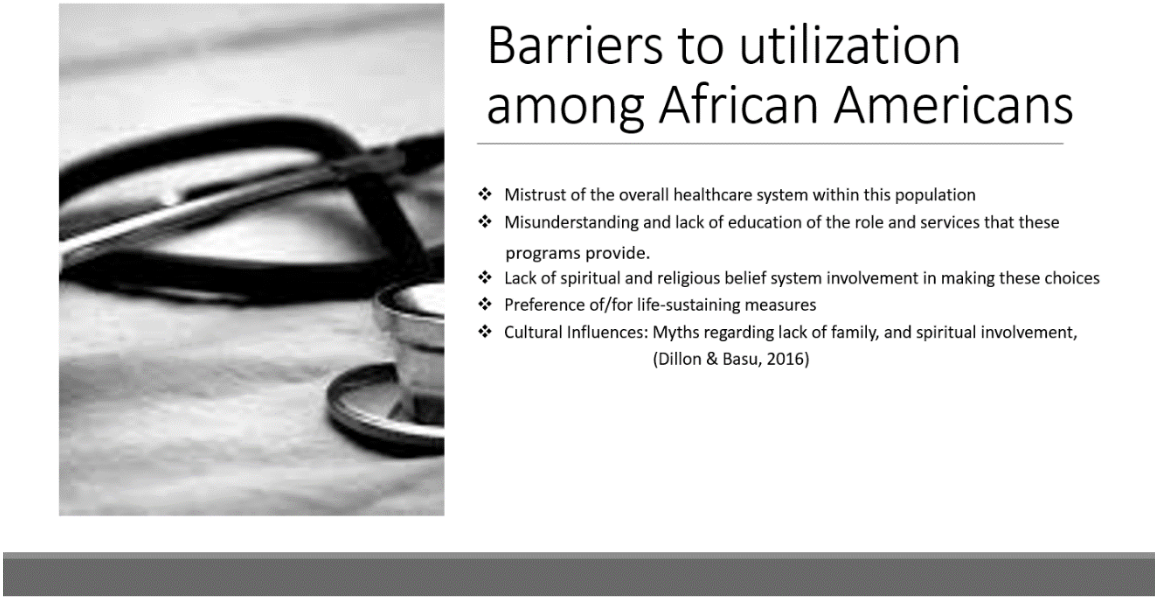
African Americans comprise approximately 12.6% of the nation's population but accounts for just 8.6% of hospice patients.

Hospice enrollment disparities are disconcerting because they lead to greater numbers of African American dying in hospitals, where they may be subject to long periods of uncontrolled pain, futile treatment and increased medical expenses

(Dillon & Basu, 2016)

Deaths in Hospice Care, by Ethnicity/Race,
Medicare Beneficiaries, California, 2010

Note: Segments may not add to 100% due to rounding.
Source: California Hospice and Palliative Care Association, California State Hospice Data Report, 2012.



Barriers to utilization among African Americans

- ❖ Mistrust of the overall healthcare system within this population
- ❖ Misunderstanding and lack of education of the role and services that these programs provide.
- ❖ Lack of spiritual and religious belief system involvement in making these choices
- ❖ Preference of/for life-sustaining measures
- ❖ Cultural Influences: Myths regarding lack of family, and spiritual involvement,

(Dillon & Basu, 2016)

Addressing Existing Barriers among African Americans

- ❖Include cultural preferences in patient and family education by having family/caregiver involvement in the various aspect of education and care.
- ❖Have spiritual/pastoral involvement as part of care services and education.
- ❖Providing education materials that are culturally sensitive and reflective of patient population.
- ❖Take the time to address patients and families' questions and concerns.
- ❖Emphasize to patients and families that choosing hospice care do not necessarily signify that this decision is final and permanent.
- ❖ Reiterate to patients and families that they can disenroll at any time and that this program exist to meet their needs and desires.

- ➢Alleviate suffering through pain and symptom management
- ➢Promote dignity
- ➢Facilitates closure for patients and families
- ➢Provides education, emotional and spiritual support to patients and families

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Benefits of Hospice Care

Identifying your feelings

- Its important to deal with one's own feelings regarding end-of-life care as you are intricately involved with patients and families at a vulnerable stage of their lives.
- Identifying and addressing one's feelings leads to the ease of proving holistic care to patients and families
- Providers have a great role of being an emotional and spiritual support system for patients and families at this phase of life

Myths vs Reality of Hospice Care

Myth: Hospice is where you go when there is nothing else a doctor can do for you.

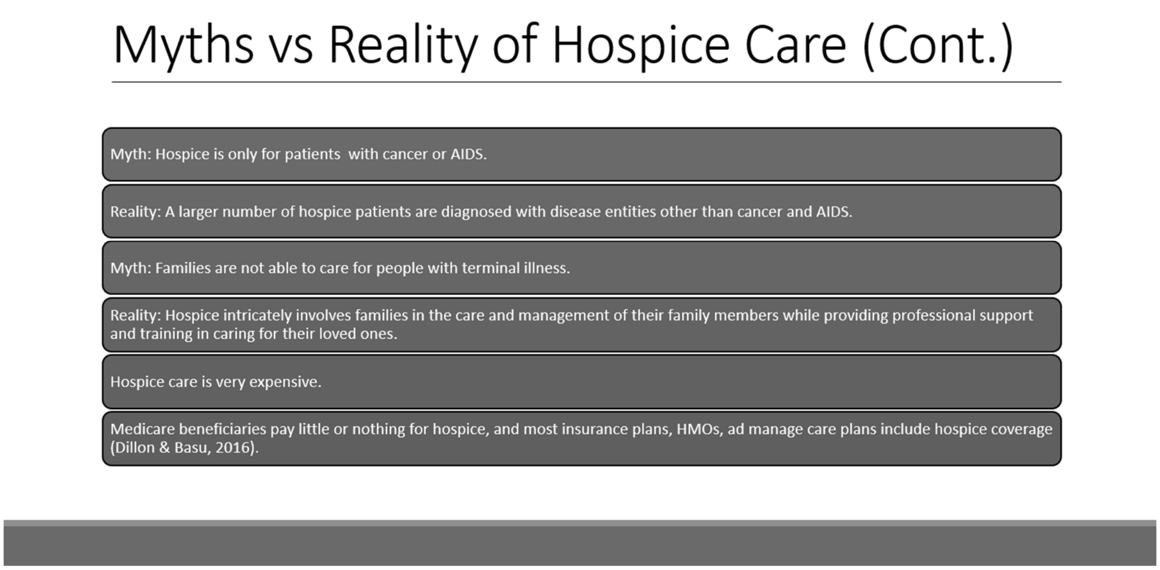
Reality: Hospice is based on the concept of providing medical, emotional and spiritual care focusing on the comfort and quality of life.

Myth: Hospice is only for the last few days of one's life.

Reality: Hospice patients and families can receive care six months or longer, depending on the course of disease entity.

Myth: Choosing hospice care mean giving up on all other medical treatments and interventions.

Reality: Hospice puts the patients and families at the center of care planning process and provides high quality comfort measures.



Myths vs Reality of Hospice Care (Cont.)

Myth: Hospice is only for patients with cancer or AIDS.

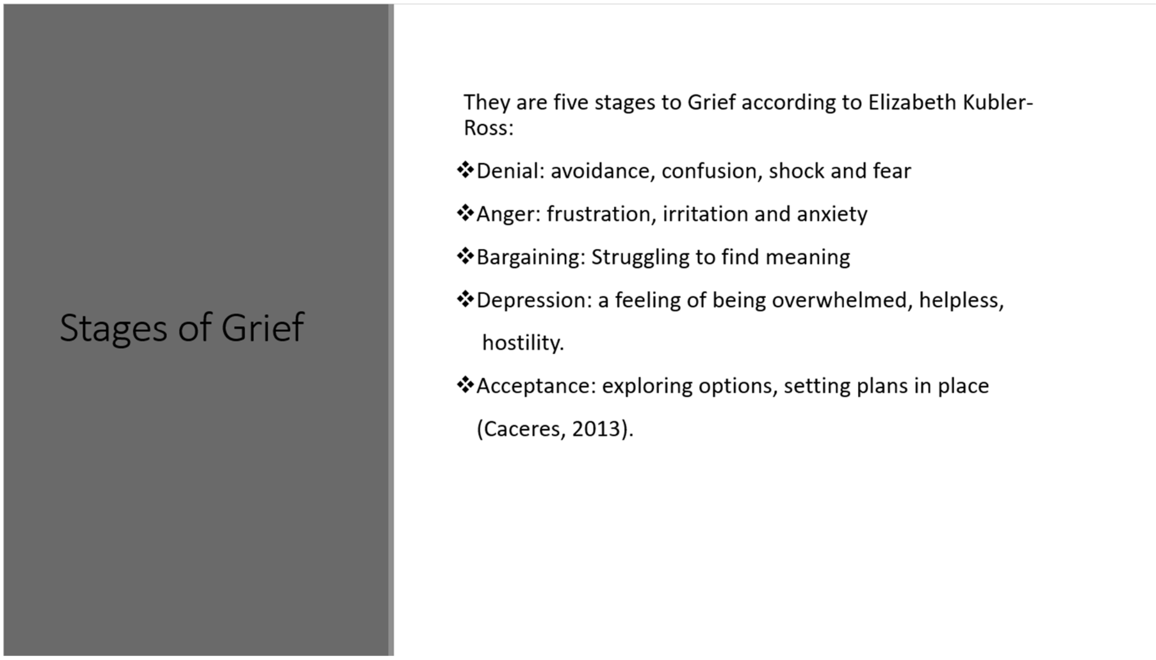
Reality: A larger number of hospice patients are diagnosed with disease entities other than cancer and AIDS.

Myth: Families are not able to care for people with terminal illness.

Reality: Hospice intricately involves families in the care and management of their family members while providing professional support and training in caring for their loved ones.

Hospice care is very expensive.

Medicare beneficiaries pay little or nothing for hospice, and most insurance plans, HMOs, ad manage care plans include hospice coverage (Dillon & Basu, 2016).



Stages of Grief

They are five stages to Grief according to Elizabeth Kubler-Ross:

- ❖Denial: avoidance, confusion, shock and fear
- ❖Anger: frustration, irritation and anxiety
- ❖Bargaining: Struggling to find meaning
- ❖Depression: a feeling of being overwhelmed, helpless, hostility.
- ❖Acceptance: exploring options, setting plans in place (Caceres, 2013).

Pain Assessment and Management

- ❖ Pain is a common symptom affecting patients at the end of life.
- ❖About 2/3 of patients with advanced cancer and more than 50% of patients with end-stage chronic disease other than cancer experience pain(Cea et al.,2016).
- ❖About 1 in 3 patients in hospice care reported uncontrolled pain at the last hospice visit before death (Cea et al., 2016).
- ❖Pain assessment and management is an important aspect of care for hospice care patients.
- ❖Although pain management is a priority of hospice care, available evidence indicates that pain is often inadequately managed in this setting (Cea et al., 2016).

Pain Assessment and Management (Cont.)

- ❖About 70% of patients assessed using a pain scale saw improvement in their level od pain.
- ❖ Non-Hispanic blacks were less likely to have pain assessments, and Hispanics were less likely to receive opioid analgesic or have pain-free status compared to non-Hispanics whites (Cea et al., 2016).
- ❖The use of a valid pain assessment scale enables providers to assess changes in the presence and intensity of pain over consecutive assessment (Cea et al., 2016).
- ❖Through valid pain assessment, pain management and treatment adjustment can be made to ensure patients' pain goals are being met
- ❖Some pain assessment scale include Numeric Rating Scale (0-10), Face Scale, or verbal rating scale (none, mild, moderate, or severe) (Cea et al, 2016).

Pain Assessment and Management (Cont.)

- ❖Pain Management include non-pharmacologic and pharmacologic
- ❖Non-Pharmacologic management include: distraction, heat and/or cold, massage and/or positioning and music therapy (Cea et al., 2016).
- ❖Pharmacologic management include: Opioid analgesics and nonopioid analgesics
- ❖Use of a valid pain assessment scale and pain management will address this gap in care among hospice care patients especially among African American patients.

Spiritual care in hospice

Spiritual care is very important in hospice care.

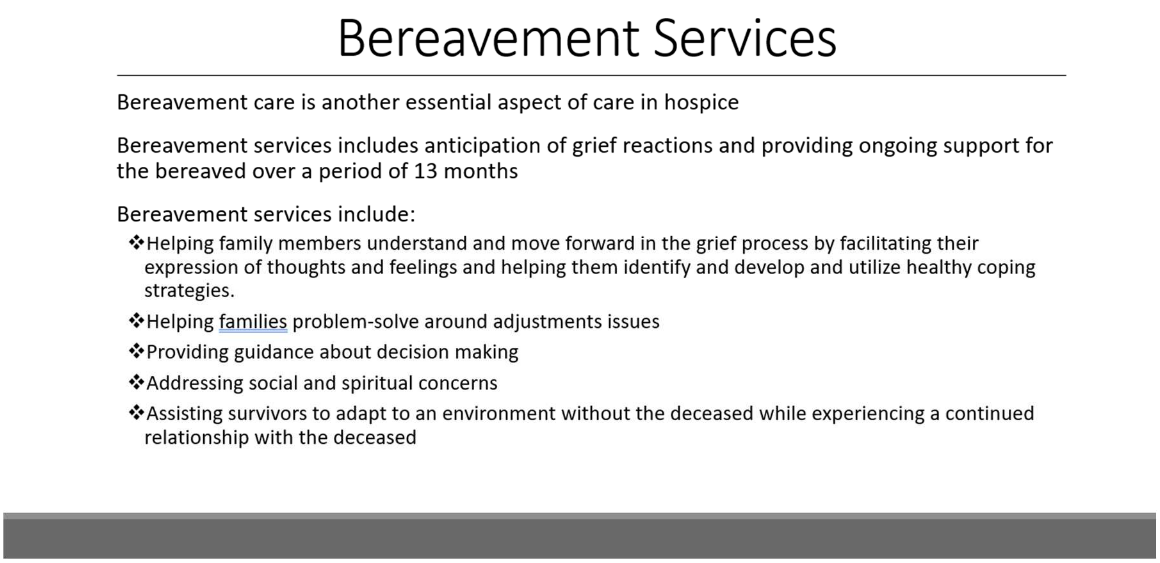
Spiritual care is compassionate care services that support patients and families through the end-of-life grieving process.

Spiritual care is usually provided by a chaplain or spiritual counselor who is trained to assess individual needs and to meet each person they serve wherever they are in their own understanding (Brown & Vaughan, 2013).

Chaplains and spiritual counselors are specially trained to listen, guide, comfort, and support patients and families through their personal experiences of illness, loss, and grief.

Benefits of spiritual care is it has a calming and uplifting effect on patients alleviating any feelings of depression, anxiety, and regrets.

Spiritual care facilitate interpersonal or universal connection, gratitude, love, forgiveness and emotional closure (Brown & Vaughan, 2013).



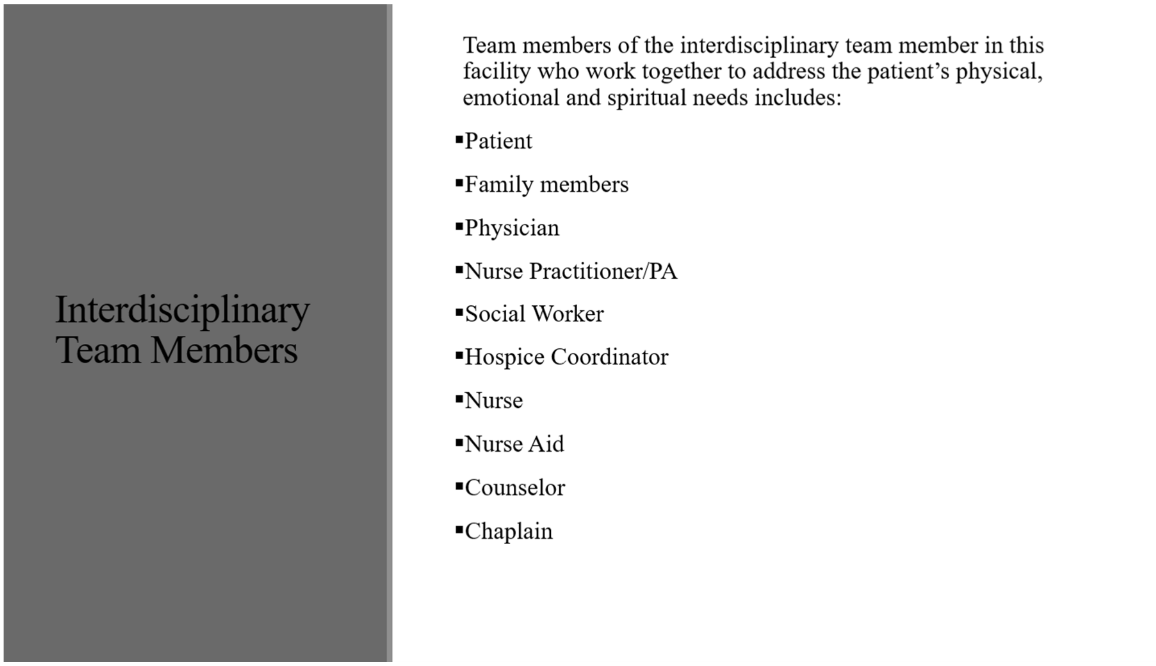
Bereavement Services

Bereavement care is another essential aspect of care in hospice

Bereavement services includes anticipation of grief reactions and providing ongoing support for the bereaved over a period of 13 months

Bereavement services include:

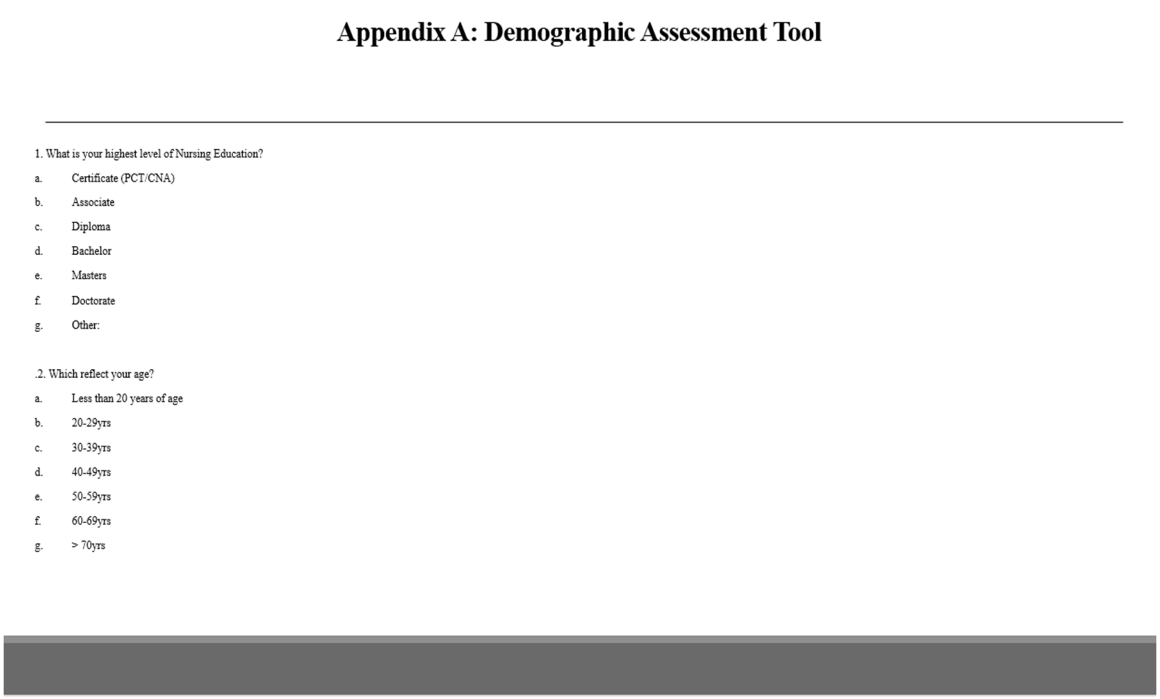
- ❖Helping family members understand and move forward in the grief process by facilitating their expression of thoughts and feelings and helping them identify and develop and utilize healthy coping strategies.
- ❖Helping families problem-solve around adjustments issues
- ❖Providing guidance about decision making
- ❖Addressing social and spiritual concerns
- ❖Assisting survivors to adapt to an environment without the deceased while experiencing a continued relationship with the deceased



Interdisciplinary Team Members

Team members of the interdisciplinary team member in this facility who work together to address the patient's physical, emotional and spiritual needs includes:

- ▪Patient
- ▪Family members
- ▪Physician
- ▪Nurse Practitioner/PA
- ▪Social Worker
- ▪Hospice Coordinator
- ▪Nurse
- ▪Nurse Aid
- ▪Counselor
- ▪Chaplain



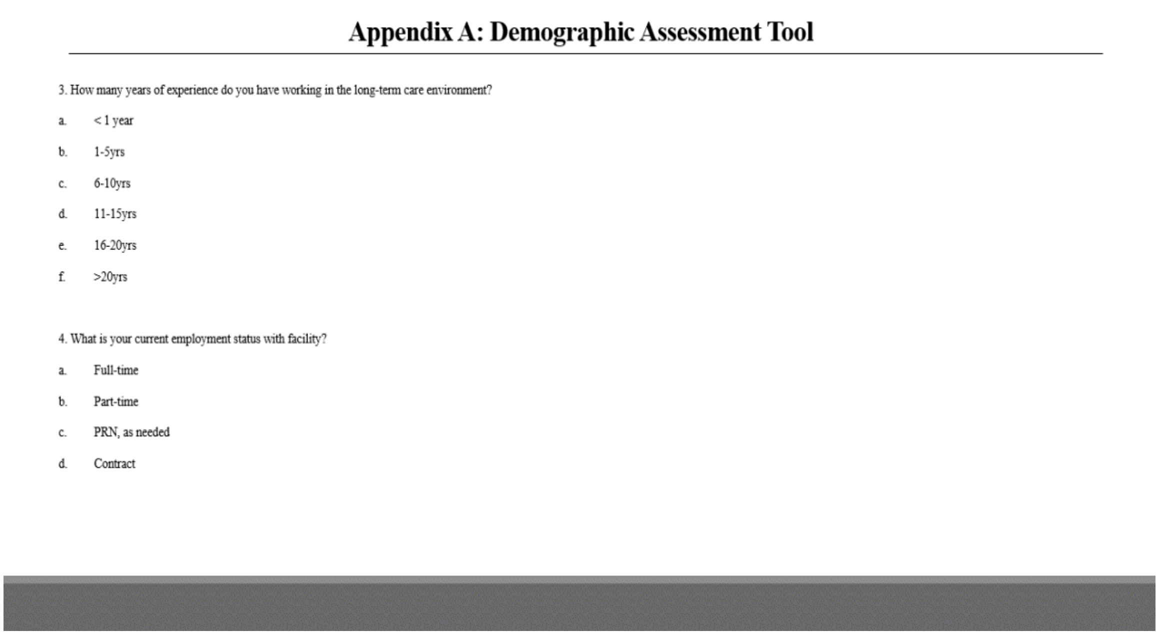
Appendix A: Demographic Assessment Tool

1. What is your highest level of Nursing Education?

a. Certificate (PCT/CNA)
b. Associate
c. Diploma
d. Bachelor
e. Masters
f. Doctorate
g. Other:

.2. Which reflect your age?

a. Less than 20 years of age
b. 20-29yrs
c. 30-39yrs
d. 40-49yrs
e. 50-59yrs
f. 60-69yrs
g. > 70yrs



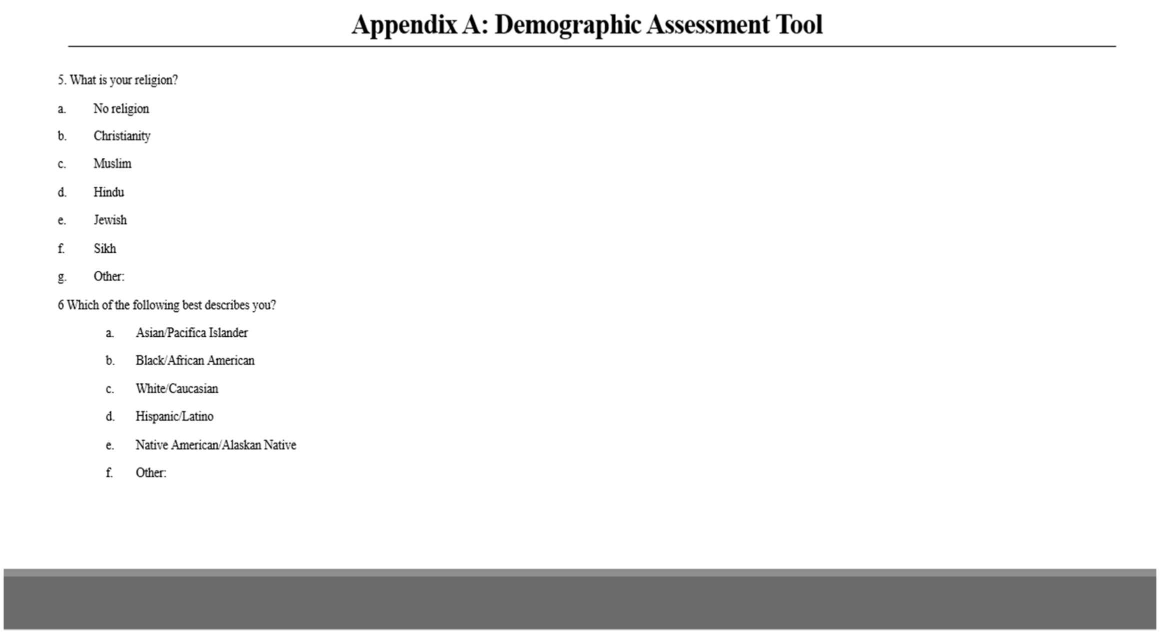
Appendix A: Demographic Assessment Tool

3. How many years of experience do you have working in the long-term care environment?

a. < 1 year
b. 1-5yrs
c. 6-10yrs
d. 11-15yrs
e. 16-20yrs
f. >20yrs

4. What is your current employment status with facility?

a. Full-time
b. Part-time
c. PRN, as needed
d. Contract



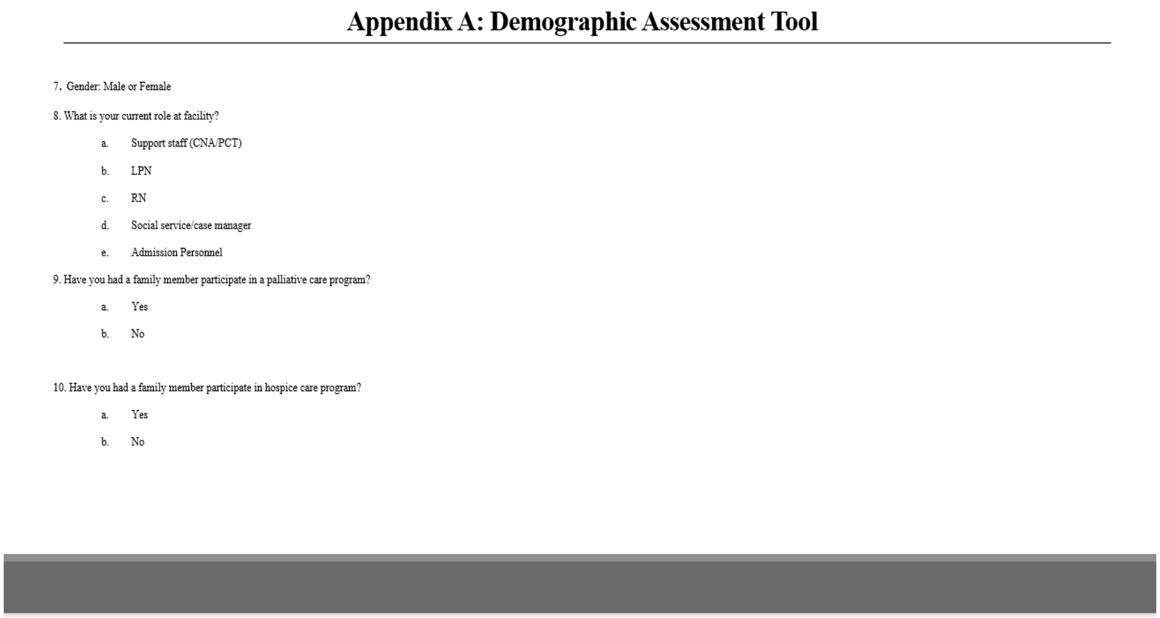
Appendix A: Demographic Assessment Tool

5. What is your religion?

a. No religion
b. Christianity
c. Muslim
d. Hindu
e. Jewish
f. Sikh
g. Other:

6 Which of the following best describes you?

  a. Asian/Pacifica Islander
  b. Black/African American
  c. White/Caucasian
  d. Hispanic/Latino
  e. Native American/Alaskan Native
  f. Other:



Appendix A: Demographic Assessment Tool

7. Gender: Male or Female

8. What is your current role at facility?

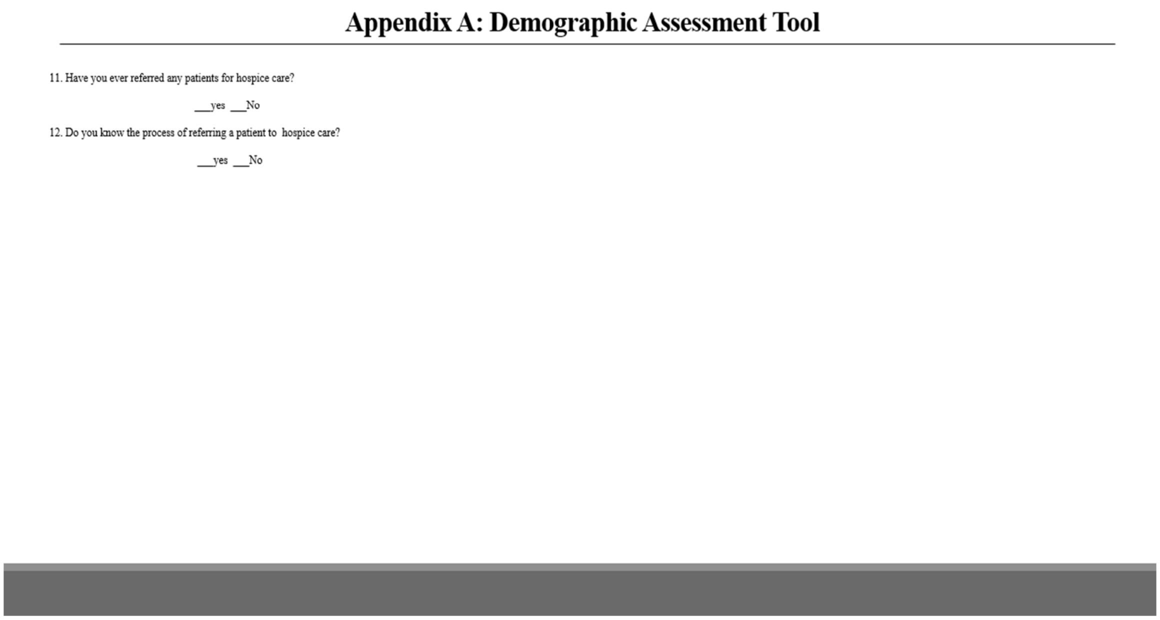
  a. Support staff (CNA/PCT)
  b. LPN
  c. RN
  d. Social service/case manager
  e. Admission Personnel

9. Have you had a family member participate in a palliative care program?

  a. Yes
  b. No

10. Have you had a family member participate in hospice care program?

  a. Yes
  b. No



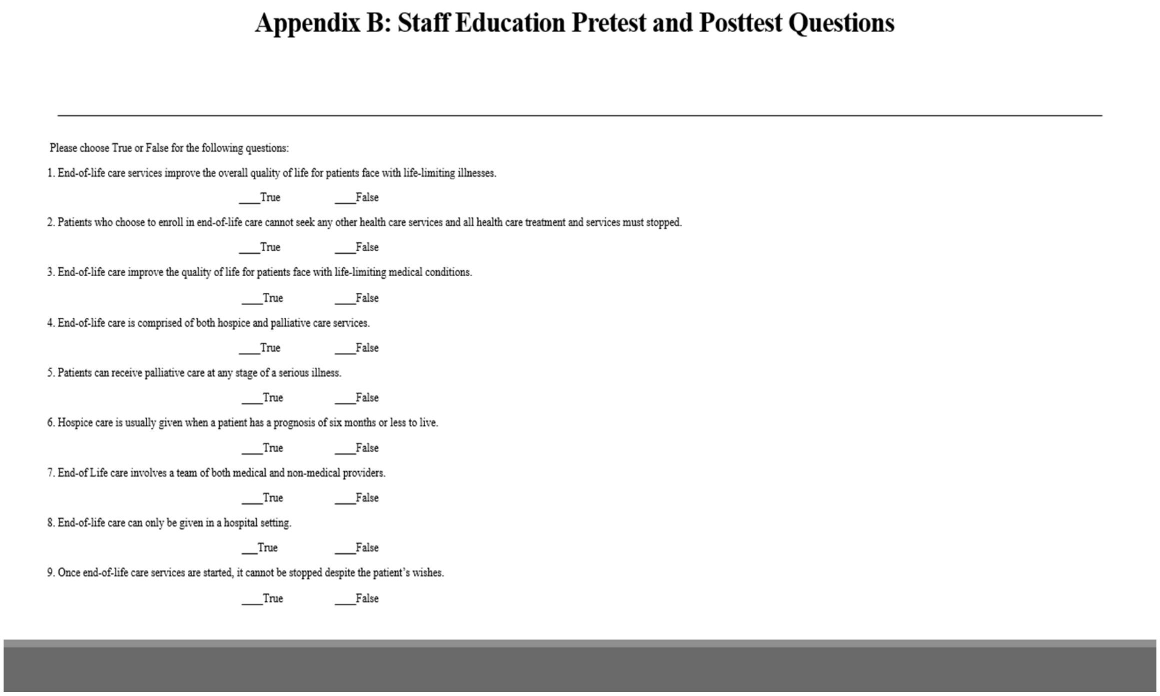
Appendix A: Demographic Assessment Tool

11. Have you ever referred any patients for hospice care?

___yes ___No

12. Do you know the process of referring a patient to hospice care?

___yes ___No



Appendix B: Staff Education Pretest and Posttest Questions

Please choose True or False for the following questions:

1. End-of-life care services improve the overall quality of life for patients face with life-limiting illnesses.

____True ____False

2. Patients who choose to enroll in end-of-life care cannot seek any other health care services and all health care treatment and services must stopped.

____True ____False

3. End-of-life care improve the quality of life for patients face with life-limiting medical conditions.

____True ____False

4. End-of-life care is comprised of both hospice and palliative care services.

____True ____False

5. Patients can receive palliative care at any stage of a serious illness.

____True ____False

6. Hospice care is usually given when a patient has a prognosis of six months or less to live.

____True ____False

7. End-of Life care involves a team of both medical and non-medical providers.

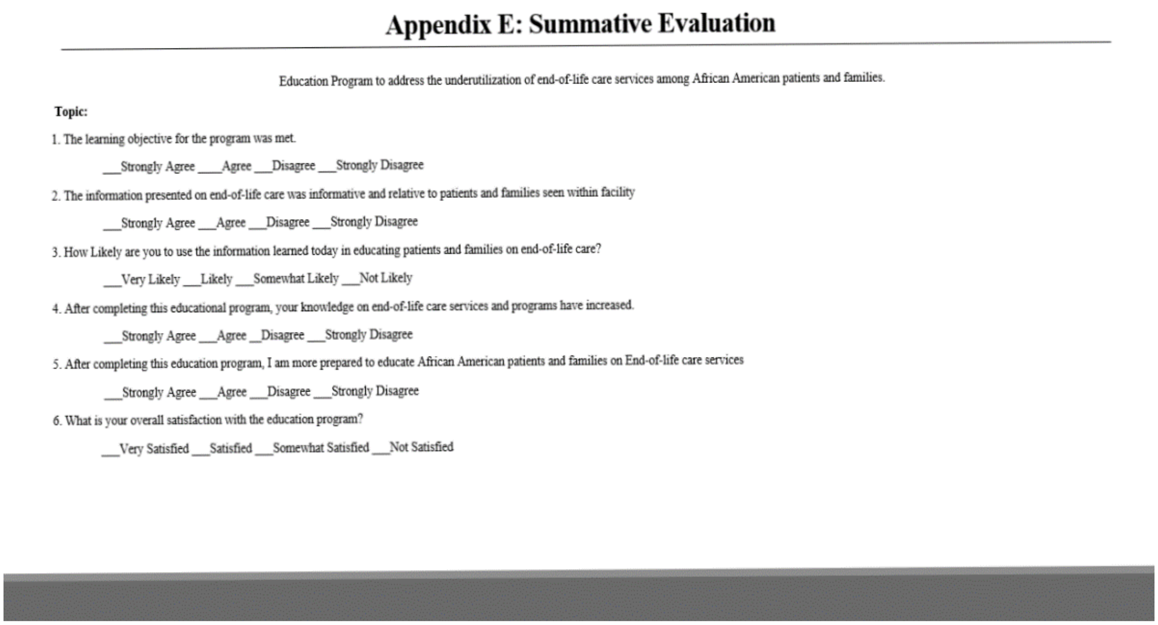
____True ____False

8. End-of-life care can only be given in a hospital setting.

___True ____False

9. Once end-of-life care services are started, it cannot be stopped despite the patient's wishes.

____True ____False



Appendix E: Summative Evaluation

Education Program to address the underutilization of end-of-life care services among African American patients and families.

Topic:

1. The learning objective for the program was met.

___Strongly Agree ____Agree ___Disagree ___Strongly Disagree

2. The information presented on end-of-life care was informative and relative to patients and families seen within facility

___Strongly Agree ___Agree ___Disagree ___Strongly Disagree

3. How Likely are you to use the information learned today in educating patients and families on end-of-life care?

___Very Likely ___Likely ___Somewhat Likely ___Not Likely

4. After completing this educational program, your knowledge on end-of-life care services and programs have increased.

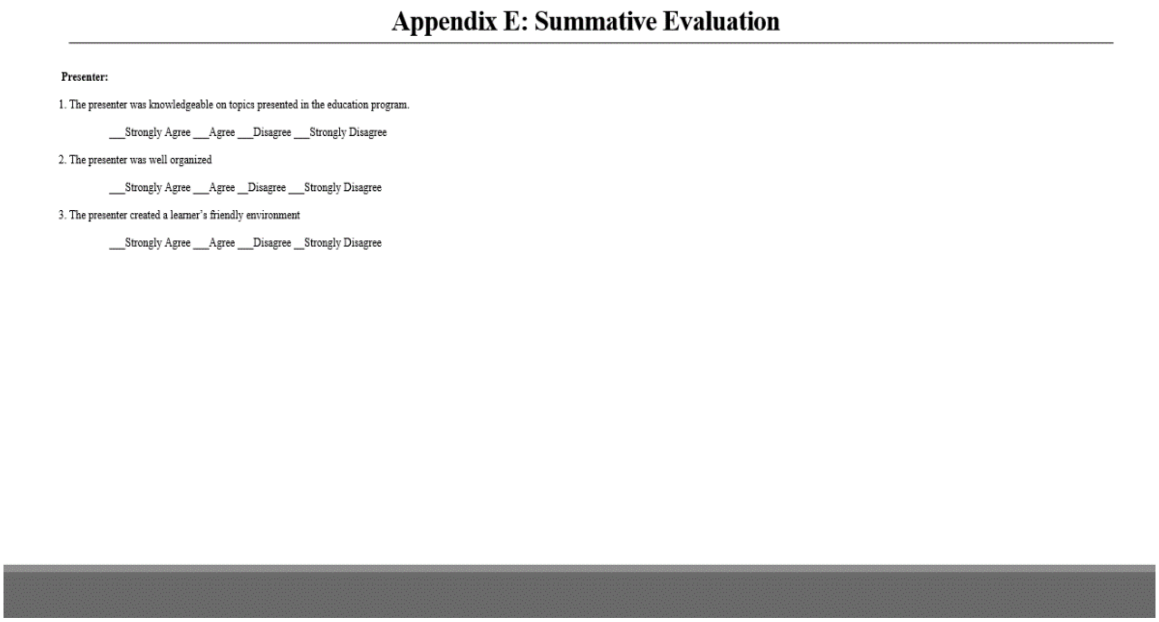
___Strongly Agree ___Agree __Disagree ___Strongly Disagree

5. After completing this education program, I am more prepared to educate African American patients and families on End-of-life care services

___Strongly Agree ___Agree ___Disagree ___Strongly Disagree

6. What is your overall satisfaction with the education program?

___Very Satisfied ___Satisfied ___Somewhat Satisfied ___Not Satisfied



Appendix E: Summative Evaluation

Presenter:

1. The presenter was knowledgeable on topics presented in the education program.

___Strongly Agree ___Agree ___Disagree ___Strongly Disagree

2. The presenter was well organized

___Strongly Agree ___Agree __Disagree ___Strongly Disagree

3. The presenter created a learner's friendly environment

___Strongly Agree ___Agree ___Disagree __Strongly Disagree

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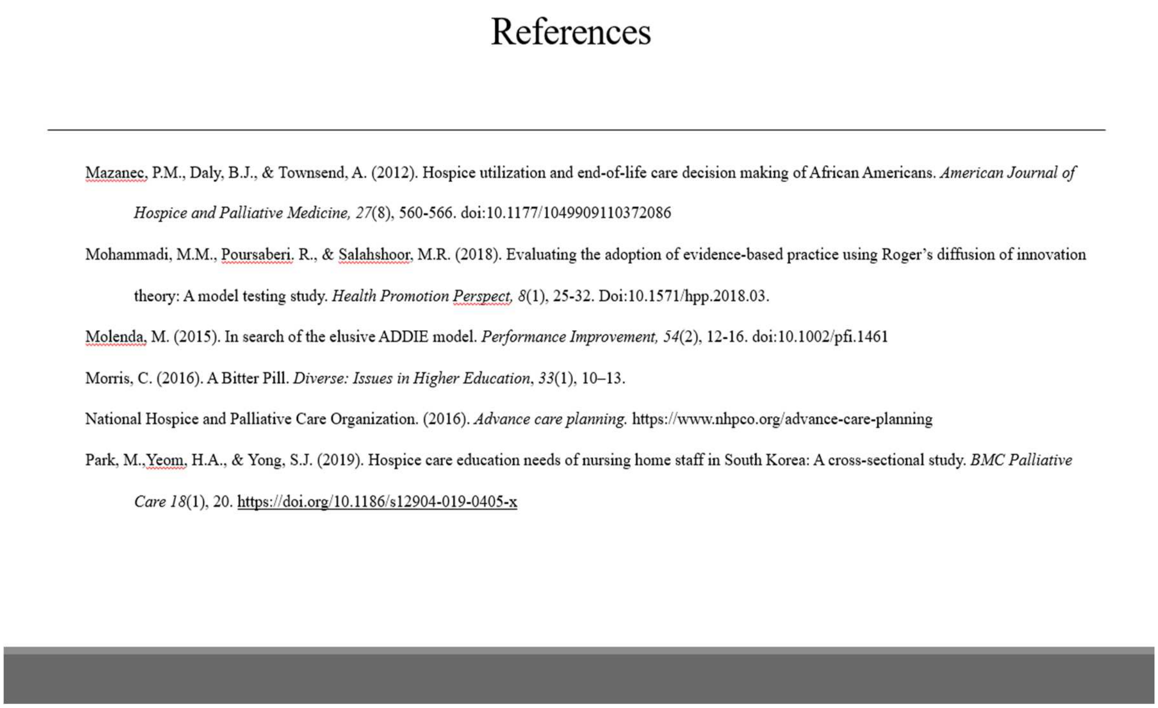

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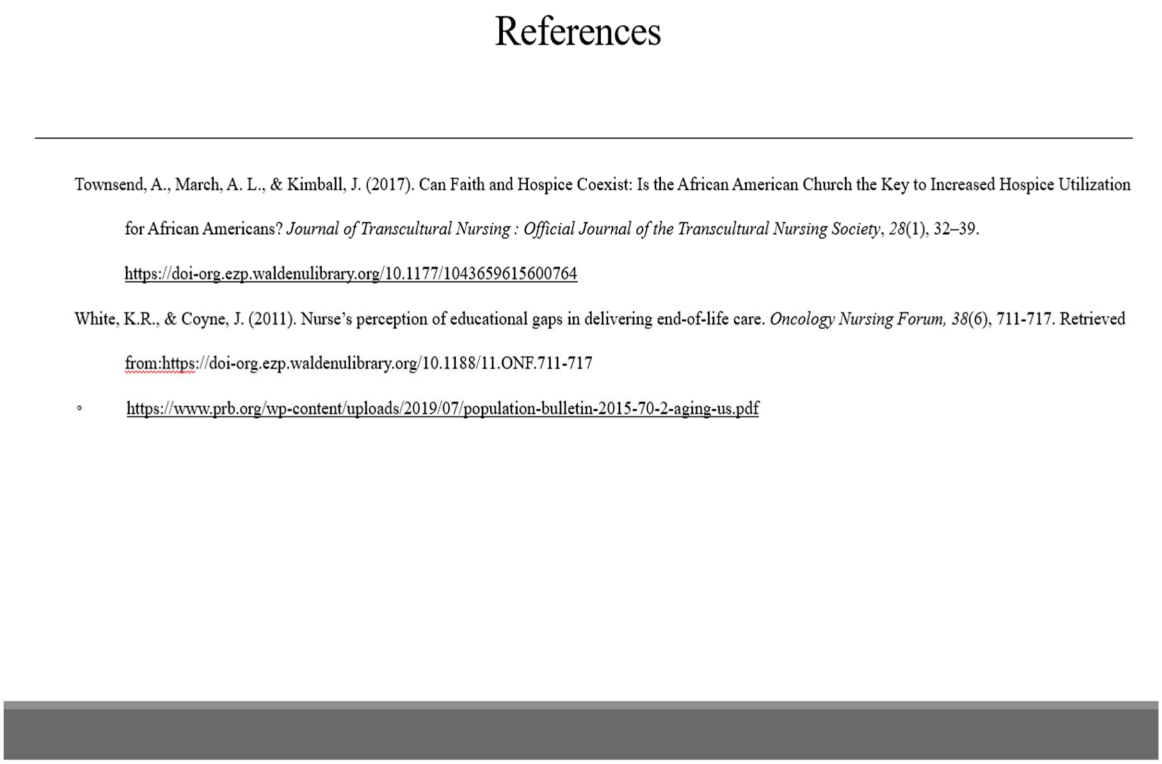

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Appendix E: Summative Evaluation

Education Program to address the underutilization of end-of-life care services among African American patients and families.

Topic:

1. The learning objective for the program was met.

   ___Strongly Agree ____Agree ___Disagree ___Strongly Disagree

2. The information presented on end-of-life care was informative and relative to patients and families seen within facility

   ___Strongly Agree ___Agree ___Disagree ___Strongly Disagree

3. How Likely are you to use the information learned today in educating patients and families on end-of-life care?

   ___Very Likely ___Likely ___Somewhat Likely ___Not Likely

4. After completing this educational program, your knowledge on end-of-life care services and programs have increased.

   ___Strongly Agree ___Agree __Disagree ___Strongly Disagree

5. After completing this education program, I am more prepared to educate African American patients and families on End-of-life care services

   ___Strongly Agree ___Agree ___Disagree ___Strongly Disagree

6. What is your overall satisfaction with the education program?

   ___Very Satisfied ___Satisfied ___Somewhat Satisfied ___Not Satisfied

Presenter:

1. The presenter was knowledgeable on topics presented in the education program.

___Strongly Agree ___Agree ___Disagree ___Strongly Disagree

2. The presenter was well organized

   ___Strongly Agree ___Agree __Disagree ___Strongly Disagree

3. The presenter created a learner’s friendly environment

   ___Strongly Agree ___Agree ___Disagree __Strongly Disagree

Appendix F: Pre-Test and Post-Test Scores and Percentage

Participants	Pre-test	Post-test
A	80	100
B	50	80
C	60	90
D	40	80
E	20	80
F	70	90
G	70	100
H	60	90
I	50	90
J	40	80
K	80	100
L	70	80
M	50	80
N	50	90
O	80	90
P	70	100
Percentage Total	**58.75**	**88.75**

Appendix G: Pretest and Posttest Results Bar Graph