

2016

Examining Nurse Practitioners' Perceptions and Beliefs Regarding Hospice Referrals for African Americans

Karen Jackson McClary
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>

 Part of the [Nursing Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Health Sciences

This is to certify that the doctoral study by

Karen Jackson McClary

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Andrea Jennings-Sanders, Committee Chairperson, Health Services Faculty

Dr. Susan Hayden, Committee Member, Health Services Faculty

Dr. Tracy Scott, University Reviewer, Health Services Faculty

Chief Academic Officer

Eric Riedel, Ph.D.

Walden University

2016

Abstract

Examining Nurse Practitioners' Perceptions and Beliefs Regarding Hospice Referrals for

African Americans

by

Karen Latrice Jackson McClary

MSN, University of Phoenix, 2011

BSN, University of Phoenix, 2009

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

August 2016

Abstract

Terminally ill patients often have difficult choices at the end-of-life, and electing to receive hospice services is one of them. Hospice has been linked to improved quality of life and death and is accessible to terminally ill patients. Despite the accessibility, African American patients often make the decision to forgo hospice services. The purpose of this descriptive study was to explore perceptions and beliefs of nurse practitioners (NPs) regarding the lack of utilization of hospice for African American patients and the feasibility of NPs for initial referral for terminally ill African American patients. The research questions addressed whether an NP's perception, beliefs, and past experiences with hospice influence their decision to refer terminally ill African American patients to hospice. This project was guided by the theory of planned behavior to identify perceptions and beliefs of NPs about referrals for African American patients as well as knowledge to develop an awareness education program. Data were collected using a modified online survey administered to 8 NPs who practiced in Georgia or were members of a NPs' Facebook social group. Descriptive statistics demonstrated that the 8 NPs viewed hospice as a valuable service and cost-effective. Microsoft Excel was used to manage qualitative content, which demonstrated that NPs felt education was important for increasing African American patients' use of hospice. The implementation of an awareness education program can benefit NPs by educating them on the possible connection between their beliefs and perceptions about African American terminally ill patients and their decision to refer African American patients to hospice. Additionally, this project has the potential to improve end-of-life care.

Examining Nurse Practitioners' Perceptions and Beliefs Regarding Hospice Referrals for
African Americans

by

Karen Latrice Jackson McClary

MSN, University of Phoenix, 2011

BSN, University of Phoenix, 2009

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

August 2016

Dedication

I would like to dedicate this project to my son, Benjamin Jackson. There were days I felt like giving up, but I look at him and realize how many obstacles he has in life every day being autistic. I encourage him to keep striving; therefore, I would like to say thank you, and I love you.

I also would like to dedicate this work to my husband, Benjamin McClary, and my mother, Darlene Mitchell, who would assist with household responsibilities while I worked on schoolwork; without your love and support I would not have been able to accomplish my dream.

Acknowledgments

First and foremost, I would like to thank God for allowing me to complete my doctoral project.

I would like to thank Dr. Andrea Jennings-Sanders and Dr. Catherine Harris for their support during my proposal journey. I am also grateful for my practicum sites Serenity Hospice and Serenity Place for providing the necessary guidance for my doctoral study. I also wish to express my sincere gratitude to my preceptors Jennifer Sizemore, MSW and Brian Coleman, LNHA, MPH. I would also like to thank the staff at Pruitt Health Monroe.

Finally, I would like to thank Dr. Kimbria Jackson for her guidance throughout my doctoral project.

Table of Contents

List of Tables	iv
List of Figures	v
Section 1: Nature of the Project	1
Introduction.....	1
Problem Statement	3
Purpose Statement and Project Goals	5
Significance/Relevance to Practice.....	5
Research Questions.....	7
Evidence-Based Significance.....	7
Implication for Social Change in Practice	8
Definitions of Terms.....	10
Assumptions and Limitations	11
Summary.....	11
Section 2: Background and Context	13
Background.....	13
Hospice Utilization	13
APRNs' Utilization in Health Care.....	15
Lack of Information Barrier.....	17
Mistrust of Health Care.....	20
Religion/Spiritual Barriers	22
Family Barriers	25

Theoretical Framework.....	27
Summary.....	33
Section 3: Collection and Analysis of Evidence.....	34
Project Design and Methods.....	34
Population and Sampling.....	35
Data Collection.....	35
Instrument.....	36
Protection of Humans Subjects.....	37
Data Analysis.....	38
Evaluation Plan.....	38
Summary.....	39
Section 4: Findings and Recommendations.....	40
Summary of Findings.....	40
Discussions of Findings.....	52
Implications.....	54
Implications for Practice/Action.....	54
Implication for Future Research.....	54
Implication for Social Change.....	54
Project Strengths and Limitations.....	55
Limitations and Recommendations.....	55
Analysis of Self.....	55
As Scholar.....	55

As Practitioner	56
As Project Developer	56
Direction for Future Research.....	56
Summary	57
Section 5: Dissemination Plan	58
References.....	59
Appendix A: Permission Letter	79
Appendix B: Permission Granted	80
Appendix C: Invitation to Participate	81
Appendix D: Consent to Participate	82
Appendix E: NPs Hospice Survey	84
Appendix F: Awareness Education Program.....	86

List of Tables

Table 1. Participant Characteristics 41

List of Figures

<i>Figure 1.</i> Theory of planned behavior.	29
<i>Figure 2.</i> Modification of the theory of planned behavior.	30
<i>Figure 3.</i> NP perceptions of African American patients about hospice.	43
<i>Figure 4.</i> NP comfort talking to African American patients and family about hospice.	45
<i>Figure 5.</i> NP belief about hospice services.	45
<i>Figure 6.</i> NP belief that hospice is valuable service.....	47
<i>Figure 7.</i> NP belief that hospice is cost-effective.....	48
<i>Figure 8.</i> NP belief that the medical director has control over the patient.....	49
<i>Figure 9.</i> NP prior experience with hospice influences referral.	50
<i>Figure 10.</i> NP thoughts on current scope of practice.	51
<i>Figure 11.</i> NP feedback on increasing hospice for African Americans.	52

Section 1: Nature of the Project

Introduction

Hospice use has continued to decrease among African American patients. Between the years of 1995 thru 2001, African Americans and Latinos were found to have a significantly lower hospice utilization (Colon & Lyke, 2013). African Americans view hospice in an undesirable light, because of the conflict with religious beliefs, mistrust in health care, and not being comfortable talking about end-of-life preferences (Benton et al., 2015; Moore et al., 2013). Those are a few of the barriers that may prevent African Americans from choosing hospice as an end-of-life decision.

The end-of-life care decisions for family members are very complex. There are many choices for end-of-life care ranging from care and comfort to aggressive treatment. Hospice care is a choice that patients and their families may decide upon during the process of dying. Hospice care is designed to supply support and comfort to patients and their caregivers when an illness is no longer responding to curative measures (Hospice Foundation of America, n.d.). The word hospice is derived from *hospitium*, originally describing a place of refuge for exhausted and sick travelers returning home from religious pilgrimages (Hospice Today, n.d.). Hospice was first introduced in the 1940s by a physician name Dame Cicely Saunders during World War II when there was a need for strong relief from anguish, affliction, and help with dignity and religious and emotional insight of death (National Hospice and Palliative Care Organization [NHPCO], n.d.). Doctor Saunders introduced hospice care in the United States in the 1960s. In order to receive the Medicare hospice benefits, an individual must meet the following criteria:

qualify for Medicare Part A, terminal illness confirmation from physician and medical director confirming the patient has 6 months or less to live if the illness progresses its normal course, signed consent choosing the hospice benefit, and hospice benefits received from a Medicare-approved program. (Centers for Medicare & Medicaid Services, n.d.).

Hospice care often consists of an interdisciplinary team: the patient, primary physician, a hospice physician, certified nursing assistant, social worker, administrator, clinical manager, case manager, activity director, volunteers, clergy, and therapy department. The interdisciplinary team uses a holistic approach to providing pain management, dying with dignity, emotional and spiritual support, and ensuring the individual wishes are met during the dying process. The NHPCO (2010) stated the hospice philosophy is to provide encouragement and care for a person in the end stage of a terminal illness so that they may live a full and comfortable life as much as possible. Medicare hospice benefits cover physicians and nursing services, durable medical equipment and medical supplies, medication pertaining to the admitting diagnosis, pain medication, therapy, social services, grief and bereavement counseling, respite care, and short-term inpatient care to manage pain or symptoms (Centers for Medicare and Medicaid Services, n.d.).

The Affordable Care Act allows individuals to have access to safe, effective, and inexpensive health care in the United States (*National Federation of Independent Business v. Sebelius*, 2012). In 2010, the Institute of Medicine (IOM) made the recommendations to remove barriers from the scope of practice for advanced practice

registered nurses (APRNs). Recommendations were also made for the Medicare program to allow APRNs to perform admission assessments and certify patients for home health services and admission to hospice and skilled nursing facilities (IOM, 2010). APRNs collaborate with physicians when providing care for patients (Regulation of Protocol Use By Advanced Practice Registered Nurses as Authorized by O.C.G.A. § 43-34-410-13-.01, 2013).

Problem Statement

African Americans have been taking care of a terminally ill family member for numerous years (Yancu, Farmer, & Leahman, 2010). Through history, African Americans have not considered hospice care as an alternative to taking care of a terminally ill family member (Anderson & Turner, 2010). The NHPCO (2012) reported that in 2011 only 8.5 % of hospice patients were African American compared to 82.8% Caucasian. African American patients are less likely than Caucasian patients to choose hospice services after being diagnosed with a terminal illness (Ramey & Chin, 2012). The majority of studies concerning hospice care in the African American community identified barriers such as cultural, distrust, religion, lack of information, and institutional (Adeloyin, 2013; Hazin & Giles, 2011; Johnson, Kuchibhatla, & Tulskey, 2009; Krakauer, Crenner, & Fox, 2002; Miller, Seib, & Dennie, 2001; O'Mahony et al., 2008; Pullis, 2011; Ramey & Chin, 2011; Reese, Ahern, Nair, O'Faure, & Warren, 1999; Taxis, 2006; Wicher & Meeker, 2012; Yancu et al., 2010). Despite the accessibility, there has been a the lack hospice use in the African American community (Noh & Schroepfer, 2014).

In 2010, 41.9% of deaths in the United States occurred on hospice services, and despite accessibility a mortality gap between African Americans and Whites receiving hospice services has continued (Reese, Smith, Butler, Shrestha, & Erwin, 2014). Hospice services have been linked with improved pain and symptom management, decreased hospitalization, dying in a location of choice, and improvement in patient and caregiver satisfaction (Reese et al., 1999). Hospice is also beneficial for improving mental health for the caregiver (Seaman, Bear, Documet, Sereika, & Albert, 2014). The lack of utilization of hospice services has the potential to negatively impact the terminally ill African Americans because the quality of life and dying with dignity is at risk for both the patient and caregiver (Gazelle, 2007). In individuals diagnosed with a progressive illness receiving hospice services, the quality of life improved, as well as the quality of death (Cagle, Pek, Clifford, Guralink, & Zimmerman, 2014; Teno et al., 2011).

A possible reason for this problem is not using APRNs as facilitators for the end-of-life care. Using APRNs would be helpful with hospice referrals for African American patients. Physicians noted that with the utilization of nurse practitioners (NPs) in their practice there was an increase in efficiency, improvement in patient and physician satisfaction, improved patient care, and increased time physicians spent on complicated cases (Moote, Nelson, Veltkamp, & Campbel Jr., 2012). NPs ease the deterioration in psychological well-being faced by terminally ill cancer patients (Dyar, Lesperance, Shannon, Sloan, & Colon-Otero, 2012). The Association of American Medical Colleges (as cited in Iglehart, 2013) estimated that by 2015 there would be a shortage of 62,100 physicians, 33,100 primary care physicians, and 29,000 other specialists.

According to Lupu (2010), there has been an acute shortage of hospice and palliative medicine physicians. Meier and Beresford (2006) implied numerous hospice programs hired APRNs because nurses emphasize the holistic approach and have the capacity to diagnose, prescribe medications, and write orders. Frogatt and Hault (2002) recommended using clinical nurse specialists as skillful practitioners and role models at the end of life. Numerous studies have demonstrated the importance of APRNs in providing quality care at the end of life (Deitrick et al., 2011; Henderson, 2004; Murphy-Ende, 2002; Quaglietti, Blum, & Ellis, 2004; Skalla, 2006).

Purpose Statement and Project Goals

The purpose of this mixed approach study was to examine NPs' perceptions and beliefs regarding hospice referrals for African American patients. The study addressed APRNs' beliefs and perceptions about the underutilization of hospice for African American patients.

The Doctor of Nursing Practice (DNP) project goals were the following:

- To identify the perceptions and beliefs of the APRNs about referring terminally ill African American patients to hospice and their suggestions on ways to improve hospice utilization for African American patients.
- To identify the APRNs' experience with referring terminally ill African American patients to hospice services.

Significance/Relevance to Practice

Ramey and Chin (2011) cited numerous studies emphasizing the significance hospice care had for patients such as enhanced quality of life, added survival time, and

increased harmony with the patient's end-of-life preferences. The leading causes of death in the African American population (heart disease, cancer, and stroke) are the main admitting diagnoses for hospice (Centers for Disease Control and Prevention, 2014; NHPCO, 2012). Individuals with a terminal illness prefer to die at home instead of in a hospital (Fried, van Dorm, O'Leary, Tinetti, & Drickamer, 1999; Kelley, Ettner, Wenger, & Sarkisian, 2011; Pullis, 2011). The lack of the utilization of hospice in the African American population has continued despite the easy accessibility of hospice care (Bullock, 2011; Yancu et al., 2010).

This project provided a different perspective on the lack of utilization of hospice in the African American community. Limited information regarding the NP as a facilitator for hospice referral in the African American population indicated that there was a need to address the issue. There has continued to be disparities in health care coverage and hospice care referrals between Caucasians and African Americans (Carrion, Park, & Lee, 2012). Wong and Tomer (2011) described death as very complex and vigorous system that encompasses biological, psychological, spiritual, societal, and cultural elements. The perception of death plays an important role, and death influences personal value and controls how individuals live (Wong & Tomer, 2011). Death is inevitable and each person deals with death differently (Parkes, Laungani, & Young, 2003). Bullock (2011) suggested cultural beliefs and values are vital to individuals making sense of death and dying. The different ethnic groups have their idea of how to cope with death and dying (Irish, Lundquist, & Nelsen, 2014).

Research Questions

The project questions were the following: What are the perceptions and beliefs for APRNs about hospice referrals for African American? What is the APRNs' experience with referring terminally ill African American patients to hospice services?

Evidence-Based Significance

In 2012, 5% of critically ill Americans received below-standard care relating to “untreated pain and physical symptoms, spiritual and emotional distress, high family caregiving burdens, and unnecessary or unwanted treatments inconsistent with their previously stated wishes and goals” (Shier, Ginsburg, Howell, Volland, & Golden, 2013, p. 552). Shier et al. (2013) noted that research has consistently demonstrated hospice helps to reduce symptoms of pain, improves patient and family contentment, and helps the family deal with the critical illness.

Also, in 2012, there were approximately 1.5 to 1.6 million patients receiving the hospice benefit (NHPCO, 2013). Statistics showed that the average length of service for hospice in 2012 was 18.7 days, a decrease from 19.1 days in 2011 (NHPCO, 2013). There are over 5,500 hospices in operation worldwide (NHPCO, 2013). Carrion et al. (2012) suggested health disparities continue in older African American patients with advanced cancer despite evidence showing that hospice services are less threatening than assertive treatments, lower the cost of health care, and reduce the encumbrance on the caregivers. The data suggested that “understanding the pattern underlying hospice referrals and use amongst different ethnic groups would contribute to developing successful evidence-based practice models for optimal end-of-life and palliative care”

(Carrion et al., 2012, p. 116). In 2002, according to a study conducted by the U. S. Medicare beneficiaries, African American used hospice at a lower rate than Caucasians (Johnson, Kuchibhatla, Payne, & Tulsky, 2013). The IOM (as cited in Fishman, Ten Have, & Casarett, 2012) stressed all individuals should be health literate on the available choices for care at the end of life.

NPs and clinical nurse specialists are often the primary care providers for the geriatric population with chronic or acute conditions. Geriatric NPs are able to guide patients through the difficult process of having a “good death” (Henderson, 2004). Henderson (2004) stated Medicare B allows repayment for APRNs in any health care setting, therefore, increasing the accessibility of health care services. Medicare also allows APRNs to certify or recertify patients for postacute care and rehabilitation services (Brassard, 2012). Brassard (2012) implied allowing NPs the capability to certify patients increases the accessibility for hospice services. APRNs are willing to provide care to underserved populations (Brassard, 2012).

Implication for Social Change in Practice

Many individuals do not receive a hospice referral promptly, many are referred during the end-stage of the illness (Teno, Casarett, Spence, & Connor, 2012). Early referrals to hospice have been proven to fulfill the needs of the patient at the start of the end-of-life, manage symptoms, and strengthen the emotional relations amongst the patients and families (Baek et al., 2011). The timing of the referral influences the experience individuals have involving hospice services. Baek et al. (2011) suggested that late referrals indicate poor quality of care. Hospice use leads to improvement in pain

management, reduction in cost, and decreased hospitalizations (Leopre, Miller, & Gozalo, 2011). When the lack hospice use is not addressed, there will continue to be a decline in utilization of hospice services in the African American population (Matsuyama et al., 2011).

The implementation of this DNP project has the potential to create social change by documenting the perceptions and beliefs of APRNs regarding hospice referrals for the African American patients. Educating the NPs on the possible connection between NPs' perceptions and beliefs of hospice for African Americans and the lack of hospice referrals for African American patients could improve patient care at the end-of-life. The NP role as a primary care provider is on the rise during the end of life (Tyree, Long, & Greenberg, 2005). NPs are rooted in clinician and patient communication, providing psychosocial, religious, and bereavement support, and coordination of care in school (Quaglietti et al., 2004). The acute care setting focuses on curative treatment; there is often stress and obstacles when transitioning to a symptom management approach (Phillips, Halcomb, & Davidson, 2011).

The IOM (2011) noted no evidence that APRNs provide lower quality care than a physician; in fact, research has shown APRNs provide quality care ranging from avoiding medication inaccuracies, decreasing or avoiding infections, and facilitating the transition from hospital to home. Currently, 18 states allow NPs to practice without restrictions. This project has the potential to provide nursing education for APRNs about the lack of utilization of hospice for terminally ill African American patients.

Definitions of Terms

Advanced directive: Pertains to patients' treatment preferences and choice of an individual to make medical decisions on their behalf if they are unable to make a medical decision (Hospice & Palliative Care Federation of Massachusetts, n.d.).

Advanced practice registered nurse (APRN): A registered nurse has education beyond the basic nursing education and certification is achieved from a nationally recognized profession organization in a nursing specialty (TheFreeDictionary.com, 2012). Examples of APRN are clinical nurse specialist, nurse anesthetist, nurse-midwife, and NP.

Clinical nurse specialist (CNS): An advanced registered nurse that is liable for diagnosing and treating illnesses, disease management, health promotion, and prevention of illness and risk behaviors among individuals, families, groups, and communities (National Council of State Boards of Nursing, 2014).

Certified nurse practitioner (CNP/NP): An advanced level registered nurse that is liable for health promotion, disease prevention, health education, counseling, diagnosing, and managing acute or chronic illnesses, in addition to, providing the initial, continuing, and comprehensive care to patients (National Council of State Boards of Nursing, 2014).

Do-not-resuscitate order: A physician order, which instructs health care providers to not attempt cardiopulmonary resuscitation (CPR) in case the patient stops breathing and has no heartbeat (Hospice & Palliative Care Federation of Massachusetts, n.d.).

Hospice care: Care to be provided when an individual is approaching the end of life, the care focuses on reassurance, respect, and management of emotional and spiritual concerns (Hospice & Palliative Care Federation of Massachusetts, n.d.).

End stage: The final phase in a progressive illness (Hospice & Palliative Care Federation of Massachusetts, n.d.).

Palliative care: A tactic to enhance the quality of life of patients, as well as, help families cope with issues linked with the terminal illness, through the avoidance of anguish (Hospice & Palliative Care Federation of Massachusetts, n.d.).

Quality of life: Individual's awareness of their position in life within the society they live in, and in regards to their ambitions, opportunities, principles, and apprehensions (Hospice & Palliative Care Federation of Massachusetts, n.d.).

Referral: The process of guiding a patient to a suitable agency for complete treatment (Merriam-Webster, n.d.).

Assumptions and Limitations

A major assumption of this project was APRNs would answer questions honestly on the survey. There was also an assumption APRNs were willing to participate in the project. Some APRNs may have had difficulty accessing survey. Time constraint could have possibly been another limitation of this project.

Summary

Lack of hospice use in the African American population has continued to be an issue despite the accessibility of hospice benefits. Cagle et al. (2014), Edmonds (2011), Emguidanos, Kogan, Lorenz, and Taylor (2011), Matsuyama et al. (2011), Molina Kim,

Berrios, and Calhoun (2014), Moore et al. (2013), Park et al. (2012), Rhodes, Batchelor, Lee, and Halm (2013), and Watkins et al (2012) addressed the African American population's perception of hospice service. However, researchers still know little about the influence of APRNs' referrals on hospice usage within the African American community (Ache, Shannon, Heckman, Diehl, & Willis, 2011; Johnson et al., 2013; Watkins et al., 2012). The studies found African Americans did not utilize hospice because of the lack of information, mistrust in health care, lack of incorporating religion or spiritual support in care, as well as family members deciding against hospice care (Matsuyama et al., 2011; Noh & Schroepfer, 2014; Spruill, Mayer, & Hamilton, 2013; Wicher & Meeker, 2012). APRNs are becoming the primary care providers for patients at the end of life. Henderson (2004) implied APRNs' advanced training puts them in a unique position to help patients at the end of life to have care and comfort. Section 2 will provide a review of the literature on the effect and the lack of utilization of hospice in the African American culture, such as lack of information, mistrust in health care, religion/spirituality, and family. The theory of planned behavior (TPB) and knowledge to action (KTA) cycle were used to develop the project.

Section 2: Background and Context

Background

A literature review was conducted using the following key terms: *hospice*, *barriers to hospice*, *lack of utilization of hospice*, *African American community hospice*, *physician perception of hospice*, *physician knowledge of hospice*, *role of advanced practice nurses*, and *utilization of advanced practice nurses*. The electronic search engines included CINAHL, MEDLINE, Ovid Nursing Journals, Google Scholar, and Nursing & Allied Health Source. The search included the majority of peer-reviewed and scholarly journals published between 1997 and 2014. The older journals provide a deeper understanding to the project study.

The review of literature suggested the lack of utilization for hospice in the African American community comes from barriers such as lack of information, mistrust in health care, religion/spirituality, and family. The literature review also revealed there have been limited studies on APRNs as a solution for hospice utilization in the African American population. The current project focused on NPs out of the APRNs group.

Hospice Utilization

In a study conducted by Carr (2012), older adults with chronic illnesses experience pain, discomfort, limited mobility, and a decrease in cognitive ability. The author described a “good death” as interventions that lessen pain, discomfort, and incorporate social, psychological, and philosophical components, such as maintaining a nurturing relationship with loved ones during the end-of-life, accepting death, and being treated with respect and dignity. The purpose of the study was to explore whether a loved

one's death causes an individual to make a decision about advance care planning. Carr conducted 90-minute face-to-face interviews with 305 participants. The study used descriptive analysis to analyze the data from the interview. Carr found that for 19% of participants, the loved one's death triggered them to plan for their advanced care to avoid pain, life support, and coma. The study also suggested that health care practitioners urge their patients to discuss their loved one's death to help the individual plan for the end of life. National Institutes of Health (2014) suggested hospice care manages pain, discomfort, and provides support for the patient and caregiver.

Frahm, Barnett, and Brown (2011) explored patterns of hospice utilization amongst different age groups of veterans from 2006 through 2009. The authors used the national database from the VHA health care system to find male patients receiving hospice. Researchers reviewed the dataset and determined that veterans on hospice services increased from 1,742 to 5,779. The researchers concluded that as the veteran population increases, importance is placed on providing quality end-of-life care for veterans.

Fairfield et al. (2012) conducted a study to explore timely hospice referrals in older women dying with cancer. The researchers used the Surveillance Epidemiology, and End Results -Medicare database to identify ($n = 8,211$) women over the age 66 diagnosed with ovarian cancer during 2001 through 2007. Only 39.7 of the women in the study were not admitted to hospice services. The results of this study showed older women diagnosed with ovarian cancer received hospice care, but the referral for hospice

was near the end of life. Also, the study suggested a need to research low-income and minority women to help with increasing timely hospice referrals in this population.

The aim of the study by Whellan et al. (2012) was to evaluate the utilization of hospice in the elderly population hospitalized with heart failure. The researchers used an observational method in 214 hospitals ($n = 58,330$) that initiated the American Heart Association's Get with the Guidelines-Heart Failure program. This study revealed that heart failure patients discharged home with hospice care was 2.5%, increasing from 2.1% to 2.9% ($p < .001$). The patients discharged home with hospice services were elderly and White.

Fauci et al. (2012) used a computerized retrospective sample to describe the characteristics of gynecologic oncology patients near the end of life. The participants ($n = 268$) in the study consisted of 76.9% White, 73.9% passed away at home or in a palliative care facility, and 70.5% of the patients were referred to hospice or palliative services. Fauci et al. found the majority of gynecologic oncology patients referred to hospice were on service for less than 30 days.

APRNs' Utilization in Health Care

Liu, Finkelstein, and Poghosyan (2014) conducted research to examine the steps organizations take to utilize NPs and the available resources to aid NPs in providing quality care. The researchers used an NP utilization model to compare productivity and cost effectiveness to support NPs. The study used data extracted from literature or government databases. The data were analyzed to identify a pattern for productivity and

cost-effectiveness of NPs. Liu et al. also found that with the support of a medical assistant an NP helped to reduce the cost of patient care from 12% to 9%.

Emergency departments in the United States are having a hard time keeping up with the demands of consumers visiting the emergency department (Abbott, Schepp, Zierler, & Ward, 2010). The researchers conducted a study to examine the effectiveness of NPs and physician assistants in the emergency room. The study used a descriptive method, 158 emergency department managers from Washington and Oregon were invited to participate in an online survey by e-mail. The study had a response rate of 59%, but only 58% of the respondents were employed NPs and PAs. The researchers found that 89% of the emergency room managers concurred that employment of NPs or PAs improved timeliness care in the emergency department.

In another study, Naylor and Kurtzman (2010) performed a literature review on the value of a NP in primary care. The researchers used 26 articles for the literature review. Naylor and Kurtzman found APRNs provided care that was equal to physicians. The researchers also found that the utilization of NPs could possibly save health care spending between \$4.2 to \$8.4 billion for 2010 to 2020. There were recommendations for legislation to standardize nursing scope of practice for practitioners.

The United States is facing a physician shortage; therefore, there is a greater need to utilize NPs as primary care providers (Dill, Pankow, Erikson, & Shipman, 2013). Dill et al. (2013) used an online survey to understand better consumers' preferences and experiences with care NPs provided. The researchers used an online survey from the Association of American Colleges Consumer Survey. The survey yielded 2,053

participants. The researchers found that 81.4% received care for an NP, and 50.3% of the respondents preferred care provided by a physician. The researchers used two different scenarios where the patient could schedule an appointment with an NP sooner than with the physician. The first scenario found that 43.0% patients would schedule an appointment with the NP and the second scenario found that 48.0% of patients would schedule an appointment with the NP.

In addition, Cooper, Loeb, and Smith (2010) found NPs played a vital role in cancer survivorship. The method for the research was a literature review. Their literature review indicated cancer patients often went through difficulties dealing with treatments, side effects, and survivorship; NPs had a strong impact on the cancer survivorship care by having a variety of roles and working to improve the quality of care being provided to cancer patients.

Lack of Information Barrier

Washington, Bickel-Swanson, and Stephens (2008) conducted a peer-reviewed literature research to explore the utilization of hospice in the African American community. The literature review consisted of eight articles. The researchers found both qualitative and quantitative studies identifying lack of awareness as a barrier to hospice for African American patients. The lack of information is significant to the underrepresented African American population receiving hospice services. The use of hospice has increased in the current years; the African American population continues to have decreased numbers for receiving hospice benefits.

Matsuyama et al. (2011) used a cross-sectional survey to examine the awareness of hospice and palliative care in the African American and non-Hispanic populations with patients in an oncology setting. Every individual participating in the study was asked to define hospice in their own words. Ninety percent of participants reported they were aware of hospice, and 49% provided an adequate definition of hospice. The participants were part of a convenience sample ($n = 133$) of cancer patients in an inner-city oncologist office. According to Matsuyama et al., individuals are less likely to utilize hospice or palliative care service if they lack knowledge about the services available. Matsuyama et al. suggested that African Americans tend not to comprehend the hospice benefits, the eligibility, or the financial feature of hospice service.

Also, Rhodes et al. (2013) conducted a qualitative research to examine barriers to end of life care. Rhodes et al. used semi-structured interviews with hospice and palliative providers. The authors implied the barriers to hospice in the African American community were the misconception and the lack of understanding of the hospice benefits.

Furthermore, Ache et al. (2011) used a survey to compare the physician's attitude and personal experience with hospice among African American and Caucasian primary care physicians. After completing a literature review, the researchers collaboratively developed a 17-question survey. The survey was mailed to 245 physicians via intranet. The results demonstrated that before patients use hospice service there must be a precondition of awareness, comprehension, and whether hospice information is reaching the African Americans. The African American population may be less informed about hospice benefits than Whites.

Equally important, Maddalena, Bernard, Davis-Murdoch, and Smith (2013) conducted a study using focus groups and concluded knowledge about palliative care services was not trickling down to African American communities in a way that was important to families dealing with end-of-life decisions. Their study consisted of a purposive sample of a group of six caregivers of individuals who were deceased. The focus group met three times to discuss their experiences with palliative care, an overview of palliative services from palliative care staff, and discuss whether the services were beneficial. After the three meetings, a follow-up meeting was conducted to discuss the results.

Jackson, Schim, Seeley, Grunow, and Becker (2000) conducted a study to understand why there has continued to be a lack of utilization of hospice for people of color. Jackson et al. used a focus group that consisted of community members and individuals who experienced hospice services. The participants ($n = 30$) were individuals who had experience with hospice and those who had no experience with hospice. Their research used a set of questions collaboratively done by hospice nurses. Four barriers were identified from the focus group: lack of information, acceptance of hospice means giving up hope, dying at home, and fear of health care systems. The top barrier for African American patients for hospice service was the lack of knowledge.

Rhodes, Reno, and Welch (2006) found African American patients were not given information about hospice services. Rhodes et al. used a retrospective cohort probability sample that consisted of 22 states. The surveyed population was 1,578 participants that included 111 offspring of non-Hispanic African Americans. Results demonstrated 53.8%

of African Americans did not receive information about hospice benefits and 8.9% that were notified refused to sign up. Rhodes et al. suggested hospice should be offered assertively to the African American patient to make hospice a valuable option at the end of life.

Mistrust of Health Care

Mistrust of health care serves as a barrier for the African American community for enrollment in hospice benefits. In the United States, African Americans have less trust in health care than Caucasians, and the distrust comes from disparities in health care (Jacobs, Ferrans, Whitaker, & Warnecke, 2006; Washington et al., 2008). The African American elderly population's distrust in health care originates from the Tuskegee study; many individuals felt they were likely to be treated as experiments (Cort, 2004; Gamble, 1997; LaViest, Wickerson, & Bowie, 2000; White, 2005).

Melhado and Bushy (2011) used a 10-item Health Literacy Skills Instrument to identify the factors that persuaded health literacy on advance care planning choices in the African American population. Melhado and Bushy noted African Americans over the age of 65 had the highest morbidity and mortality rates, linked to lack of sources and knowledge of health issues. Furthermore, Melhado and Bushy noted race and ethnicity played a vital role in making end-of-life decisions. Melhado and Bushy also implied individuals within the African American community value communication, respect, and a nurturing relationship with the physician when diagnosed with a terminal illness.

According to Ludke and Smucker (2007), African Americans are less likely to use hospice at the end of life. Ludke and Smucker conducted a study to examine whether

racial disparities affected the readiness to utilize hospice in the future in Black and White communities. They conducted random phone interviews. The study consisted of responses from 473 participants. Ludke and Smucker found Whites were more likely to use hospice services (89.0% vs. 70.9%). Their research suggested the reluctance related to previous exposure to hospice, as well as mistrust in their doctor. Additionally, numerous surveys have shown African Americans distrust health care relating to the fear of being treated as subjects in an experiment (Kennedy, Mathis, & Woods, 2007). Prior experience with health care is linked to mistrust in health care.

Armstrong et al. (2013) investigated the contribution of self-reported experiences of racial discrimination to racial differences in health care system distrust. The researchers conducted a random survey ($n = 2,179$) that consisted of a health care distrust scale that used nine questions addressing discrimination and a nine questions in an experiences of discrimination scale. The data were collected for 6 months. Armstrong et al. found health care distrust was linked with a decrease in the rate of suggested disease prevention and treatment of illnesses as the illness progress.

Ross, Lybson, and Kumagai (2012) conducted research in the suburban Midwest to explore racial disparities in health care. The researchers used a purpose and snowball sampling for the study. Flyers and posters were displayed in churches, school organizations, community organizations, and physicians' offices after permission was obtained to conduct on-site interviews. The researchers used open-ended questions to encourage in-depth explanations of insights and incidences in health care. The participants involved in the research described their encounters with the health care

systems. The study revealed four major themes: (a) relative examinations of disparity in treatment, (b) making assumptions about the African American population, (c) using instinctive ways of understanding, and (d) developing methods to avoid mistreatment. According to Ross et al., the participants felt optimum care was available but was withdrawn because of race.

Religion/Spiritual Barriers

Religion and spiritual emerged as barriers to the African American population as a choice to receive hospice care. Dillon, Roscoe, and Jenkins (2012) conducted a qualitative meta-ethnography, which suggests the individual's spiritual beliefs leads them to view death as a transition and the death experience as getting right with God. The meta-ethnography was used to identify and connect themes and concept of studies. The research involved a literature review about hospice care and African Americans. Dillon et al. found 788 abstracts about African Americans and hospice; the initial inclusion criteria entailed articles that are written in English and focused on African Americans and hospice in the United States. The studies were synthesized and categorized according to themes. The participant's in the abstracts health care decisions about the end-of-life were based on their faith. According to Dillon et al. concluded significance is placed on the end-of-life care that integrates and emphasizes spiritual support rather than tolerating spiritual support. Religion in the African American community helps the individual to make decisions about health care.

The purpose of a study by Bullock (2011) was to encourage cultural competency at the end of life. Bullock semi-structured interview and focus group implied African

Americans believed you did not postpone death with hospice care, but you wait on the Lord. The participants in the study were 12 focus groups African American and 12 focus groups Whites. The participants in the study were asked to describe their experience with hospice services; many participants felt their loved ones were denied the inclusion of religion as part of end-of-life care. After 3 months, a follow-up interview was performed, and both a Cultural Value Scale and Cultural Belief Scale were distributed. The follow-up interview found African did not make a decision about end-of-life care, because the decision would not change the dying experience, mistrust in health care, having an advanced directive result in withholding care, and religion influences end-of-life choices.

In another study, Jackson et al. (2014) used a narrative interview to recognize the possible advantages and obstacles for support teams. The study involved African Americans ($n = 30$) from the Midwest, the participants were placed in four focus group. Jackson et al. found the spiritual needs of African Americans are magnified when diagnosed with a terminal illness. In addition, Jackson et al. (2014) also suggested to enhance the quality of life in the terminally ill, care needs to be culturally fitting.

Also, the purpose of a study by Yancu, Farmer, Graves, Rhinehardt, and Leahman (2014) was to explore African American feelings and views about dying, death, and end of life care. In an interactive focus group, Yancu et al. (2014) found African Americans are more than likely to choose faith support within the community and forgo the decision to receive hospice services. Yancu et al. (2014) implied death was easier to accept if the individual has lived a full life, develops a good relationship with God; the outcome is a peaceful death.

In order to understand the lack of the utilization of hospice in the African American community, Noh and Schroepfer (2014) interviewed 28 African American hospice guided by the Behavioral Model for Vulnerable population, the study revealed educating and addressing spiritual/religious issues in making decisions about hospice services plays a significant role in encouraging the hospice within the African American population. From the content analysis, three themes were identified; God provided hospice, relied on God for health care decisions, and spiritual and religious practices are accepted in hospice care.

Additionally, Conner (2011) also found using a prospective, correlational study guided by the Behavior Model of Health and incorporating spiritual relationship along with other factors increases the usage of hospice within the African American population 13% to 19%. Green et al. used the Support Team model contentment to guide the focus group decision of church members diagnosed with a terminal illness, the study revealed the Support Team model was beneficial to African Americans churches to lessen the silent agony of the members living with cancer.

Born, Greiner, Sylvia, Butler, and Ahluwalia (2004) used a focus group to explore African Americans and Latinos needs and preferences at the end-of-life and examine what extent hospice services meet these needs or preferences. Born et al. (2004) realized there was limited research about opinions and perspectives of minorities at the end-of-life, and there is a need for clarity on how these issues are associated with lack of the utilization of hospice in minorities. The research focused on 26 African Americans and 27 Latinos who helped to identify four main themes relating to preferences at the

end-of-life care: family members provide direct care, need to reduce caregiver burden, rely on spirituality as the main source to cope with grief and death, and holistic contentment of patient and family. The significance of this study is African Americans, and Latinos would accept end-of-life care if the service provides relief for patient and caregiver, stress spirituality, and family consent.

Family Barriers

The African American population prefers to have members of the family as caregivers. Vigs, Starks, Taylor, Hopley, and Fryer-Edwards (2010) were interested in finding why individuals eligible for hospice did not enroll in the hospice services. An interview was conducted with patients and family members who were approached by a hospice admission coordinator but did not enroll. The authors used semi-structured interviews with content analysis revealed family members felt accepting hospice services meant they were giving up on their loved one. The study also revealed other reasons why patients did not enroll in hospice care such as patient/family perceptions of hospice benefits and understanding of hospice services.

In addition, Washington et al. (2008) explored literature about hospice services in the African American population. The research included peer-reviewed journals written in English. Data was gathered from eight articles using a form with categories for methodology and design, sample size, obstacles to African Americans enrolling in hospice care, and interventions. The study revealed in both quantitative and qualitative research vital elements that influence the lack of hospice utilization in the African American population: personal or cultural values, lack of information about hospice care,

lack of minority staff in hospice organizations. The results showed African Americans with terminal illness felt hospice care would be a financial burden for their family member.

In the United States, African Americans have the highest mortality rate for cancer and shortest survival rate than any other race (Zhang, Zyzanski, & Sminoff, 2012). Zhang et al. (2012) explored the reason for racial differences in attitudes and preferences about cancer treatment between African Americans and Whites caregivers. The study used a convenience sample ($n = 199$) consisting of African Americans and Whites. The authors conducted telephone interview evaluating the differences amongst African Americans and White caregivers about cancer treatment and care; the study revealed there are issues with end-of-life decisions with the African American caregiver such as belief in curative treatments, lack of understanding end-of-life care, and refusing to allow family or caregivers to make choices about advance care planning.

Additionally, Piamjariyakul, Myers, Werkowitch, and Smith (2014), using a purposive sample, examined the end of life choices and advanced directive implementation in ethnic and severely ill cardiac patients. The authors discovered in a study using an open-ended question interview that individuals diagnosed with a terminal illness wanted family members to be involved in end-of-life decisions.

Kwak, Kramer, Lang, and Ledger (2012) used a case study to examine issues that were encountered while providing end-of-life care for low-income elders in Wisconsin. The case study consisted of purposeful sample of 17 participants that consisted of county administrators, lead supervisors, and focus groups with care management team affiliates

(Kwak et al., 2012). The study found five themes that created obstacles when making decisions about end-of-life care. Kwak et al. discovered the five themes are the acuity of care and lack of family support, family members or caregivers not aware of patient's preference for advanced care planning, family struggles about end-of-life decisions, lack of communication amongst the different health professionals, and no bereavement support offered to the family.

As stated above, the literature expressing the lack of hospice use among African Americans includes the areas of misperceptions, lack of understanding, spiritual beliefs, and familial concerns. It is the expression of this researcher that the NPs play a role with this decision for families as well. Unfortunately, there was no literature to be found to support this writer's thoughts. Research is needed in this area to discern whether NPs' input contributes to the lack of hospice utilization for the African American family.

Theoretical Framework

The theory of planned behavior and KTA cycle was used to facilitate change for the NP for referrals privileges and to identify perceptions and beliefs of NPs about referrals for the African American patient.

The theory of reasoned action describes the association of philosophies, approaches, purposes, and actions (McEwen & Willis 2011). The theory of reasoned action assumes an individual make rational decisions based on the information readily accessible (McEwen & Willis, 2011). Modifications were later made to the theory of reasoned action. Ajzen, a professor at the University of Massachusetts, in 1985 added perceived behavioral control to the existing theory of reasoned action to develop the

theory of planned behavior indicated in Figure 1. (McEwen & Willis, 2011). The theory of planned behavior describes intentions that contribute to an individual's willingness to accomplish an action, which is influenced by belief concerning the action; personal standard, and apparent social influence (McEwen & Willis, 2011). Azjen (1991) cites the greater the intentions to accomplish the action the individual is more than likely to perform an action. The theory of planned behavior "proposes that an individual's intention is determined, in turn by his/her attitude and subjective norm regarding the performance of the behavior" (McEwen & Willis, 2011, pg. 293). McEwen and Willis (2011) implied the theory of planned behavior believes people are capable of making competent decisions based on data presented to them. The processes of the theory of planned behavior will help individuals to understand the NPs' attitude, belief, perceptions, intentions, and behavior concerning hospice referrals in the African American population. McEwen and Willis (2011) cited the most significant cause of an individual's behavior is intention according to the theory of planned behavior. The theory of planned behavior has been proven to be appropriate predictor of intention and behavior explaining 40-49% of the variance in intention and 26-36% of the variance in behavior (Ajzen, 1991; Armitage & Conner, 2001; Godin & Kock, 1996; Hagger et al., 2002; McEachan, Conner, Taylor, & Lawton, 2011; Trafimow, Sheeran, Conner, & Finlay, 2002).

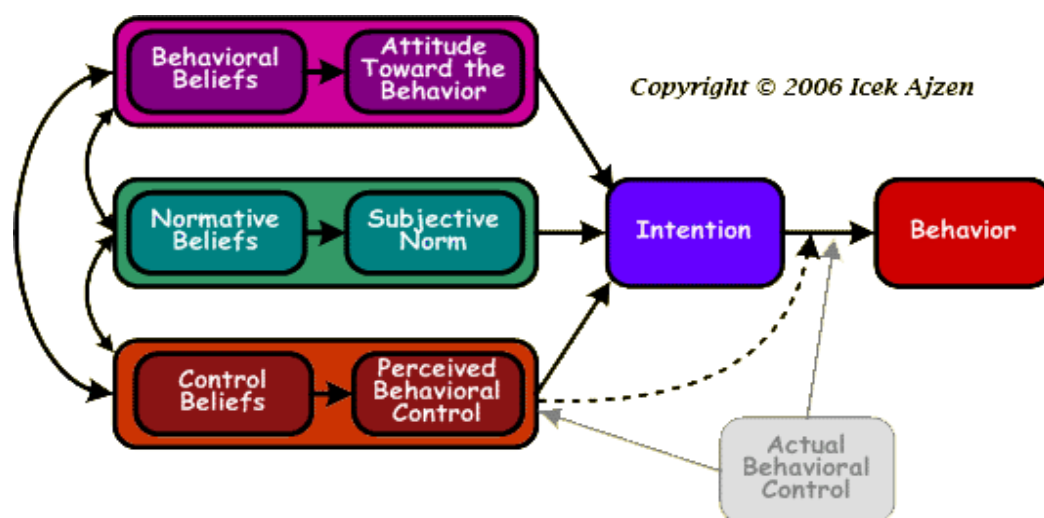


Figure 1. Theory of planned behavior.

Kam, Knott, Wilson, and Chambers (2012) used the theory of planned behavior to understand better health professionals' attitudes and intentions for referring cancer patients to psychosocial support. The study used a survey distributed to 72 oncology health care professionals in 2010. Using the theory of planned behavior, the study outcome indicated vital predictors of intentions to refer cancer patients for psychosocial support were attitudes about the services and subjective norms (Kam et al., 2012). Ramsay, Thomas, Croal, Grimshaw, and Eccles (2010) used the theory of planned behavior to explore the cognitions of physicians predicting their test requesting behaviors; the study results found an intention as 11% of the variance in behavior, and attitude was the leading predictor of intention. In another study, the intention was found attitude the leading predictor of intentions, and intention was the leading factor with 29% of the variance in physician urging physical activity (Sassen, Kok, & Vanhees, 2011). The theory of planned behavior can help guide NPs on making a decision to refer African American patient for hospice services as indicated in Figure 2. The theory of planned behavior

guided this project study. The theory of planned behavior process entails the NP making a decision for a hospice referral according to the approval or disapproval of colleagues', likelihood referring the African American patient to hospice may enhance the quality of end-of-life, and belief or power to influence hospice referrals in the African American population, as well as, the intention to improve the quality of care at the end of life predicts whether the physician will refer an African American patient to hospice.

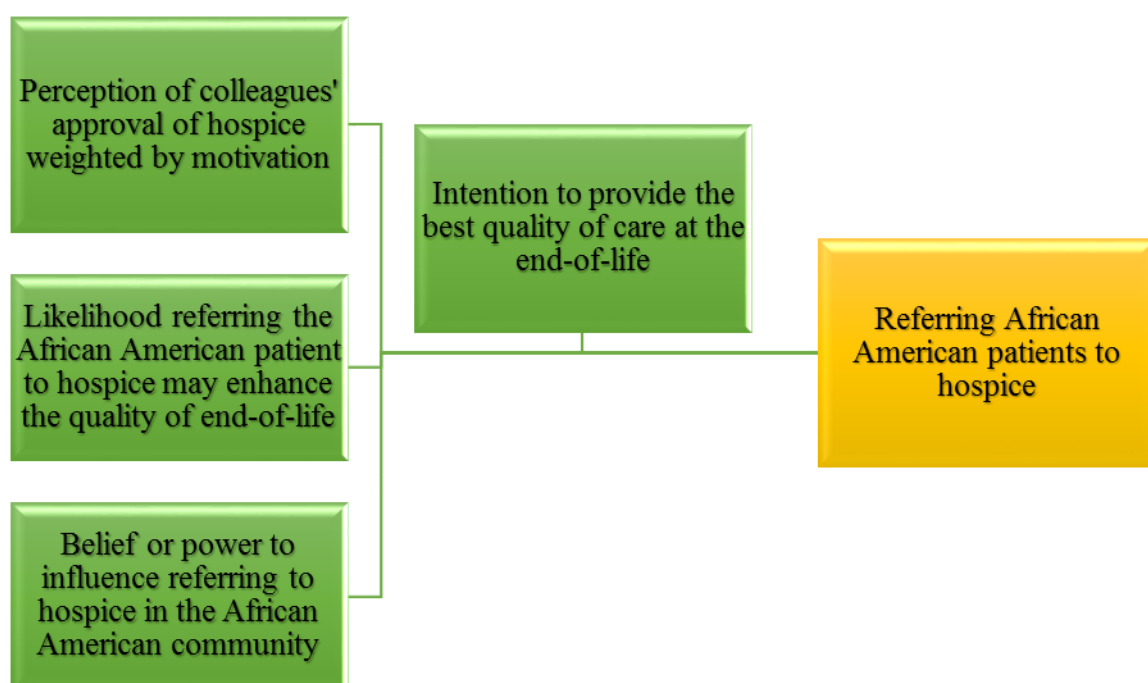


Figure 2. Modification of the theory of planned behavior.

Graham et al. (2006) created the KTA framework to provide clarification in the KTA field and to help explain the key elements of the KTA process. The KTA framework foundation is an analysis of over 30 planned action theories and disseminates an evidence-based method to apply knowledge (Kastner & Straus, 2012). The KTA framework has two distinct but necessary components: knowledge creation surrounded

by the action cycle (Field, Booth, Ilott, & Gerrish, 2014). In the center of the framework there is knowledge creation. The center also consists of steps of inquiry, synthesis, and the creation of tools/products (Graham et al., 2006). Graham et al., (2006) has seven steps:

1. The problem is identified, as well as, knowledge needed.
2. Knowledge will be adapted for local context by evaluating the value and utility.
3. Assess for any obstacles to knowledge adoption and the usage of context.
4. Create a plan and implement KTA and any approaches to encourage the use of knowledge.
5. Examine knowledge usage and determine if any changes are needed.
6. Knowledge maintains over time.

This DNP project focused on the first four phases of KTA. As previous stated, the center of KTA concentrates on knowledge creation, inquiry, synthesis, and tools.

Inquiring and synthesis are accomplished by conducting a literature review on NPs utilization in health care, as well as, the benefits of the utilization of NPs. Knowledge tools involve a literature review of evidence-based practices. Once knowledge has been created a problem has been recognized: The barriers in the NP scope of practice may limit referrals to African American patients with terminal illness. The problem is then adapted to where the barriers for NPs can do the initial referral for the consumer to other health care resources. The barriers related to knowledge use are the physician and lack of knowledge about the need of NPs in the hospice setting. This DNP project intervention

focused on being an advocate for NPs to assist with hospice referrals for the African American patient. The knowledge will be disseminated to American Association of Nurse Practitioners and Georgia Nurses Association. Field et al. (2014) conducted research to see if the KTA framework is being used in practice and how. Citation analysis and systematic review were chosen to categorize reports of usage of KTA. The citation search was restricted from 2006 to 2013 (Field et al., 2014). Each article was categorized according to each phase of the KTA framework. The researchers found that 146 articles attributed to using the KTA framework (Field et al., 2014). Ten studies used the KTA framework and explained how the framework guided their study.

Kastner and Straus (2012) used both knowledge-to-action and the medical research council frameworks to develop an osteoporosis clinical decision support instrument. The researchers used both KTA and the medical research council frameworks to concentrate on gaps in osteoporosis disease management (Kastner & Straus, 2012). The researchers used KTA to involve pertinent end users of knowledge being applied and the medical research council because it balances the iterative phase method of the KTA (Kastner & Straus, 2014).

Douglas et al. (2013) applied the KTA framework when trying to implement an asthma educational program named “Roaring Adventures of Puffs” (RAP) for Aboriginal children and their caregivers. The researchers focused on the first four phases of KTA (Douglas et al., 2013). The First Nation (FN) youth had a high incidence of asthma-related conditions and a literature review was conducted for evidence-based practices for RAP (Douglas et al., 2013). The researchers conducted a pilot study that leads to the

recommendations for using RAP in the FN neighborhoods. A culturally appropriate survey developed by RAP instructors, the survey was given to 13 FN youths and caregivers, as well as, interviews being conducted (Douglas et al., 2013). The data gathered from the surveys and interviews were used to guide interventions. Douglas et al., (2013) found KTA was reasonable and important for adapting RAP for the FN districts.

Summary

The literature review provided insight on the lack of information, mistrust of health care, religion/spiritual, and family barriers to hospice referrals within the African American community. The theory of planned behavior is vital to understanding the NPs decision to refer African American patients to hospice care. KTA is vital for advocating for NPs to have barriers removed from APRNs scope of practice. There continues to remain a gap in literature pertaining to the physician influence on the referrals of African Americans diagnosed with a terminal illness admitted to hospice services. The theoretical frameworks for the project were presented. The theoretical model described the intentions that contributed to an NP's willingness to refer African American patients to hospice, and how the intent is influenced by beliefs, standards, and social influence. KTA model allowed knowledge translation into health care policy. Section 3, will provide detail on the design and method used in the DNP project.

Section 3: Collection and Analysis of Evidence

Project Design and Methods

The design of the study involved mixed methods. This study was a descriptive study and involved both descriptive statistics and qualitative content analysis of responses to a survey to examine the NPs' perceptions and beliefs regarding hospice referrals for African Americans and barriers to the scope of practice for APRNs. In a quantitative study, the researcher can put data into categories. A descriptive research focuses on a phenomenon without manipulating the environment (Grove, Burns, & Gray, 2013). Descriptive research depicts the qualities of the chosen population or area of relevance correctly and within an appropriate context thoroughly (Grove et al., 2013). Descriptive research is used to create new information about theories or areas about which limited or no research has been performed (Grove et al., 2013). Grove et al. (2013) described qualitative research as a method to describe life experiences from the perspective of the individual involved. Beliefs and perceptions were measured by a modified Nurse Practitioner Survey on African Americans patients' hospice referrals and barriers to current scope of practice of NPs (Appendix E). The survey is a modified version of the survey developed by Karen Ogle, MD. I sent a letter to Karen Ogle, MD requesting permission to make modifications to the survey via e-mail (Appendix A); Karen Ogle, MD granted permission for modifications (Appendix B). Once the modified survey was keyed into Survey Monkey, a custom URL was generated for the survey.

Population and Sampling

In this project, the target populations were NPs practicing in Georgia and members of a Facebook group for NPs. The project used a purposive sample. Ten NPs from the Georgia State Board of Nursing website received invitations to partake in the survey for this project. The survey was also posted on Facebook to reach NPs. Terry (2012) implied a purposive sampling is appropriate when the population being researched is uncommon. The inclusion criteria were that the NPs have an active certification, be members of the NPs Facebook social group, and/or practice in Georgia.

The NPs mailing list consisted of randomly chosen participants from the Georgia Board of Nursing as well as random participants from the NPs social group on Facebook. A consent letter and survey link were included in the invitations (Appendix C). NPs interested in participating in the project copied the URL for the survey link to their computer. Once he or she clicked the link, the participant was forwarded to the consent page (Appendix D). At that time, the participants decided whether or not to participate. Once the participant made a decision to participate, the participant clicked on the next tab and was forwarded to the survey.

Data Collection

Data collection began after Institutional Review Board (IRB) approval. The Walden University approval number for this study is 05-26-15-0416068. I mailed the NPs a letter and placed a post on a Facebook social group explaining the purpose of the survey as well as voluntary participation in the study. The invitation and survey link were sent to the potential participants asking them to participate in the project concerning NPs'

perceptions and beliefs regarding hospice referrals for African American patients. The survey was set up to receive up to 20 responses. NPs agreeing to participate in the study gave consent by reading the study background information; consent was assumed when the participants continued with the survey. Participants were encouraged to read the instructions thoroughly before proceeding to survey. The completion of the survey averaged 10 minutes. Data were collected over 4 weeks. At the end of each week for 4 weeks, I sent a reminder to the NPs' addresses and posted on a Facebook group about participating in the research project. The reminder notices were resent to all potential participants.

A web link collector sent the responses back to me. Web link collector is the quickest way to disperse the survey and gather responses (Survey Monkey, 2014). The IP addresses were made anonymous by turning off the IP address collector. Confidentiality and anonymity were maintained because there were no identifiers obtained such as names, telephone numbers, e-mail addresses, or office locations. The data collected were assessed through my personal account set up on the Survey Monkey website.

Instrument

The survey instrument was developed by Karen, Ogle, MD grounded on literature review and input from hospice workers; then a pilot study was conducted (Ogle, Mavis, & Wyatt, 2002). In 2003, Ogle, Mavis, and Wang used the survey tool to assess physicians' knowledge, beliefs, and barriers to hospice referrals. A modified survey addressed the areas of concerns about referrals of hospice services for the African American patient. The survey tool was modified from a survey developed by Karen Ogle,

MD (Ogle et al., 2003; Ogle et al., 2002). The survey has been used in numerous studies to identify perceptions and beliefs of a physician about health care. The survey included demographic information such as the state of practice, years of experience, and specialty area. The second section of the survey consisted of questions about the NP perception of the African American community and hospice. The third section consisted of six questions about the NP perception of hospice. The last section consisted of two questions about barriers to practicing. A cover letter went with the survey. The modification of the survey included the removal of the third section about hospice knowledge as well as the fourth section pertaining to NP rating the importance of specific benefits. The first section was modified by adding demographic questions about the number of hospice consultations to African Americans in the past 3 months and consultations to Caucasians in past 3 months. Section B was modified to examine the NPs' perceptions of the African American patient. Section C was modified to address the NPs' beliefs about hospice. Section D was added to address NPs' barriers in a practice setting. The survey allowed the participants to skip questions.

Protection of Humans Subjects

The proposal was sent to the IRB at Walden University. No participants partook in the project before the completion of the IRB process. No participant was excluded according to race, ethnicity, or religion. No risks were expected for participants in this project study. No identifying factors were used in the project study. There were no monetary compensations for participating in the project study.

Data Analysis

The data analysis was conducted using descriptive statistics and qualitative content analysis. Descriptive statistics provided percentages and frequencies that described the characteristics of the participants and responses from the survey. Survey Monkey automatically analyzed the data. A view summary appeared by default creating a horizontal bar chart for all the questions on the survey. I exported the summary report to Microsoft Excel via Survey Monkey.

The qualitative content analysis provided recurrent thoughts or patterns of the participants' responses from the survey. To conduct the content analysis, I imported the data from Survey Monkey into NVivo 10. NVivo 10 software was used to organize and analyze the participants' responses for thematic data. NVivo 10 is a software that makes sense of nonnumerical data from the survey by classifying, sorting, and arranging phrases from transcripts to help the researcher examine transcripts for correlations in data. Dr. Kimbria Jackson assisted with qualitative content analysis. Dr. Jackson was provided a transcript of open-ended question responses from the survey. Dr. Jackson wrote down key words from the transcript and grouped them according to commonalities. The areas evaluated were perceptions, beliefs about hospice, hospice for African American patients, and restrictions on the scope of practice of APRNs to determine if these factors were barriers to hospice referrals for terminally ill African Americans.

Evaluation Plan

Program evaluation is an ongoing process. The evaluation plan is a process that involves identifying weaknesses or strengths within a program. The plan, do, study, act

(PDSA) cycle was an appropriate evaluation tool for the DNP project. The PDSA cycle is a continuous tactic for enhancement. For the planning stage, goals and objectives were established. In the do stage, possible solutions are generated and implemented. During the study stage, the implemented solutions are evaluated, and modifications are made if necessary. In the last stage, act, the programmers reevaluate the program results and make adjustments according to the findings. The goals of this project were to shed light on APRNs' perceptions and beliefs about hospice utilization for African American patients, their suggestions on ways to improve hospice utilization for the African American patient, and identify the APRNs' experience with referring terminally ill African American patients to hospice services. Data from the study are available as an educational awareness program for local hospices, American Association of Nurse Practitioners, Georgia Board of Nursing, and Georgia Nurses Association.

Summary

In Section 3, data collection, methodology, and ethical implications were discussed. There was a rationale on why a quantitative study was chosen for the project. The survey and modifications were described in detail. A purposive sample from Georgia Board of Nursing was selected for the project and from social media group. Data were collected using a mailed survey with a web link. The data analysis was also described. The data were analyzed using descriptive statistics and content analysis. Once the data were analyzed from the surveys, the findings were used in Section 4 for further discussion and implications of a project.

Section 4: Findings and Recommendations

Summary of Findings

The purpose of the project was to examine NPs' perceptions and beliefs regarding hospice referrals for African American patients. An invitation to participate in the project study was mailed to 10 participants in Georgia and posted on a NP-specific Facebook page. The invitation provided a link to participate in a survey that was created and posted on Survey Monkey. The survey was set up to close when 20 participants responded or by the expiration date. Nine participants responded to the survey.

A total of nine nurses (45%) responded to the survey. A total of eight nurses completed, which indicated a 40% completion rate. Table 1 summarizes the demographic characteristic of the participants.

Table 1

Participant Characteristics

Characteristics	<i>N</i>	%
State		
Wisconsin	1	11
West Virginia	1	11
Georgia	6	67
Years Practicing		
1-5 years	6	75
6-10 years	1	12.5
10-15 years	0	0
> 15 years	1	12.5
Specialty Area		
Family Practice	4	50
Other	2	25
Internal Medicine	2	25
Geriatrics	1	12.5
Cardiologist	0	0
Oncologist	0	0
Neurologist	0	0
Nephrologist	0	0

As depicted in Table 1, the sample consisted of NPs from Georgia, West Virginia, and Wisconsin. Seventy-five percent of the participants had been practicing as an NP for 1 to 5 years, 12.5% had been practicing 6 to 10 years, and 12.5% had been practicing more than 15 years. Four of the respondents (50%) worked in the specialty area of family practice, two respondents (25%) indicated their specialty as other, 25% as internal medicine, and 12.5% as geriatrics. One respondent worked in both internal medicine and family practice specialty areas.

Respondents were asked how many African American patient referrals had they made to hospice in the past 3 months. The responses indicated most of the NPs did not refer African American patients for hospice services. The survey responses indicated 62.5% did not refer African American patients to hospice, and 37.5% referred one to five African American patients to hospice services.

The NPs were also asked how many patients of other races they referred to hospice in the past 3 months. The responses indicated most of the NPs had not referred patients of any other race to hospice services. The survey responses indicated 62.5% did not refer to other races, 12.5% referred one to five, 12.5% referred six to ten, and 12.5% made more than 15 referrals for other races for hospice services.

As shown in Figure 3, the results of Survey Question 6 (African American patients and families prefer family members to care for them at the end of life?) showed diverse responses. Thirty-seven percent of respondents agreed and strongly agreed, 25% neither agreed nor disagreed, and 11% disagreed.

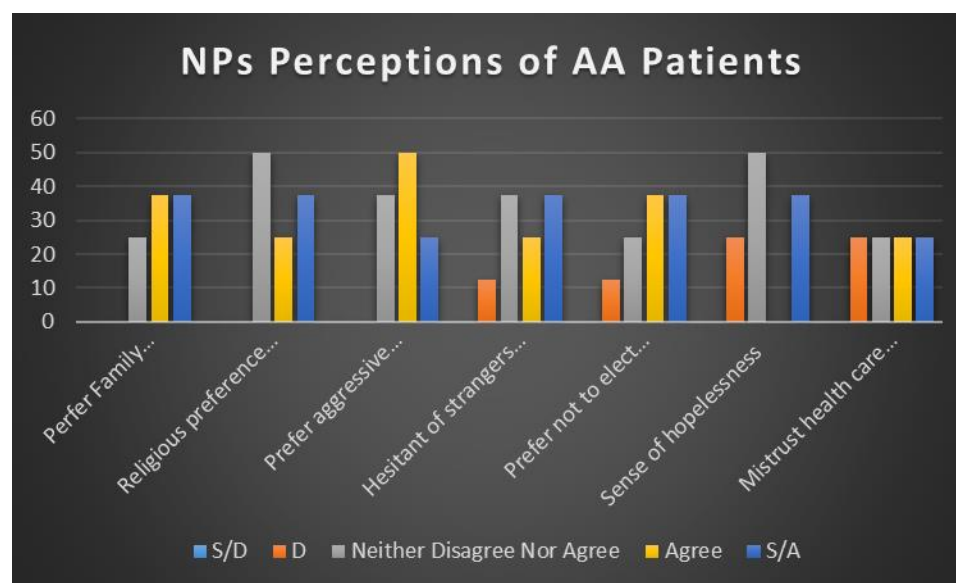


Figure 3. NP perceptions of African American patients about hospice.

As shown in Figure 3, responses to Survey Question 7 (Religious preference for the African American patient influence my decision about hospice referral?) revealed 50% neither disagreed or agreed that the African American religion influenced the decision to refer the patient to hospice services. Thirty-three percent of the respondents strongly agreed religion influenced the decision to refer African American patients to hospice services. Twenty-five percent agreed African American religion influenced the decision for hospice referral.

For Survey Question 8, 37.5% neither disagreed nor agreed, 50% agreed, while 37.5% of NPs believed African American patients and families preferred aggressive treatment, as shown in Figure 3.

For Survey Question 9, 12.5% disagreed, 37.5% neither disagreed nor agreed, 25% agreed, while 37.5% of NPs believe African American patients were hesitant to have strangers in their homes, as shown in Figure 3.

For Survey Question 10, 12.5% disagreed, 25% neither disagreed nor agreed, 37.5% agreed, while 37.5% strongly agreed African American patients preferred not to elect hospice benefits, as indicated in Figure 3.

For Survey Question 11, as depicted in Figure 3, 25% disagreed, 50% neither disagreed nor agreed, while the remaining 37.5% strongly agreed African American patient and family felt a sense of hopelessness when hospice was discussed.

For the question about the belief that African Americans mistrust health care professionals, 25% disagreed, 25% neither disagreed nor agreed, 25% agreed, and 25% strongly agreed, as shown in Figure 3.

For Survey Question 13, as depicted in Figure 4, 12.5% of NPs were very comfortable discussing hospice with African American patients and families while 75% were comfortable. Responses to Survey Question 13 also indicated 12.5% of NPs were very uncomfortable discussing hospice with African American patients and families.

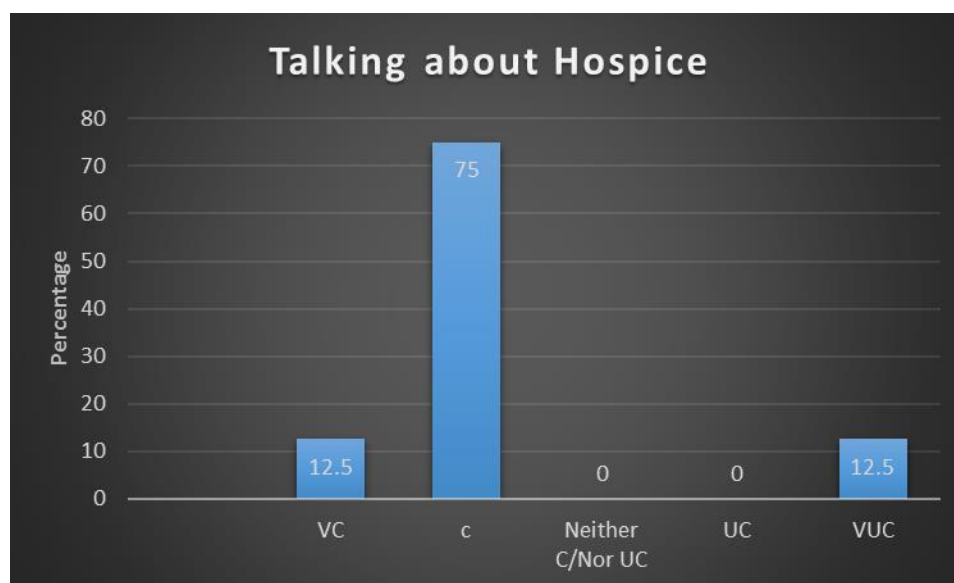


Figure 4. NP comfort talking to African American patients and family about hospice.

For Survey Question 17, 62.5% neither disagreed nor agreed, 25% agreed, while the remaining 12.5% strongly agreed there was timely communication between the NPs and hospice as shown in Figure 5.

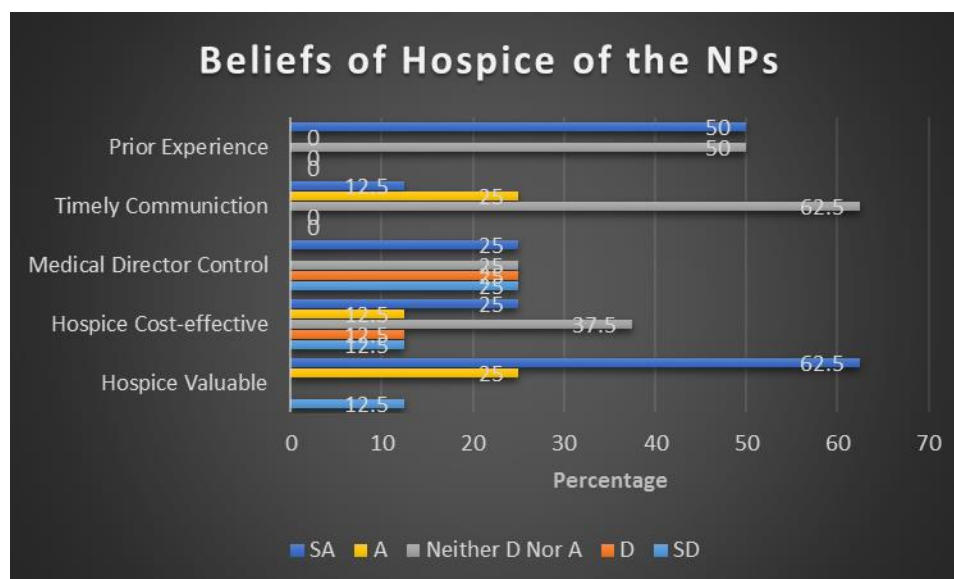


Figure 5. NP belief about hospice services.

For the question about hospice being more cost-effective than care and comfort provided by nursing homes, families, and hospitals, 12.5% strongly disagreed, 12.5% disagreed, 37.5% neither disagreed nor agreed, 12.5% agreed, and 25% strongly agreed, as shown in Figure 5.

As indicated in Figure 5, 50% of NPs neither agreed nor disagreed that prior experiences with hospice influenced the decision for hospice referrals and/or consultations while the remaining 50% strongly agreed.

For Survey Question 17, 62.5% neither disagreed nor agreed, 25% agreed, while the remaining 12.5% strongly agreed there was timely communication between the NPs and hospice as shown in Figure 5.

For the question about hospice being more cost-effective than care and comfort provided by nursing homes, families, and hospitals, 12.5% strongly disagreed, 12.5% disagreed, 37.5% neither disagreed nor agreed, 12.5% agreed, and 25% strongly agreed, as shown in Figure 5.

As indicated in Figure 5, 50% of NPs neither agreed nor disagreed that prior experiences with hospice influenced the decision for hospice referrals and/or consultations while the remaining 50% strongly agreed.

The qualitative analysis began by exporting the open-ended question responses from Survey Monkey to NVivo 10. NVivo 10 was unsuccessful with identifying specific themes from the open-ended questions. Therefore, qualitative data were manually placed in Microsoft Excel and color coded to allow the identification of themes and specific words. Microsoft Excel was used to demonstrate the statistical findings from the open-

ended questions. However, some data were missing because some participants skipped some open-ended questions. The statistical data were checked by Dr. Kimbria Jackson.

Survey Question 14 focused on whether NPs found hospice to be a valuable service, as seen in Figure 6. The completed survey revealed 57% believed hospice was a valuable service. Respondent 3 stated, “Hospice is a great benefit. Allows the family additional help with health care needs. The benefits are great for the patient, as well as, family.” Respondent 8 stated, “Hospice has come a long way since hospice that begun. They are great asset for the family. Hospice helps to give the families relief and comfort. The patient also in return is at ease knowing they are not going through the illness alone.” Respondent 6 stated, “Hospice provides holistic end of life care not only for the patient, but for the family as well.” Respondent 1 further suggested, “End of life services is invaluable for patients and families to assist in transition.”

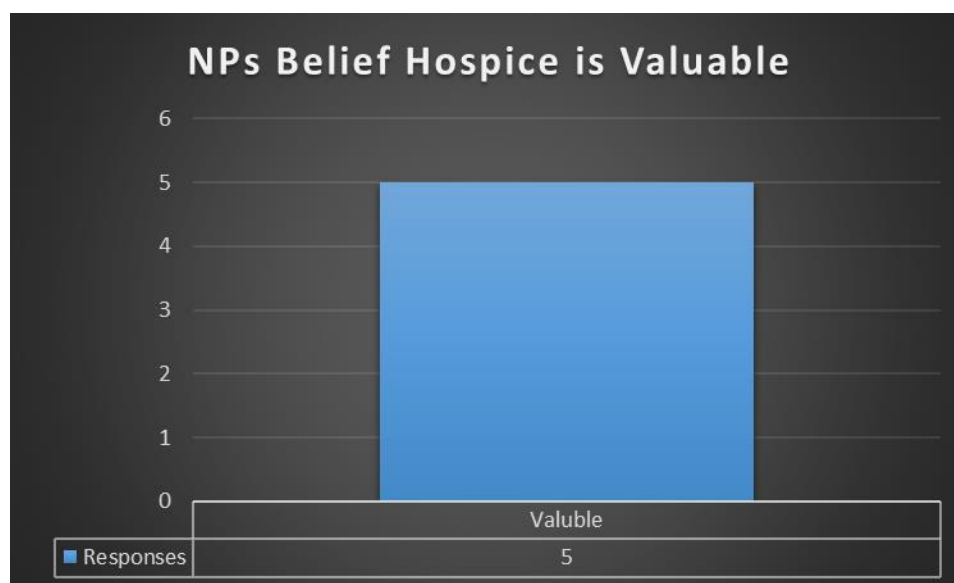


Figure 6. NP belief that hospice is valuable service.

According to responses to Survey Question 15 as shown in Figure 7, four respondents believed hospice was cost-effective compared to care and comfort provided by nursing homes, families, and hospitals. One response implied other health care facilities could provide the same service. The majority of the respondents recognized hospice as being cost-effective compared to care and comfort provided by other health care facilities.

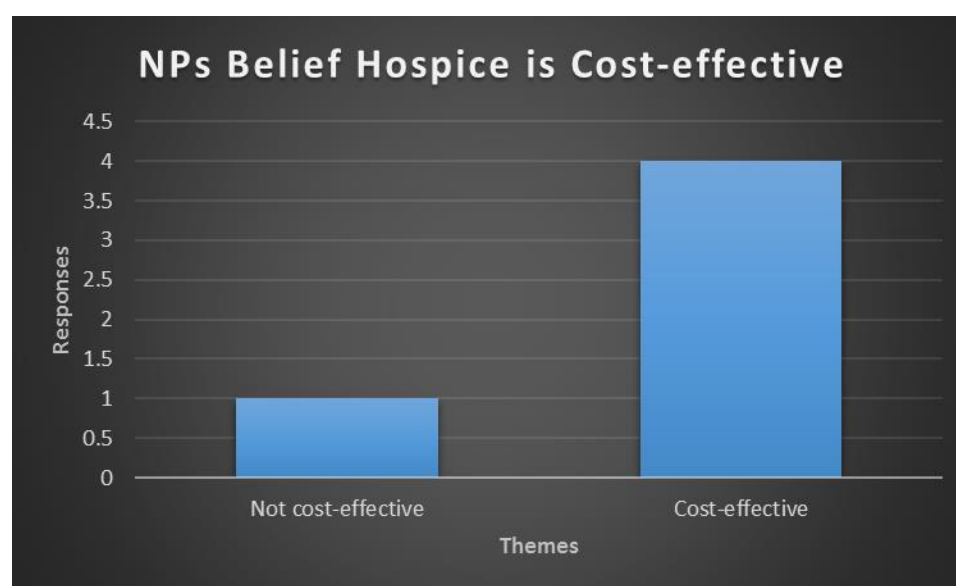


Figure 7. NP belief that hospice is cost-effective.

Respondent 6 for survey question 16 shown in Figure 8 stated, “The patient and family are the ultimate decision makers.” Respondent 1 stated, “Leadership may provide guideline for services, but do not determine how services are conducted.” Respondents 3 and 6 work “collaboratively” with the hospice medical director.

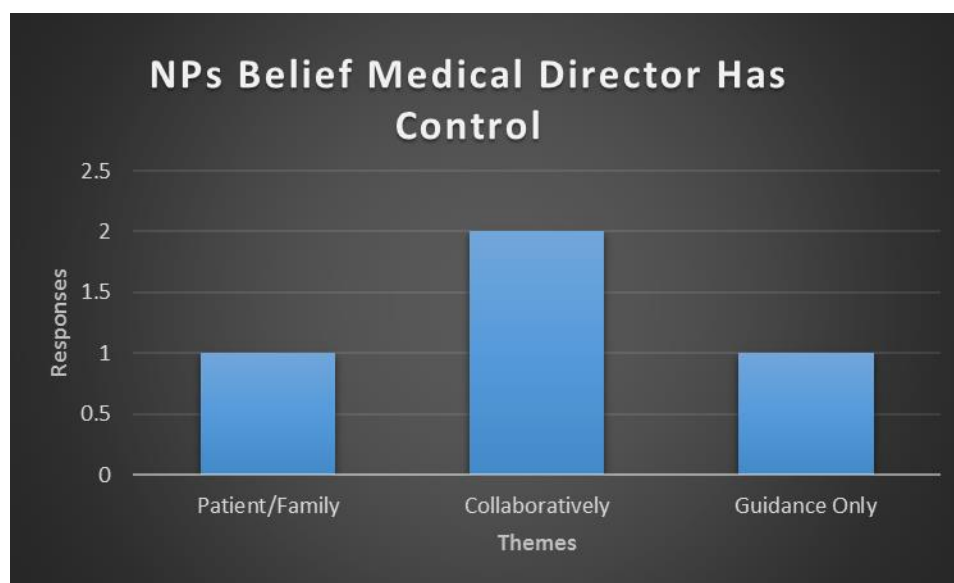


Figure 8. NP belief that the medical director has control over the patient.

Survey Question 18 focused on whether prior experiences with hospices services influences the NPs decision for hospice referrals and/or consultations shown in Figure 9. The majority of NPs 37.5% had a “great experience’ with prior hospices. Respondent 9 stated,

I love hospice and believe there is a time for patients who are at the end of their lives and choose hospice. I also believe that there is a time to stop treatment. I once saw an oncologist tell my best friend that he would discontinue her chemotherapy because it would kill her. He offered her hospice. She decided that she would think about it and allowed them to come in to talk to her that night. She went into a coma that night. I was so glad that hospice came in. If family members decide to care for their loved ones- that this is okay. I do not believe that it is right to code a patient who is dying from cancer. I think the family needs to

digest this- but there comes a point that this is wrong- and that to do so is inhumane.

One respondent would refer the patients based on what was best for the patient. Another respondent would refer to another hospice if the patient did not receive quality care from the previous hospice.

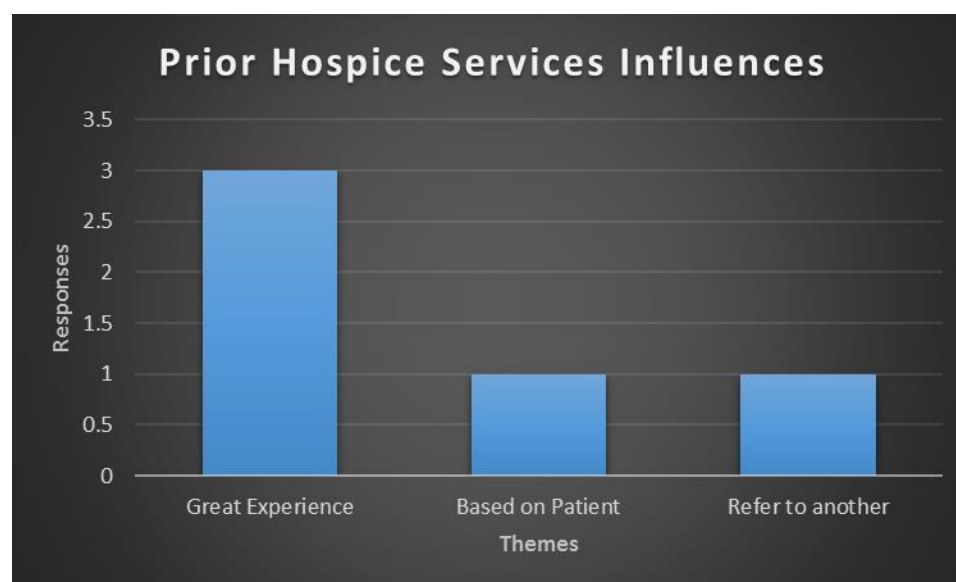


Figure 9. NP prior experience with hospice influences referral.

The NPs thoughts on the current scope of practice for NPs was the focus of Survey Question 19. In this particular question, limited was mention by five participants. Another participant mentions the scope practice was adequate, but could expand shown in Figure 10.

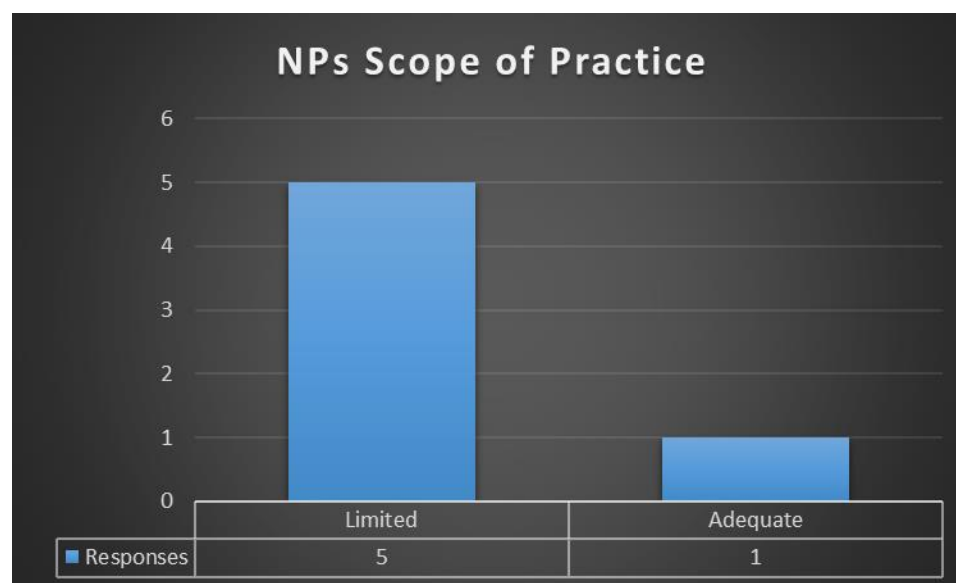


Figure 10. NP thoughts on current scope of practice.

Responses to Survey Question 20 (What additional constructive feedback would you offer to help with increasing hospice services for the African American patient?) provided additional information about what NPs felt would increase the utilization of hospice for the African American patient in Figure 11. Four respondents commented on the importance of “education” to help increase referrals for the African American patient. Participant 1 stated,

African Americans are relational and will not seek services from those deemed untrustworthy due to historical events e.g. Tuskegee and history of experiments as well frequent disregard for African American lives. Providers must “earn” the right to speak into African American lives.

Respondent 2 stated, “I think that counseling from a Chaplin or the patient’ s spiritual leader/pastor, and a certified counselor should be included in the process of offering hospice services to African American patients” indicated in Figure 11.

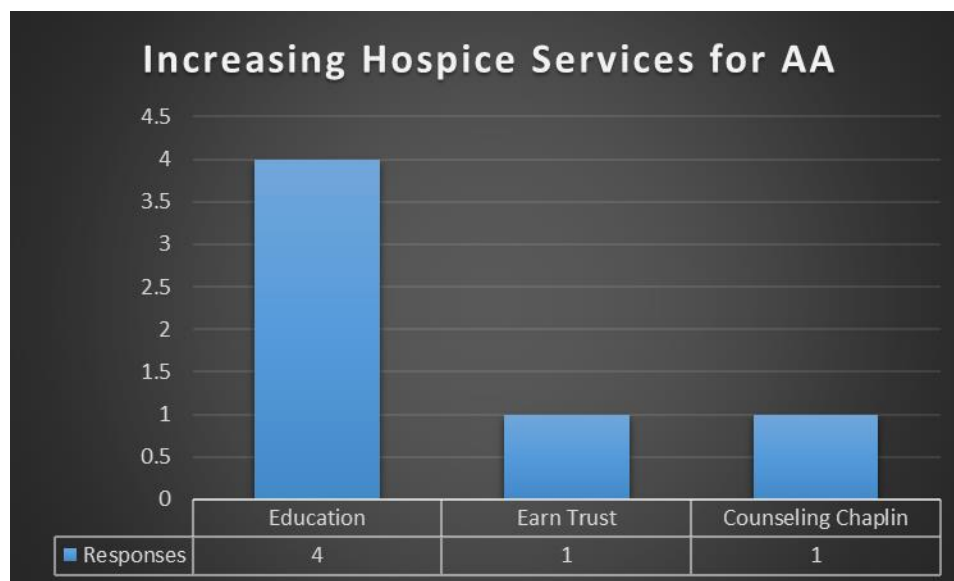


Figure 11. NP feedback on increasing hospice for African Americans.

Discussions of Findings

In my current project, NPs expressed positive and negative views about the lack hospice utilization for African American patients. The data from the project revealed 37.5% of the NPs referred one to five African American to hospice service, but 12.5% have referred one to five, 12.5% referred 6-10, and 12.5% referred 15 or more other races to hospice. These findings are consistent with the literature; African American patients are less likely to choose hospice than other races after being diagnosed with a terminal illness (Ramey & Chin, 2012). More than 75% of the NPs believed African American patients prefer family members to provide end of life care and 63% believed African American religion influenced the decision to refer the patient to hospice. Seventy-five percent of the NPs agreed African American patients prefer aggressive treatment and 63% were reluctant to having strangers come to care for them in their homes. NPs 75% also agreed African American patients prefer not to elect hospice services at the end of

life. A little over 37% strongly agreed African American felt a sense of hopelessness when hospice as discussed and 50% of NPs felt mistrust of health care professionals influenced the decision to accept hospice services. These findings are consistent with literature supporting; there are barriers to the lack of utilization of hospice for African American patients (Jacobs et al., 2006; Washington et al., 2008; Zhang et al., 2012).

Furthermore, 87.5% of the NPs believed hospice was a valuable service and 37.5% believed hospice is cost-effective compared to care and comfort provided by nursing homes, families, and hospitals. Twenty-five percent of the NPs believed the Medical Director had control over their patient while 37.5% believed there was timely communication between NPs and hospice. NPs 50% strongly agreed prior experience with hospice services influenced their decision for hospice referral or consult. The project shows a correlation between a previous study by Ogle et al. (2003).

The project indicated there was a need for education to increase the utilization of hospice for the African American patient. The educational program was developed from the data collected during the project. The project helped to provide some insight on NPs perceptions and beliefs about referring terminally ill African American patients to hospice and their suggestions on ways to improve hospice utilization for the African American patient, as well as, NPs experience with referring terminally ill African American patients to hospice services.

Implications

Implications for Practice/Action

There continues to be a lack of referrals to hospice for the African American patient. It is clear that NPs perceptions and beliefs play a role in whether to refer African American patient to hospice. It is also clear that education is needed for health care professionals and families.

The majority of the NPs who completed the survey believed hospice was a valuable service, comfortable discussing hospice, and expressed interest in education to help increase hospice utilization for the African American patient. NPs that participated in the project showed an interest in education to African American patient and family about hospice is significance to the increase of hospice utilization for the African American patient.

Implication for Future Research

The findings from this project has the potential to improve referral patterns for NPs for African American patients. The end product can also be used to educate or guide NPs when making a decision to discuss hospice with an African American patient with a terminal diagnosis. This project may be used to enlighten physicians about also discussing hospice early for terminally ill African American patients. The data from the project could also be used to establish quality improvement program.

Implication for Social Change

The documentation of perceptions and beliefs of APRNs regarding hospice referrals for the African American patient is likely to increase utilization of hospice for

this particular patient. The documentation will enlighten APRNs there is a connection between NPs perceptions/beliefs of hospice for the African American patient impacts the lack of hospice referrals for this particular patient. Future findings of this project have the potential to increase hospice utilization for African American patients at the end-of-life.

Project Strengths and Limitations

This project helped to bring awareness to NPs perceptions and beliefs about referring African American patients to hospice. The use of Facebook helped to reach NPs from other states to help bring diversity to the project. Posting on an NPs social web page allowed only NPs to access the survey.

Limitations and Recommendations

The sample size was a limitation for this project. Only a few states were represented, I would have like more individuals from other states to participate in this project study. One respondent did not complete the survey; therefore, their data was not used for the project. I would recommend the project be completed with a larger sample size. Also, would recommend some type of compensation for participating in a project study.

Analysis of Self

As Scholar

This project helped me to identify an issue within the African America community and create an educational program for APRNs and local hospices. This project educated not only NPs, but also physicians, patients, families, and other individuals involved in the referral process for hospice. This project also addressed some

of the issues that involved hospice referrals for a terminally ill African American. This project helped me to gain new knowledge, which I was able to share with my colleagues.

As a scholar, I identified perceptions and beliefs of APRNs about hospice referrals for the African American patient and analyzed the data to develop an awareness education program. I would love to speak to my church family about hospice.

As Practitioner

My journey through the DNP program has been very challenging at times, but I have gained respect from many of my colleagues because of the knowledge I have gained. Because my colleagues have seen my determination during the DNP journey, many have returned to school to further their education. This project has the potential to enlighten many individuals such as families, practitioners, and organizations.

As Project Developer

During this project, I took on the role of an educator for hospice providers and APRNs. As an educator, I analyzed the data from this project to develop an education program that would benefit APRNs and African American patients. This project includes a modified survey to identify perceptions and beliefs of NPs about referring terminally ill African American to hospice.

Direction for Future Research

This project provided insight into beliefs and perceptions of NPs referring African Americans to hospice at the end of life. This DNP project revealed NPs believed hospice to be valuable at the end-of-life, but a majority of NPs did not refer terminally ill African Americans to hospice services. Further studies are needed to explore the terminally ill

African American beliefs and perceptions of hospice. The study can be conducted using a mixed method design. The information gathered from future research can help NPs to reevaluate their perceptions and beliefs about terminally ill African Americans and hospice referrals or consults.

Summary

This section provided information on analyzed data, implications, strengths and limitations, and analysis of self. A modified survey developed by Karen Ogle, MD was used to identify perceptions and beliefs of NPs about hospice and terminally ill African Americans. The results discovered that NPs believe hospice is a valuable service and cost-effective. This project also discovered NPs were comfortable discussing hospice services, but not many African American patients were referred to hospice. The analyzed data identifies perceptions and beliefs of NPs about hospice referrals for terminally ill African Americans. The analyzed data were used to develop an education program.

Section 5: Dissemination Plan

The DNP project will be presented in an awareness education program for local hospices. A PowerPoint presentation was developed for the awareness education program. The DNP awareness project will be submitted to Georgia Board of Nursing, Georgia Nurses Association, and American Association of Nurse Practitioners. This DNP project emphasized the identified beliefs and perceptions of NPs about hospice referrals for African American with a terminal diagnosis. For detailed awareness education program, see Appendix F.

References

- Abbott, P. D., Schepp, K. G., Zierler, B. K., & Ward, D. (2010). The use of nurse practitioners and physician assistants in Washington and Oregon emergency departments: A descriptive study of current practice. *Advanced Emergency Nursing Journal*, 32(4), 338-345. Doi:10.1097/TME.0b013e3181f91aed
- Adedoyin, C. (2013). A systematic review of the roles of congregations and faith-based organizations in the care and support of African Americans living with HIV/AIDS in the United States. *Social Work & Christianity*, 40(2), 184-205. Retrieved from <http://www.nacsw.org/sampleswc.html>
- African American. (n.d.). In *Dictionary.com Unabridged*. Retrieved from <http://dictionary.reference.com/browse/AfricanAmerican>
- Ajzen, I. (1991). The theory of planned behavior. *Organizational Behavior and Human Decision Processes*, 50(2), 179-211. Doi:10.1016/0749-5978(91)90020-T
- Anderson, J. R., & Turner, W. E. (2010). When caregivers are in need of care: African-American caregivers' preferences for their own life care. *Journal of Aging Studies*, 24(1), 65-73. Doi:10.1016/j.jaging.2008.06.002
- Armitage, C. J., & Conner, M. (2001). Efficacy of the theory of planned behavior: A meta-analytic review. *British Journal of Social Psychology*, 40, 471-499. Doi:10.1348/014466601164939
- Armstrong, K., Putt, M., Halbert, C. H. Grande, D., Schwartz, J. S., Liao, K., ... & Shea, J. A. (2013). Prior experiences of racial discrimination and racial differences in health care system distrust. *Medical Care*, 51(12), 144-150.

Doi:10.1097/MLR.0b013e31827310a1

- Baek, Y. J., Shin, D. W., Choi, J. Y., Kang, J., Mo, H. N., Kim, Y. H., ... & Park, E. C. (2011). Late referral to palliative care services in Korea. *Journal of Pain and Symptom Management*, 1(4), 692-699. Doi:10.1016/j.jpainsymman.2010.06.019
- Benton, K., Stephens, J., Vogel, R., Ledlow, G., Ackerman, R., Babcock, C., & McCook, G. (2015). The influence of race on end-of-life choices following a counselor-based palliative consultation. *American Journal of Hospice & Palliative Medicine*, 32(1), 84-89. Doi:10.1177/1049909113506782
- Born, W., Greiner, K. A., Sylvia, E., Butler, J., & Ahluwalia, J. S. (2004). Knowledge, attitudes, and beliefs about end-of-life care among inner-city African Americans and Latinos. *Journal of Palliative Medicine*, 7(2), 247-256. Doi:10.1089/109662104773709369
- Brassard, A. (2012). *Removing barriers to advanced practice registered nurse care: Home health and hospice services*. Retrieved from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/removing-barriers-advanced-practice-registered-nurse-home-health-hospice-insight-july-2012-AARP-ppi-health.pdf
- Bullock, K. (2011). The influence of culture on end-of-life decision making. *Journal of Social Work in End-of-Life & Palliative Care*, 7(1), 83-98. Doi:10.1080/15524256.2011.548048
- Cagle, J. G., Pek, J., Clifford, M., Guralink, J., & Zimmerman, S. (2014). Correlates of good death and the impact of hospice involvement: Findings from the national

survey of households affected by cancer. *Supportive Care in Cancer*, 1-10.

Doi:10.1007/s00520-014-2404-z

Carlson, M. D. A., Barry, C. L., Cherlin, E. J., McCorkle, R., & Bradley, E. H. (2012).

Hospices' enrollment policies may contribute to underuse of hospice care in the United States. *Health Affairs*, 31(12), 2690-8. Doi:10.1377/hlthaff.2012.0286

Carr, D. (2012). "I don't want to die like that...": The impact of significant others' death quality on advance care planning." *The Gerontologist*, 52(6), 770-781.

Doi:10.1093/geront/gns051

Carrion, I. V., Park, N. S., & Lee, B. S. (2012). Hospice use among African Americans, Asians, Hispanics, and Whites implications for practice. *American Journal of Hospice and Palliative Medicine*, 29(2), 116-121.

Doi:10.1177/1049909111410559

Centers for Disease Control and Prevention. (2014). *Black or African American populations*. Retrieved from

<http://www.cdc.gov/minorityhealth/populations/REMP/black.html#10>

Centers for Medicare & Medicaid Services. (n.d.). *Medicare Hospice Benefits*. Retrieved from <http://www.medicare.gov/Pubs/pdf/02154.pdf>

Colon, M., & Lyke, J. (2013). Comparison of hospice use by European Americans, African Americans, and Latinos a follow-up study. *American Journal of Hospice & Palliative Medicine*, 32(2), 205-209. Doi:10.1177/1049909113511143

Conner, N. E. (2012). Predictive factors of hospice use among blacks: Applying Andersen's behavioral model. *American Journal of Hospice & Palliative*

Medicine, 29(5), 368-374. Doi:10.1177/1049909111425227

- Cooper, J., Loeb, S., & Smith, C. (2010). The primary care nurse practitioner and cancer survivorship care. *Journal of the American Academy of nurse practitioners*, 22(8), 394-402. Doi:10.1111/j.1745-7599.2010.00528.x
- Cort, M. A. (2004). Cultural mistrust and use of hospice care: challenges and remedies. *Journal of Palliative Medicine*, 7(1), 63-71. Doi:10.1089/109662104322737269
- Deitrick, L. M., Rockwell, E. H., Gratz, N., Davidson, C., Lukas, L., Stevens, D., ... & Sikora, B. (2011). Delivering specialized palliative care in the community: A new role for nurse practitioners. *Advances in Nursing Science*, 34(4), 23-36. Doi:10.1097/ANS.0b013e318235834f
- Dill, M. J., Pankow, S., Erikson, C., & Shipman, S. (2013). Survey shows consumers open to a greater role for physician assistants and nurse practitioners. *Health Affairs*, 32(6), 1135-42. Doi:10.1377/hlthaff.2012.1150
- Dillon, P. J., Roscoe, L. A., & Jenkins, J. (2012). African Americans and decisions about hospice care: Implications for health message design. *Howard Journal of Communications*, 23(2), 175-193. Doi:10.1080/10646175.2012.667724
- Douglas, M. L., McGhan, S. L., Tougas, D., Fenton, N., Sarin, C., Latycheva, O., & Befus, A. D. (2013). Asthma education program for first nations children: An exemplar of knowledge-to-action framework. *Canadian Respiratory Journal*, 20(4), 295-300. Retrieved from <http://www.hindawi.com/journals/crj/>
- Dyar, S., Lesperance, M., Shannon, R., Sloan, J., & Colon-Otero, G. (2012) A nurse practitioner directed intervention improves the quality of life of patients with

- metastatic cancer: Results of randomized pilot study. *Journal of Palliative Medicine*, 15(8), 890-895. Doi:10.1089/jpm.2012.0014
- Edmonds, B. T. (2011). Moving beyond the impasse: Discussing death and dying with African patients. *Obstetrics & Gynecology*, 117(2, Part 1), 383-387. Doi:10.1097/AOG.0b013e31820773e9
- Enguidanos, S., Kogan, A., Lorenz, K., & Taylor, G. (2011). Use of role model stories to overcome barriers to hospice among African Americans. *Journal of Palliative Medicine*, 14(2), 161-168. Doi:10.1089/jpm.2010.0380
- Fairfield, K. M., Murray, K. M., Wierman, H. R., Han, P. K.J., Hallen, S., Miesfeldt, S., . . . Earle, C. C. (2011). Disparities in hospice care among older women dying with ovarian cancer. *Gynecologic Oncology*, 125(1), 14-18. Doi:10.1016/j.ygyno.2011.11.041
- Fauci, J., Schneider, K., Walters, C., Boone, J., Whitworth, J., Killian, E., & Jr. Straughn, J. M. (2012). The utilization of palliative care in gynecologic oncology patients near the end of life. *Gynecologic Oncology*, 127(1), 175-179. Doi:10.1016/j.ygyno.2012.06.025
- Field, B., Booth, A., Ilott, I., & Gerrish, K. (2014). Using the knowledge to action framework in practice: A citation analysis and systematic review. *Implementation Science*, 9(172), 1-14. Doi:10.1186/s13012-014-0172-2
- Fishman, J. M., Ten Have, T., & Casarett, D. (2012). Is public communication about end-of-life care helping to inform all? Cancer news coverage in African American versus mainstream media. *Cancer*, 118(8), 2157-2162. Doi:10.1002/cncr.26499

- Frahm, K. A., Barnett, S. D., & Brown, L. M. (2011). Trends in hospice utilization across age Among the veteran population. *American Journal of Hospice & Palliative Medicine*, 28(6),424-428. Doi:10.1177/10499909110397655
- Fried, T., van Doorn,C., O’Leary, J., Tinetti, M., & Drickamer, M. (1999). Older persons’ preferences for site of terminal care. *Annals of Internal Medicine*, 131(2), 109-112. Doi:10.7326/0003-4819-131-2-199907200-00006
- Froggatt, K., & Hault, L., (2002). Developing palliative care practice in nursing and residential care homes: The role of the clinical nurse specialist. *Journal of Clinical Nursing*, 11(6), 802-808. Doi:10.1046/j.1365-2702.2002.00698.x
- Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health*, 87(11), 1773-1778.
Doi:10.2105/AJPH.87.11.1773
- Gazelle, G. (2007). Understanding hospice – an underutilized option for life’s final chapter. *The New England Journal of Medicine*, 357(4), 321-324.
Doi:http://dx.doi.org/10.1056/NEJMp078067
- Godin, G., & Kok, G. (1996). The theory of planned behavior: A review of its applications to health-related behaviours. *American Journal of Health Promotion*, 11(2), 87-98. Doi:http://dx.doi.org/10.4278/0890-1171-11.2.87
- Graham, I., Logan, J., Harrison, M., Straus, S., Tetroe, J., Caswell, W., & Robinson, N. (2006). Lost in knowledge translation: Time for a map? *Journal of Continuing Education in the Health Profession*, 26(1), 13-24. Doi:10.1002/chp
- Green, M. A., Lucas, J., Hanson, L. C., Armstrong, T., Hayes, M., Peacock, S., ...

- Corbie-Smith G. (2013). Carrying the burden: Perspectives of African Americans pastors on peer support for people with cancer. *Journal of Religion and Health*, 1-16. Doi:10.1007/s10943-013-9729-7
- Grove, S., Burns, N., & Gray, J. (2013). *The practice of nursing research: Appraisal, synthesis and generation of evidence* (7th ed.). St. Louis, MO: Saunders Elsevier.
- Hagger, M. S., Chatzisarantis, N. L. D., & Biddle, S. J. H. (2002). A meta-analytic review of the theories of reasoned action and planned behavior in physical activity: Predictive validity and the contribution of additional variables. *Journal of Sport & Exercise Psychology*, 24(1), 3-32. Retrieved from <http://journals.humankinetics.com/JSEP>
- Hazin, R., & Giles, C. A. (2011). Is there a color line in death? An examination of end-of-life care in African American community. *Journal of the National Medical Association*, 103(7), 609-13. Doi:Retrieved from <http://search.proquest.com/docview/921729613?>
- Henderson, M. L. (2004). Gerontological advance practice nurses: As end-of-life care facilitators. *Gerontological Advance Practice Nurses*, 25(4), 233-237. Doi:10.1016/j.gerinurse.2004.06.014
- Hospice Foundation of America. (n.d.). *What is hospice?* Retrieved from <http://www.hospicefoundation.org/whatishospice>
- Hospice & Palliative Care. (n.d.). *HPCFM glossary of terms*. Retrieved from <http://www.hospicefed.org/?page=glossary>
- Hospice Red River Valley. (2013). *Glossary of hospice terms*. Retrieved from

http://www.hrrv.org/wp-content/uploads/2013/02/GlossaryofHospiceTerms_1212.pdf

Hospice Today. (n.d.). *What is hospice?* Retrieved from <http://hospicetoday.org/what-is-hospice/>

Iglehart, J. K. (2013). Expanding the role of advanced nurse practitioners—risks and rewards. *The New England Journal of Medicine*, 368(20), 1935-41.
Doi:10.1056/NEJMhpr1301084

Institute of Medicine. (2011). *The future of nursing; Focus on scope of practice*. Retrieved from <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Report-Brief-Scope-of-Practice.aspx?page=2>

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health report recommendations*. Retrieved from <http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health/Recommendations.aspx?page=1>

Irish, D. P., Lundquist, K. F., & Nelsen, V. J. (Eds.). (2014). *Ethnic variations in dying, death, and grief: Diversity in universality*. Taylor & Francis.

Jackson, F., Shim, S., Seeley, S., Grunow, K., & Baker, J. (2000). Barriers to hospice care for African Americans: Problems and solutions. *Journal of Hospice & Palliative Nursing*, 2(2), 65-72. Doi:10.1097/00129191-200002020-00005

Jackson, L. C., Hanson, L. C., Hayes, M., Green, M., Peacock, S., & Corbie-Smith, G. (2014). They lift my spirit up: Stakeholders' perspectives on support teams for African Americans facing serious illness. *Health and Education & Behavior*.

Doi:10.177/1090198114529591

- Jacobs, E. A., Rolle, I., Ferrans, C. E., Whitaker, E. E., & Warnecke, R. B. (2006). Understanding African Americans' views of the trustworthiness of physicians. *Journal of General Internal Medicine, 21*(6), 642-647. Doi:10.1111/j.1525-1497.2006.00485.x
- Jensen, C. B. (2008). Sociology, systems and (patient) safety: Knowledge translations in healthcare policy. *Sociology of Health & Illness, 30*(2), 309-324. Doi:10.1111/j.1467-9566.2007.0103.x
- Johnson, K., Kuchibhatla, M., & Tulsky, J. (2009). Racial differences in self-reported exposure to information about hospice care. *Journal of Palliative Medicine, 12*(10), 921-927. Doi:10.1089/jpm.2009.006
- Johnson, K.S., Kuchibhatla, M., & Tulsky, J. A. (2013). Race and residence intercounty variation in black-white differences in hospice use. *Journal of Pain and Symptom Management, 46*(5), 681-690. Doi:10.1016/j.painsymman.2012.12.006
- Kam, L., Knott, V., Wilson, C., & Chambers, S. (2012). Using the theory of planned behavior to understand health professionals attitudes and intentions to refer cancer patients for psycho-social support. *Psycho-Oncology, 21*(3), 316-323. Doi:10.1002/pon.1897
- Kastner, M., & Straus, S. E. (2012). Application of the knowledge-to-action and medical research council frameworks in the development of an osteoporosis clinical decision support tool. *Journal of Clinical Epidemiology, 65*(11), 1163-1170. Doi:10.1016/j.jclinepi.2012.04.011

- Kelley, A. S., Ettner, S. L., Wegner, N. S., & Sarkisian, C. A. (2011). Determinants of death in the hospital among older adults. *Journal of the American Geriatrics Society, 59*(12), 2321-2325. Doi:10.1111/j.1532-5415.2011.03718.x
- Kennedy, B., Mathis, C., & Woods, A. (2007). African Americans and their distrust of the health care system: Healthcare for diverse populations. *Journal of Cultural Diversity, 14*(2), 56-60. Retrieved from <http://www.tuckerpub.com/jcd.htm>
- King, D. E., Matheson, E., Chirina, S., Shankar, A., & Broman-Fulks, J. (2013). The status of baby boomers' health in the United States: The healthiest generation?. *JAMA Internal Medicine, 173*(5), 385-386.
Doi:10.1001/jamainternmed.2013.2006
- Krakauer, E. L., Crenner, C., & Fox, K. (2002). Barriers to optimum end-of-life care for minority patients. *Journal of the American Geriatrics Society, 50*(1), 182-190.
Doi:10.1046/j.1532-5415.2002.50027.x
- Kwak, J., Kramer, B. J., Lang, J., & Ledger, M. (2012). Challenges in end-of-life care management for low-income frail elders: A case study of the Wisconsin family care program. *Research on Aging, 35*(4), 393-419.
Doi:10.1177/0164027512446939
- LaVeist, T. A., Nickerson, K. J., & Bowie, J. V. (2000). Attitudes about racism, medical mistrust, and satisfaction with care among African American and white cardiac patients *Medical Care Research and Review, 57*(4 suppl), 146-161.
Doi:10.1177/107755800773743637
- Lepore, M. J., Miller, S. C., & Gozalo, P. (2011). Hospice use among urban black and

- white U. S. nursing home decedents in 2006. *The Gerontologist*, 51(2), 251-260.
Doi:10.1093/geront/gnq093
- Liu, N., Finkelstein, S. R., & Poghosyan, L. (2014). A new model for nurse practitioner utilization in primary care: Increased efficiency and implications. *Health Care Management*, 39(1), 10-20. Doi:10.1097/HMR.0b013e318276fadf
- Ludke, R. L., & Smucker, D. R. (2007). Racial differences in the willingness to use hospice services. *Journal of Palliative Medicine*, 10(6), 1329-1337.
Doi:10.1089/jpm.2007.0077
- Maddalena, V., Bernard, T., Davis-Murdoch, S., & Smith, D. (2013). Awareness of palliative care and end-of-life options among African Canadians in Nova Scotia. *Journal of Transcultural Nursing*, 24(2), 144-152.
Doi:10.1177/104365961247190
- Matsuyama, R. K., Balliet, W., Ingram, K., Lyckholm, L. J., Wilson-Genderson, M., & Smith, T. J. (2011). Will patients want hospice or palliative care if they do not know what it is? *Journal of Hospice & Palliative Nursing*, 13(1), 41-46.
Doi:10.1097/NJH.0b013e3182020520
- McEachan, R., Conner, M., Taylor, N., & Lawton, R. (2011). Prospective prediction of health-related behaviours with the theory of planned behavior: A meta-analysis. *Health Psychology Review*, 5(2), 97-144. Doi:10.1080/17437199.2010.521684
- Melhado, L. & Bushy, A. (2011). Exploring uncertainty in advance care planning in African Americans: Does low health literacy influence decision making preference at end of life. *American Journal of Hospice & Palliative Medicine*,

28(7), 495-500. Doi:10.1177/1049909110398005

Miller, S. T., Seib, H. M., & Dennie, S. P. (2001). African American perspectives on health care: The voice of the community. *Journal of Ambulatory Care Management, 24*(3), 37-44. Doi:10.1097/00004479-200107000-00007

McEwen, M., & Willis, E. M. (2011). *Theoretical basis for nursing*. Philadelphia, PA: Lippincott Williams & Wilkins.

Molina, Y., Kim, S., Berrios, N., & Calhoun, E. A. (2014). Medical mistrust and patient satisfaction with mammography: The mediating effects of perceived self-efficacy among navigated African American women. *Health Expectations, 18*(6), 2941-2950 . doi:10.1111/hex.12278

Moore, A. D., Knafl, G. J., Hamilton, J. B., Godley, P. A., Carpenter, W. R., Bensen, J. T., & Mishel, M. (2013). The influence of mistrust, racism, religious participation, and access to care on patient satisfaction for African-American men: The North Carolina-Louisiana prostate project (pcap). *Journal of the National Medical Association, 105*(1), 59-66. Retrieved from <http://www.journalnma.org/>.

Moote, M., Nelson, R., Veltkamp, R., & Campbell Jr., D. (2012). Productivity assessment of physician assistant and nurse practitioners in oncology in an academic medical center. *Journal of Oncology Practice, 8*(3), 167-172. doi:10.1200/JOP.2011.000395

Murphy-Ende, K. (2002). Advanced practice nursing: Reflections on the past, issues for the future. *Oncology Nursing Forum, 29*(1), 106-112. doi:10.1188/02.ONF.106-

112

National Cancer Institute. (n.d.). *NCI dictionary of cancer terms*. Retrieved from

<http://www.cancer.gov/dictionary>

National Federation of Independent Business v. Sebelius, 567 U.S. ____ (2012).

National Hospice and Palliative Care Organization. (n.d.). *History of hospice care*.

Retrieved from <http://www.nhpco.org/history-hospice-care>

National Hospice and Palliative Care Organization. (2010). *Preamble and philosophy*.

Retrieved from <http://www.nhpco.org/ethical-and-position-statements/preamble-and-philosophy#2>

National Hospice and Palliative Care Organization. (2012). *NHPCO facts and figures:*

Hospice care in America. Retrieved from

http://www.nhpco.org/sites/default/files/public/Statistics_Research/2012_Facts_Figures.pdf

National Hospice and Palliative Care Organization. (2013). *NHPCO facts and figures:*

Hospice care in America. Retrieved from

http://www.nhpco.org/sites/default/files/public/Statistics_Research/2013_Facts_Figures.pdf

National Institutes of Health. (2014). Hospice care. *MedlinePlus Encyclopedia*. Retrieved

from <http://www.nlm.nih.gov/medlineplus/ency/patientinstructions/000467.htm>

Naylor, M. D., & Kurtzman, E. T. (2010). The role of nurse practitioners in reinventing

primary care. *Health Affairs*, 29(5), 893-899. doi:10.1377/hlthaff.2010.0440

Noh, H. & Schroepfer, T. A. (2014). Terminally ill American elders' access to and use of

hospice care. *American Journal of Hospice & Palliative Medicine*.

doi:10.1177/1049909113518092

Ogle, K., Mavis, B., & Wang, T. (2003). Hospice and primary care physicians: Attitudes, knowledge, and barriers. *American Journal of Hospice and Palliative Medicine*, 20(1), 41-51. doi:10.1177/104990910302000111

Ogle, K. S., Mavis, B., & Wyatt, G. (2002). Physicians and hospice care: Attitudes, knowledge, and referrals. *Journal of Palliative Medicine*, 5(1), 85-92.

doi:10.1089/10966210252785042

O'Mahony, S., McHenry, J., Snow, D., Cassin, C., Schumacher, D., & Selwyn, P. A. (2008). A review of barriers to utilization of the medicare hospice benefits in urban populations and strategies for enhanced access. *Journal of Urban Health*, 85(2), 281-90. doi:http://dx.doi.org/10.1007/s11524-008-9258-y

Parkes, C. M., Laungani, P., & Young, W. (2003). *Death and bereavement across cultures*. Routledge. doi:10.4324/9780203435199

Phillips, J. L., Halcomb, E. J., & Davidson, P. M. (2011). End-of-life pathways in acute and hospice care: An integrative review. *Journal of Pain and Symptom Management*, 41(5), 940-955. doi:10.1016/j.jpainsymman.2010.07.020

Piamjariyakul, U., Myers, S., Werkowitch, & Smith, C. E. (2014). End-of-life preferences and presence of advance directives among ethnic populations with severe chronic cardiovascular illnesses. *European Journal of Cardiovascular Nursing*, 13(2), 185-189. doi:10.1177/1474515113519523

Polit, D. F. (2010). *Statistics and data analysis for nursing research* (2nd ed.). Upper

Saddle River, NJ: Pearson Education Inc.

Pullis, B. (2011). Perceptions of hospice care among African Americans. *Journal of Hospice & Palliative Nursing, 13*(5), 281-287.

doi:10.1097/NJH.0b013e31821adb18

Quaglietti, S., Blum, L., & Ellis, V. (2004). The role of adult nurse practitioner in palliative care. *Journal of Hospice Palliative Nursing, 6*(4), 209-214.

doi:10.1097/00129191-200410000-00009

Quest, T. E., Marco, C. A., & Derse, A. R. (2009). Hospice and palliative medicine: New subspecialty, new opportunities. *Annals of Emergency Medicine, 54*(1), 94-102.

doi:10.1016/j.annemergmed.2008.11.019

Ramey, S. J., & Chin, S. H. (2011). Disparity in hospice utilization by African American patients with cancer. *American Journal of Hospice & Palliative Medicine, 29*(5), 346-354. doi:10.1177/1049909111423804

Ramsay, C. R., Thomas, R. E., Croal, B. L., Grimshaw, J. M., & Eccles, M. P. (2010).

Using the theory of planned behaviour as a process evaluation tool in randomized trials of knowledge translation strategies: A case study from UK primary care.

Implementation Science, 5(71), 1-9. doi:10.1186/1748-5908-5-71

Reese, D. J., Ahern, R. E., Nair, S., O'Faire, J. D., & Warren, C. (1999). Hospice access and use by African Americans: Addressing cultural and institutional barriers through participatory action research. *Social Work, 44*(6) 549-59.

doi:10.1093/sw/44.6.549

Reese, D. J., Smith, M. R., Butler, C., Shrestha, S., & Erwin, D. O. (2014). African

- American client satisfaction with hospice: A comparison of primary caregiver experiences within and outside of hospice. *American Journal of Hospice & Palliative Medicine*, 31(5), 495-502. doi:10.1177/1049909113494462
- Referral. (n.d.). *Merriam-Webster.com*. Retrieved from <http://www.merriam-webster.com/medical/referral>
- Regulation of Protocol Use By Advanced Practice Registered Nurses as Authorized by O.C.G.A. § 43-34-410-13-.01 (2013). Retrieved from <http://rules.sos.state.ga.us/docs/410/13/01.pdf>
- Rhodes, R. L., Batchelor, K., Lee, S. C., & Halm, E. A. (2013). Barriers to end-of-life care for African Americans from the providers' perspective: Opportunity for intervention development. *American Journal of Hospice & Palliative Medicine*, 00(0), 1-7. doi:10.1177/1049909113507127
- Rhodes, R. L., Teno, J. M., & Welch, L. C. (2006). Access to hospice for African Americans: Are they informed about the option of hospice? *Journal of Palliative Medicine*, 9(2), 266-272. doi:10.1089/jpm.2006.9.268
- Roberts, E. S. (1999). In defence of the survey method: An illustration from a study of user information satisfaction. *Accounting & Finance*, 39(1), 53-77. doi:10.1111/1467-629X.00017
- Ross, P. T., Lybson, M. T., & Kumagai, A. K. (2012). Using illness narratives to explore African American perspectives of racial discrimination in health care. *Journal of Black Studies*, 43(5), 520-544. doi:10.1177/0021934711436129
- Sacco, J., Deravin Carr, D. R., & Viola, D. (2012). The effects of the palliative medicine

consultation on the dnr status of African Americans in a safety-net hospital.

American Journal of Hospice & Palliative Medicine, 30(4), 363-369.

doi:10.1177/104990911

Sassen, B., Kok, G., & Vanhees, L. (2011). Predictors of healthcare professionals' intention and behaviour to encourage physical activity in patients with cardiovascular risk factors. *BMC Public Health*, 11(246), 1-11. doi:10.1186/1471-2458-11-246

Seaman, J. B., Bear, T. M., Documet, P. I., Sereika, S. M., & Albert, S. M. (2014). Hospice and family involvement with end-of-life care: Results from a population-based survey. *American Journal of Hospice & Palliative Medicine*, 1-6. doi:10.1177/1049909114550392

Shier, G., Ginsburg, M., Howell, J., Volland, P., & Golden, R. (2013). Hospice enrollment saves money for medicare and improves care quality across a number of different lengths-of-stay. *Health Affairs*, 32(3), 552-61. doi:10.1377/hlthaff.2012.0851

Skalla, K. (2006). Blended role advanced practice nursing in palliative care of the oncology patient. *Journal of Hospice & Palliative Nursing*, 8(3), 155-163. doi:10.1097/00129191-200605000-00014

Spruill, A. D., Mayer, D. K., & Hamilton, J. B. (2013). Barriers in hospice use among African Americans with cancer. *Journal of Hospice & Palliative Nursing*, 15(3), 136-144. doi:10.1097/NJH.0b013e31827951f3

Survey Monkey. (2014). *Web collector*. Retrieved from

http://help.surveymonkey.com/articles/en_US/kb/Web-Link-Collector

- Taxis, J. C. (2006). Attitudes, values, and questions of African Americans regarding participation in hospice programs. *Journal of Hospice & Palliative Nursing*, 8(2), 77-85. doi:10.1097/00129191-200603000-00011
- Ten, J. M., Casarett, D., Spence, C., & Connor, S. (2012). It is “too late” or is it? Bereaved family member perceptions of hospice referral when their family member was on hospice for seven days or less. *Journal of Pain and Symptom Management*, 43(4), 732-738. doi:10.1016/j.jpainsymman.2011.05.012
- Teno, J. M., Gazlo, P. L., Lee, I. C., Kuo, S., Spence, C., Connor, S. R., & Casarett, D.J. (2011). Does hospice improve quality of care for persons dying from dementia? *Journal of the American Geriatrics Society*, 59(8), 1531-1536. doi:10.1111/j.1532-5415.2011.03505.x
- Terry, A. J. (2012). *Clinical research for the doctor of nursing practice*. Sudbury, MA: Jones & Bartlett Learning.
- Trafimow, D., Sheeran, P., Conner, M., & Finlay, K. A. (2002). Evidence that perceived behavioural control is a multidimensional construct: Perceived control and perceived difficulty. *British Journal of Social Psychology*, 41(1), 101-121. doi:10.1348/014466602165081
- Tyree, T., Long, C., & Greenberg, E. (2005). Nurse practitioners and end-of-life care: Beliefs, practices, and perceptions. *Journal of Hospice & Palliative Nursing*, 7(1), 45-51. doi:10.1097/00129191-2005010000-00014
- Vigs, E. K., Starks, H., Taylor, J. S., Hopley, E. K., & Fryer-Edwards, K. (2010). Why

don't patients enroll in hospice? can we do anything about it? *Journal of General Internal Medicine*, 25(10), 1009-19. doi:<http://dx.doi.org/10.1007/s11606-010-1423-9>

Washington, K. T., Bickel-Swenson, D., & Stephens, N. (2008). Barriers to hospice use among African Americans: A systematic review. *Health & Social Work*, 33(4), 267-74. doi:10.1093/hsw/33.4.267

Watkins, Y. J., Bonner, G. J., Wang, E., Wilkie, D. J., Ferrans, C. E., & Dancy, B. (2012). Relationship among trust in physicians, demographics, and end-of-life treatment decisions made by African American dementia caregivers. *Journal of Hospice and Palliative Nursing: JHPN: The Official Journal of the Hospice and Palliative Nurses Association*, 14(3), 238-243. doi:10.1097/NJH.0b013e318243920c

White, R. M. (2005). Misinformation and misbeliefs in the Tuskegee study of untreated syphilis fuel mistrust in the healthcare system. *Journal of the National Medical Association*, 97(11),1566. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2594917/pdf/jnma00300-0116.pdf>

Wicher, C. P., & Meeker, M. A. (2012). What influences African American end-of-life preferences? *Journal of Health Care for the Poor and Underserved*, 23(1), 28-58. doi:10.1353/hpu.2012.0027

Whellan, D., Cox, M., Hernandez, A., Heidenreich, P., Curtis, L., Peterson, E., & Fonarow, G. (2012). Utilization of hospice and predicted mortality risk among older patients hospitalized with heart failure: Findings from gwtg-hf. *Journal of*

Cardiac Failure, 18(6), 471-477. doi:10.1016/j.cardfail.2012.02.006

Wong, P. P., & Tomer, A. (2011). Beyond terror and denial: The positive psychology of death acceptance. *Death Studies*, 35(2), 99-106.

doi:10.1080/07481187.2011.535377

Yancu, C. N., Farmer, D. F., & Leahman, D. (2010). Barriers to hospice use and palliative care services use by African American adults. *The American Journal of Hospice & Palliative Care*, 27(4), 248-253. doi:10.1177/1049909109349942

Yancu, C. N., Farmer, D. F., & Leahman, D. (2014). Accepting transitions: African Americans discuss end of life. *American Journal of Hospice & Palliative Medicine*. doi:10.1177/1049909114528567

Zhang, A., Zyzanski, S., & Siminoff, L. (2012). Ethnic differences in the caregiver's attitudes and preferences about the treatment and care of advanced lung cancer patients. *Psycho-Oncology*, 21(11), 1250-1253. Retrieved from

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3612394/pdf/nihms427440.pdf>

Appendix A: Permission Letter

September 8, 2014

Karen Ogle, M.D.



Dear Dr. Ogle,

I am currently working on my Doctor Nursing Practice at Walden University. I am doing a quantitative study on “Examining Physicians Perception Regarding Hospice Referrals for African Americans”. I am requesting permission to make modifications on the survey used in “Physicians and Hospice Care: Attitudes, Knowledge, and Referrals”, 2002, *Journal of Palliative Medicine*, 5(1), 85-92. I would need to make modifications to the survey according to the African American population and some of the information may be deleted that do not pertain to my study. The DNP project will be made public through ProQuest Information. Please supply a signed letter granting me permission to modify your work. You can email to [REDACTED] or mail to [REDACTED].

If you do not solely control copyright to the survey, I would greatly appreciate any information you can provide about the others whom I should contact, if available.

Thanks you for your help.

Sincerely,

Karen Jackson McClary, RN MSN

Appendix B: Permission Granted

The screenshot displays an email client interface. At the top, there is a navigation bar with a 'Mail' dropdown, several icons for actions like back, forward, and delete, and a 'More' dropdown. On the right, it shows '7 of 477' and a settings gear icon.

The main content area is titled 'Permission Letter' and is in the 'Inbox' folder. It shows an email from Karen Jackson McClary with the subject 'Thanking you in advance.' dated 'Sep 8 (1 day ago)'. Below this is a reply from Karen Ogle, dated 'Sep 8 (1 day ago)', addressed 'to me'. The body of the email contains the following text:

You have my permission to use the instrument and to make any adaptations you wish for your work.

Best wishes for your research.

Karen Ogle

On Mon, Sep 8, 2014 at 7:25 PM, Karen Jackson McClary <karen.jacksonmcclary@waldenu.edu> wrote:
Thanking you in advance.
Karen

At the bottom of the email, there is a text box with the prompt 'Click here to Reply or Forward'.

On the left side of the interface, there is a 'Compose' button, an 'Inbox (8)' section with a 'Starred' filter, and a chat window for 'Karen' with a search icon and the message 'No recent chats. Start a new one'. On the right side, there is a 'People (2)' section listing 'Karen Ogle' with her email address 'karen.ogle@gmail.com' and a 'Show details' link.

Appendix C: Invitation to Participate

Study Title: *Examining Nurse Practitioners Perceptions and Beliefs Regarding Hospice Referrals for African Americans*

Dear (Mr./Ms. Individual Last Name),

My name is Karen Jackson McClary. I am a doctoral student in the Doctor Nursing Practice program at Walden University. I am conducting a doctoral project study as part of the requirements of my degree, and I would like to invite you to participate.

I am examining nurse practitioners perceptions and beliefs regarding hospice referrals for the African American patient and addressing APRNs beliefs and perceptions about the underutilization of hospice for terminally ill African American patient. If you decide to participate, you will be asked to complete an online survey.

Participation is confidential. Study information will be kept in a secure location on Survey Monkey. The results of the study will be published, but your identity will not be revealed.

There will be no compensation for participating in project. Taking part in the study is your decision. Participation for the doctoral project is voluntarily. You may also quit being in the study at any time.

We will be happy to answer any questions you have about the study. You may contact me at [REDACTED] or [REDACTED] or my chair Dr. Jennings-Sanders, [REDACTED] or [REDACTED] if you have study related questions or problems. If you have any questions about your rights as a research participant, you may contact Dr. Leilani Walden University representative at [REDACTED].

Thank you for your consideration. If you would like to participate, please copy the web link below to your computer.

Web link: <https://www.surveymonkey.com/r/FGLXQZN>

I will be sending you a weekly reminder to participate in the survey.

With kind regards,

Karen Jackson McClary



Appendix D: Consent to Participate

Dear Participants,

My name is Karen Jackson McClary and I am a doctoral student at Walden University. For my Doctor of Nursing Practice (DNP) doctoral project, I am examining nurse practitioner's perceptions and beliefs regarding hospice referrals for African Americans.

I am inviting you to participate because you are a member of American Association Nurse Practitioners, nurse practitioner in Georgia and/or practice within the United States. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

Background Information: The purpose of this study is to examine nurse practitioners' perceptions and beliefs regarding hospice referrals for African American.

Procedure: If you agree to be in this study, you will be asked to complete an online survey that will take approximately 10 minutes to complete.

Voluntary Nature of the Study: This project is voluntary. I will respect your decision of whether or not you choose to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study: Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as stress, fatigue or becoming upset. Being in this study would not pose risk to your safety or wellbeing.

Participating in the research project will help to understand how the nurse practitioner's beliefs or perceptions contribute to the lack of hospice utilization for the African American patient.

Payment: There is no payment, but I am grateful for you taking the time to participate in my survey.

Privacy: Any information you provide will be kept anonymous. No personal information is used for any purposes outside of this research project. Data will be kept for a period of at least 5 years, as required by the University.

Contacts and Questions: If you have questions later, you may contact me via email [REDACTED] or by phone [REDACTED]. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is Walden University representative who can discuss this with you. Her phone number is [REDACTED]. Walden University's approval number for this study is 05-26-15-0416068 and it expires on May 25, 2016.

Please print or save this consent form for your records.

Statement of Consent: I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By clicking the next button below, I understand that I am agreeing to the terms described above.

Appendix E: NPs Hospice Survey

Section A

1. State in which you practice

2. How many years have you been practicing?

1-5

6-10

11-15

> 15 years

* 3. What is your specialty area? (Please check all that apply)

Geriatrics

Cardiologist

Oncologist

Family Practice

Internal Medicine

Neurologist

Nephrologist

Other

* 4. Number of African American referrals in the past three months for hospice.

1-5

6-10

11-15

>15

N/A

* 5. Number of referrals to other races in the past three months for hospice.

1-5

6-10

11-15

>15

N/A

Perceptions of the African American Patients**Section B**

* 6. African American patients and families prefer family members to care for them at the end of life.

Strongly Disagree Disagree Neither Disagree nor Agree Agree Strongly Disagree

* 7. Religious preference for the African American patient influence my decision about hospice referral.

Strongly Disagree Disagree Neither Disagree Nor Agree Agree Strongly Agree

* 8. African American patients and families prefer aggressive treatment.

Strongly Disagree Disagree Neither Disagree Nor Agree Agree Strongly Agree

* 9. African American patients are hesitant to have strangers in their homes.

Strongly Disagree Disagree Neither Disagree Nor Agree Agree Strongly Agree

* 10. African American patients prefer not to elect hospice benefits.

Strongly Disagree Disagree Neither Disagree Nor Agree Agree Strongly Agree

* 11. When hospice is discussed with the African American patient and family there is a sense of hopelessness.

Strongly Disagree Disagree Neither Disagree Nor Agree Agree Strongly Agree

* 12. African Americans mistrust health care professionals.

Strongly Disagree Disagree Neither Disagree Nor Agree Agree Strongly Agree

Beliefs of Hospice of the NPs**Section C**

* 13. How comfortable do you feel talking about hospice with African American patients and family member?

Very Comfortable Comfortable Neither Comfortable NorUncomfortable Uncomfortable Very uncomfortable

* 14. Hospice is a valuable service.

Strongly Disagree Disagree Neither Disagree NorAgree Agree Strongly Agree
Please explain

* 15. Hospice is cost-effective compared to care and comfort provided by nursing homes, families, and hospitals.

Strongly Disagree Disagree Neither Disagree NorAgree Agree Strongly Agree
Please explain

* 16. I feel the Medical Director has control over my patient.

Strongly Disagree Disagree Neither Disagree NorAgree Agree Strongly Agree
Please explain

* 17. There is timely communication between the NPs and hospice.

Strongly Disagree Disagree Neither Disagree NorAgree Agree Strongly Agree

* 18. My experience with prior hospices services influences my decision for hospice referrals and/or consultations.

Strongly Disagree Disagree Neither Disagree NorAgree Agree Strongly Agree
Please explain.

19. What do you think about the current scope of practice for APRNs?

20. What additional constructive feedback would you offer to help with increasing hospice services for the African American patient?

Appendix F: Awareness Education Program

Examining Nurse Practitioners Perceptions and Beliefs Regarding Hospice Referrals for African Americans



Karen L. Jackson McClary RN.
BSN, MSN, DNPc
Walden University



Identification of Problem



- African American patients decrease in utilization of hospice
- African Americans view hospice in an undesirable light, not comfortable talking about end of life preferences (Benton et al., 2015; Moore et al., 2013)
- African Americans family have been taking care of terminally ill family members for years (Yanu, Farmer, & Leahman, 2010)

Identification of Problem...



- Hospice has not been considered an option by African Americans
- 2011 8.5% hospice patients African American; 82.8% Caucasian patients (NHPCO, 2012)
- 2010 41.9% deaths occurred hospice service (Reese, Smith, Butler, Shrestha, & Erwin, 2014)
- Despite accessibility remains mortality gap between African Americans and Caucasians
- Possible reason lack of utilizing NPs as facilitators

Purpose



- Examine NPs perceptions and beliefs regarding hospice referrals for African American patients
- Address APRNs beliefs and perceptions about underutilization of hospice for African American patients

Evidenced-Based Significance



- 2012, 5% of terminally ill American received below standard care (Shier, Ginsburg, Howell, Volland, & Golden, 2013)
- Understanding patterns for hospice referrals and usage of different ethnic groups would contribute to developing evidence-based practice (Carrion, Park, & Lee, 2012)
- APRNs becoming primary care providers

Methodology

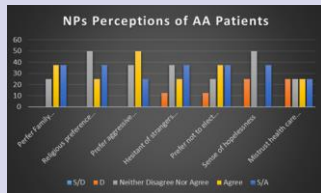


- Mixed Method (Descriptive & Qualitative Content Analysis)
- Purposive sampling
 - NPs certified, member of NPs Facebook social group, and/or practice in GA
 - Random
- Modified survey developed by Karen Ogle, M.D.

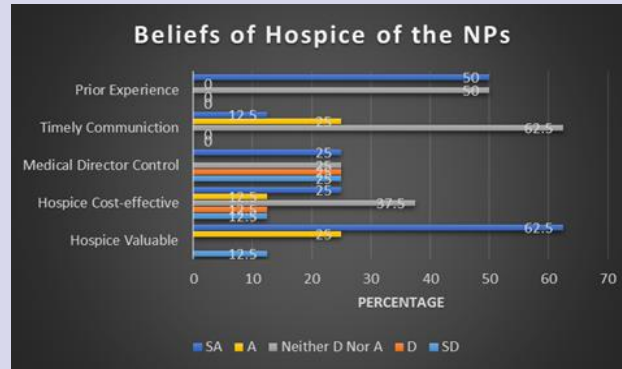
Participants Characteristics

Characteristics	N	%
State		
Wisconsin	1	11
West Virginia	1	11
Georgia	6	67
Years Practicing		
1-5 years	6	75
6-10 years	1	12.5
10-15 years	0	0
> 15 years	1	12.5
Specialty Area		
Family Practice	4	50
Other	2	25
Internal Medicine	2	25
Geriatrics	1	12.5
Cardiologist	1	0
Oncologist	0	0
Neurologist	0	0
Nephrologist	0	0

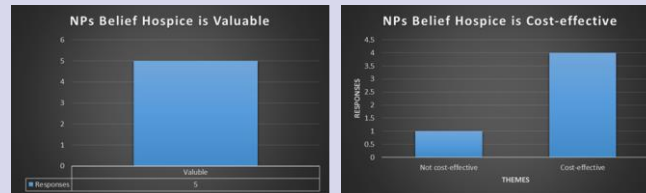
Quantitative Data



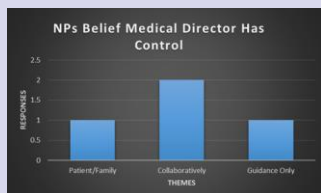
Quantitative Data....



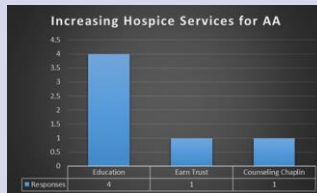
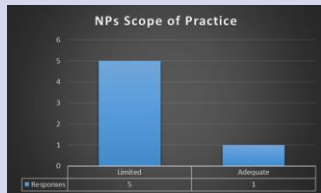
Qualitative Data



Qualitative Data...



Qualitative Data



Discussion of Findings



- 37.5% NPs referred 1-5 African American patients
- 12.5% NP referred 1-5; 12.5% referred 6-10; 12.5% referred > 15 other races
- 75% NPs believed African American prefer family members for end-of-life care
- 63% NPs believed African American religion influenced decision for hospice

Discussion of Findings.....



- 75% NPs agreed African Americans prefer aggressive treatment
- 63% NPs agreed African Americans reluctant to have strangers in home
- 75% NPs agreed African Americans prefer not to elect hospice
- 37% NPs strongly agreed African Americans felt a sense of hopelessness when hospice was discussed

Discussion of Findings....



- 50% NPs felt mistrust of health care professionals influenced African Americans decision about hospice
- 87.5% NPs felt hospice was valuable; 37.5% felt hospice was cost-effective
- 25% NPs believed the Medical Director controlled patients; 37.5% timely communication with NPs and staff

Discussion of Findings....



- Need for education to increase utilization of hospice for terminally ill African Americans

Future Research



- Explore African American perceptions and beliefs about hospice

References



- Benton, K., Stephens, J., Vogel, R., Ackerman, R., Babcock, C., & McCook, G. (2015). The influence of race on end-of-life choices following a counselor-based palliative consultation. *American Journal of Hospice and Palliative Medicine*, 32(1), 84-89. doi:10.1177/1049909113506782
- Carrion, I. V., Park, N. S., & Lee, B. S. (2012). Hospice use among African Americans, Asians, Hispanics, and Whites implications for practice. *American Journal of Hospice and Palliative Medicine*, 29(2), 116-121
- Moore, A. D., Knaff, G. J., Hamilton, J. B., Godley, P. A., Carpenter, W. R., Bensen, J. T., & Mishel, M. (2013). The influence of mistrust, racism, religious participation, and access to care on patient satisfaction for African-American men: The North Carolina-Louisiana prostate project (pcap). *Journal of the National Medical Association*, 105(1), 59-68. doi:10.1016/S0027-9684(15)30086-9
- National Hospice and Palliative Care Organization. (2012). *NHPCO facts and figures: Hospice care in America*. Retrieved from http://www.nhpco.org/sites/default/files/publications_Research/2012_Facts_Figures.pdf
- Reese, D. J., Ahern, R. E., Nair, S., O'Faire, J. D., & Warren, C. (1999). Hospice access and use by African Americans: Addressing cultural and institutional barriers through participatory action research. *Social Work*, 44(6) 549-59. doi:10.1093/sw/44.6.549
- Shier, G., Ginsburg, M., Howell, J., Volland, P., & Golden, R. (2013). Hospice enrollment saves money for medicare and improves care quality across a number of different lengths-of-stay. *Health Affairs*, 32(3), 552-61
- Yancu, C. N., Farmer, D. F., & Leahman, D. (2010). Barriers to hospice use and palliative care services use by African American adults. *The American Journal of Hospice & Palliative Care*, 27(4), 248-253