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Rural Healthcare Providers' Behavioral Intentions with Hospice Referrals: Attitudes, Knowledge, Beliefs, Benefits and Barriers

Meki Jacobs Graham
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Rural Healthcare Providers' Behavioral Intentions with Hospice Referrals:
Attitudes, Knowledge, Beliefs, Benefits, and Barriers

by

Mēki J. Graham

A capstone project submitted to the faculty of
Gardner-Webb University Hunt School of Nursing
in partial fulfillment of the requirements for the degree of
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Approval Page

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Abstract

As hospice programs gain recognition, hospice referrals are gaining momentum. Yet for multiple reasons hospice referrals are challenging amongst rural healthcare providers (HCPs). For rural healthcare providers, lack of knowledge about hospice services and care contributes to a decrease in hospice referrals. The purpose of this capstone project was to develop an intervention to improve rural health care providers' behavioral intention to make hospice referral. The study sought to determine if an educational intervention would improve behavioral intentions to make a hospice referral resulting in increased hospice referral rates. Outcome data was based on utilizing a pretest/posttest survey design. An educational intervention was implemented to enhance rural HCPs' behavioral intentions to make a hospice referral. The findings of the project indicated a significant impact on the knowledge-base of the HCPs. After one month, this resulted in increased behavioral intentions.

Keywords: hospice, palliative, hospice referrals, advanced practitioners, health care providers

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God’s work, that’s what life is all about anyway. Doing God’s work in the most loving way possible is the key. With that being said, I close this doctoral chapter in my life and look forward to new and exciting adventures. Prayers and peace be with you all.

Ah-ho



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CHAPTER I

Introduction

Look around; at any place, during any time, one can find a friend, loved one, or relative battling a chronic illness in our surroundings. Depending upon the approach, the disease progression of chronic illnesses can be the precursors toward the end of life (EOL). Death can be as simple, yet as complex, as life itself. When reviewing the elements of caring for patients during the EOL, one will find hospice and palliative care serves as an exemplary model. In rural locations, healthcare providers (HCPs) are the “gatekeepers” for the initiation of hospice referrals. However, low referral rates can be due to a plethora of challenges, such as time consumption with regards to discussing goals of care with a patient, but also not limited to, lack of understanding, or socioeconomic and health statuses. This capstone project examined the knowledge about, attitudes toward, and perceived beliefs, benefits and barriers rural HCPs have when contemplating a hospice referral.

Background

According to the Center to Advance Palliative Care (CAPC) (n.d.a), palliative (pronounced “pal-lee-uh-tiv”) care focuses on medical support, goals of care, and issues with symptom management, when caring for chronically ill patients and/or their family members. CAPC (n.d.a) also defined palliative care as specialized medical care for people with serious illnesses, with a focus on providing patients relief from the symptoms, pain, and stress of the serious illness. Hospice is a form of palliative care, yet some people use the words synonymously and interchangeably (Fink, Oman, Youngwerth, & Bryant, 2013; Hatcher et al., 2014; Lorenz et al., 2008). Hospice is an

entity of palliative care services. Differentiating and defining hospice from palliative care can be a daunting task, even to those within the health care arena. Both services encompass a focus on quality of life versus quantity (Meier, 2011). In the *Oxford American Handbook of Hospice and Palliative Medicine*, Harrold and von Gunten (2011) defined hospice care as “palliative care at the end of life” (p.230). Palliative care usually begins at the onset of a chronic or life-limiting illness and is used to improve the burdens of the disease process (Snyder, Hazelett, Allen, & Radwany, 2013). According to Snyder et al. (2013), “Palliative care and hospice care are 2 treatment modalities that embrace advance care planning (ACP)” (p. 419). To be clear, several research studies cited in this project use the terms hospice and palliative care interchangeably, but for the purpose of this educational intervention, the terms will be separated. Palliative care services will be an umbrella encapsulating hospice care. Hospice care and services will be defined as caring for a chronically ill patient at any age, who meets eligibility requirements and has a prognosis of six-months or less (McGorty & Bornstein, 2003). For a detailed explanation of these and other terms refer to Figure 1: *The Continuum of Palliative Care* (Macaden, 2011).

Palliative Care Model

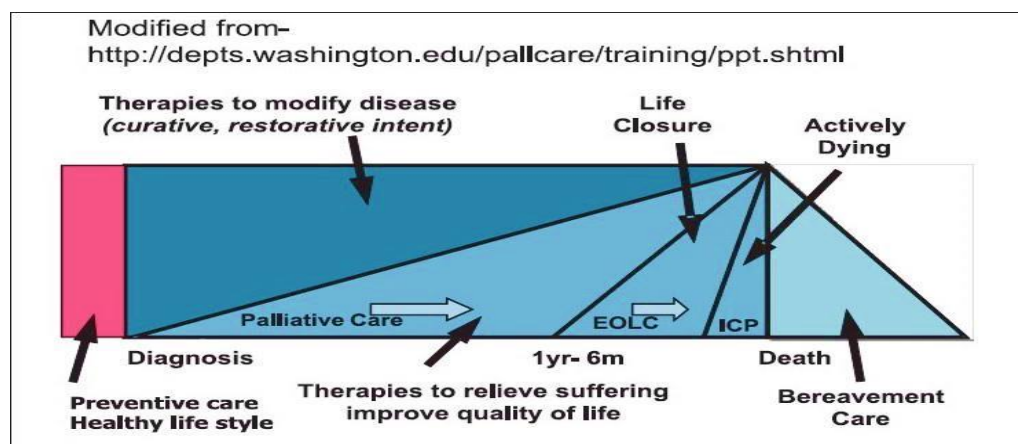


Figure 1. The Continuum of Palliative Care (Macaden, 2011)

Since United States' conception of hospice in 1974, there has been a steady increase in patients receiving hospice and palliative services. (Buckingham & Lupu, 1982; National Hospice and Palliative Care Organization (NHPCO), 2012, 2013). In 2013, there were 2,596,993 deaths in the United States (US) (Kochanek, Murphy, Xu, & Arias, 2013). During this same year, the NHPCO estimates that about 1.1 million American deaths occurred while under the care of hospice (NHPCO, 2013). "The percent of U.S. deaths served by hospice is calculated by dividing the number of deaths in hospice (as estimated by NHPCO) by the total number of deaths" (NHPCO, 2013, p. 4). In 2013, the hospice deaths were just over 40% of the total deaths in the US (NHPCO, 2013).

Living a longer quality filled life can result in many opportunities as well as challenges. Hospice services are available for all ages, however, it is significant to point out that a majority of patients served are over the age of 65 and the greater part of the financial reimbursement comes from Medicare (MCR) (Meier, 2011; Rice & Betcher,

2010, Weckmann, 2008). In fact, in 2013, hospice agencies served over 1.5 million people and 84% of this group was 65 years of age and older (NHPCO, 2014). The average age of mortality is 78.8 years (Kochanek et al., 2013), which was no change from the previous year (Hoyert & Xu, 2012). From 2011 – 2013 over 72% of the deaths were at or above age 65 years (Hoyert & Xu, 2012; Kochanek et al., 2013). As longevity increases, a dilemma arises, leaving chronically ill patients and families with a decision to choose quality of life versus quantity of life.

With the exception of suicide, unintentional injuries and pneumonitis due to solids and liquids, the primary causes of death were related to diseases that are associated with life-limiting illnesses (Hoyert & Xu, 2012). See Figure 2 below.

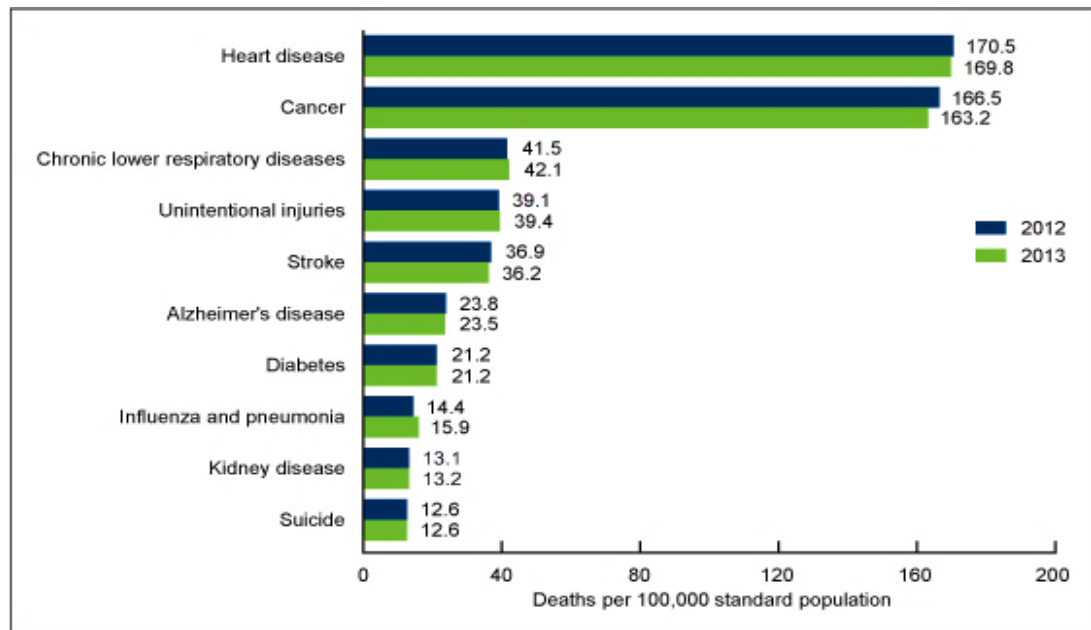


Figure 2. Top 10 Leading Causes of US Deaths, 2012 - 2013 (Kochanek, Murphy, Xu, & Arias, 2013)

Patients dying from chronic illness without hospice services suggest there are barriers to hospice services. Considering chronic illness were 40% of the deaths, this suggests there are barriers to hospice care access (Kirolos et al., 2014; Upchurch & Thornton, 2012). This is especially true for eligible patients in rural areas where providers neglect to complete hospice referrals (Lynch, 2012; Meier, 2011; NHPCO, 2005; Robinson et al., 2009).

Palliative care and hospice services can be a key patient-centered service to improve utilization outcomes and quality of care for the chronically ill (Meier, 2011). With hospice and palliative care services, the direct costs to hospitals related to reoccurring visits and long lengths of stay could be significantly lowered. Additionally, when HCPs make hospice referrals earlier, the patients and families have better outcomes, and there is a tremendous cost savings to the patients, families, and hospitals (McGorty & Bornstein, 2003; Penrod et al., 2006; Weckmann, 2008). Having hospice services can save up to 40% of health care cost (Kirolos et al., 2014). According to Meier (2011):

Of the \$491 billion spent by Medicare in 2009, 27 percent (\$132.5 billion) was spent on acute care (hospital) services and a small proportion—10 percent—of the sickest Medicare beneficiaries accounted for about 57 percent of total program spending, which was more than \$44,220 per capita per year (MedPAC 2010a). The costliest beneficiaries include those using hospital services, those with multiple chronic conditions or functional dependencies, those with dual eligibility for Medicare and Medicaid, and those in their last year of life—all of whom are the

appropriate target population for palliative care and, when eligible, hospice services (Office of Assistant Secretary for Planning and Evaluation et al. 2010). (pp. 346-347)

Barriers to Hospice

If a terminal patient has been deemed disabled for longer than two years, or is older than 65 years, finances should not be a deterrent because MCR covers the hospice benefits (Weckmann, 2008). Harrold and von Gunten, (2011) noted, “In the US, over 80% of hospice care is paid by MCR” (p. 230). Rice and Betcher (2010) compared the clinical and financial viability of such services to those without the service. They concluded that HCP should be educated to be more responsive to the care of patients during the EOL because 70% of hospitalized MCR dollars is spent during the last month (Rice & Betcher, 2010). Therefore, the evidence is clear; poor health care quality produces high expenditures for patients with multiple chronic conditions, functional impairment, and serious and life-threatening illnesses.

The significance is MCR benefits are the largest source of payment services for hospice agencies certified by the Centers for Medicare and Medicaid Services (CMS). In 2012, MCR accounted for 83% of patients served by MCR payer source for hospice (NHPCO, 2013). This payer source has risen to 87.2% in 2013 (NHPCO, 2014). The use of MCR dollars can become very expensive when the HCP is utilizing the dollars for extreme measures such as tests and diagnostics without end or resolution. Having hospice services bill MCR instead will assist with reducing the financial strain on the local, state, and national entities (Oji-McNair, 1985; Penrod et al., 2006; Vesely, 2009).

More often than not, HCPs gravitate to medicinal ways of curing and caring for patients (Carlson, Morrison & Bradley, 2008; Claessen, Francke, Engles, & Deliens, 2013; Davis, 2009; Friedman, Harwood, & Shields, 2002). In 2011, the first of the baby boomers reached retirement age, and for the next 18 years, they will be turning 65 at a rate of about 8,000 per day (Keehan et al., 2008); therefore healthcare leaders should consider the inevitable decline in health and EOL process with chronic illnesses. The preparation for death, when given the opportunity, can be just as beautiful and serene as birth. Access to hospice and palliative care is the first step in improving a patient's quality of care during a time of serious illness (Carlson et al., 2008; Schenck, Rokoske, Durham, Cagle, & Hanson, 2010). As hospice services continue to increase in urban areas, the services in rural areas continue to be a challenge (Kaufman & Forman, 2005; Robinson et al., 2009; Virnig, Ma, Hartman, Moscovice, & Carlin, 2006; Virnig, Moscovice, Durham, & Casey, 2004). This issue is important because as "gatekeepers" (Kolbe & Dwyer, 1986) rural HCPs should be more likely to recognize the need, and make the initial hospice referral (Kolbe & Dwyer, 1986; Kirolos et al. 2014; Lamond & Christakis, 2002; Sanders, Burkett, Dickinson & Tournier, 2004; Upchurch & Thornton, 2013; Weckmann, 2008).

State and Local Statistics

In 2010, the total population for North Carolina was over 9.5 million. In 2013, the state's population increased to over 9.7 million, while the county selected for this capstone project had a population of 57,246 (U.S. Census Bureau, 2014) with 722 deaths, yet 273 (37.81% of deaths) in this rural county were served with hospice care (Carolina's Center for Hospice and End of Life, 2012).

Alarming data is that from 2011 to 2013 the deaths served by the hospice market in this rural county have declined despite continued increase for the state (Carolina's Center for Hospice and End of Life, 2012), see Table 1.

Table 1

2011 – 2013 Deaths Served by Hospice Market

	2011	2012	2013
North Carolina	39.96%	40.42%	45.07%
Capstone Project County	42.20%	40.73%	37.81%

MCR was and continues to be the primary payor source for hospice services (Huskamp, Kaufmann, & Stevenson, 2011). As of 2011 in the identified rural county, MCR pays 91.6% with Medicaid and private insurance equally sharing the remaining 6.4% (Carolina's Center for Hospice and End of Life, 2012). This rural county was chosen as the location of this capstone project because in the state of North Carolina, this county has been the unhealthiest county for the past four years (Robert Wood Johnson & The University of Wisconsin Population Health Institute, 2014; WECT, 2013). This ranking was based upon RWJ evaluating variables such as tobacco use, quality of care, employment, educational, and socioeconomic status. See Figure 3 below.

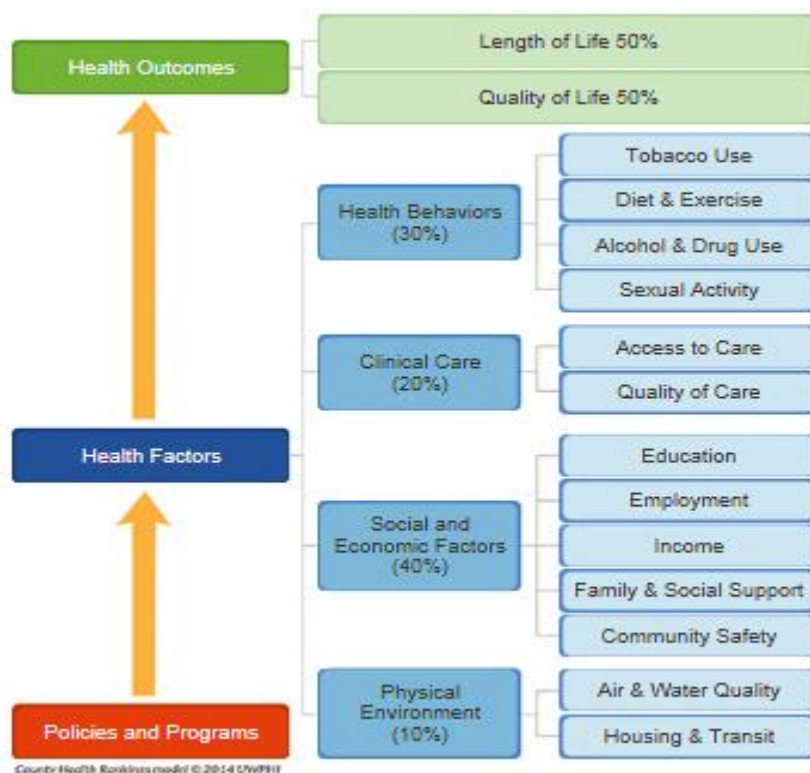


Figure 3. Variables for Determining County Health Rankings

At the time of this project implementation, there was no financial data for hospice services in this county, and there were no palliative programs in the county. The local rural hospital's interim chief executive officer (CEO) and vice president (VP) of the medical staff indicated there were no plans for an acute care palliative care program (D. Erwin & R. Berry personal communication, October 7, 2014). This rural county does have three hospice agencies serving the catchment area (Carolina's Center for Hospice and End of Life, 2012). In 2011, the agencies serving the county were Lower Cape Fear Hospice & Life Care Center serving 76%; Liberty Hospice serving 13%; and Community Hospice serving 10% of the deaths in the identified rural county (Carolina's Center for

Hospice and End of Life, 2012). The remaining 1% had services rendered by an agency that does not exist today (Carolina's Center for Hospice and End of Life, 2012).

There are a plethora of reasons as to why healthcare providers (HCPs) find it challenging to make hospice referrals. Oftentimes, the rationales for underutilization are grounded in the lack of knowledge (Upchurch & Thorton, 2012) and receptiveness of the HCPs (Brickner, Scannell, Marquet, & Ackerson, 2004; Ogle, Mavis, & Wang, 2003). A reluctance is felt to be related to the HCPs' giving up the healing/treatment process and novelty of prognostication with end of life issues (Claessen et al., 2013; Morris & Christie, 1995; Upchurch & Thorton, 2012; Weckmann, 2008), as medical care is traditionally focused on curing the patient. Even more, some providers may not see hospice as a true practice of medicine (Davis, 2009). Yet other research shared barriers such as time constraints, lack of knowledge about the services, and determining patients' and/or families' receptiveness and overall comfort as it relates to hospice services (DeVader & Jeanmonod, 2012; Melvin, 2008; Ogle, Mavis, & Wyatt, 2002).

Additionally, as with rural access, families and patients in these areas may not be aware of the services or benefits hospice can offer (Friedman et al., 2002; Virnig et al., 2006; Virnig et al., 2004). The desire is for HCPs to instinctively know that patients with chronic terminal illnesses and a prognostication of six months or less may qualify for hospice care. The principle administrator focused on the attitude and knowledge-base the HCPs have toward making hospice referrals, as they are the primary resource or the "gatekeepers" for referrals (Kolbe & Dwyer, 1986; Robinson et al., 2009; Weckmann, 2008). These providers are considered "gatekeepers" due to the hospice certificate of participation which requires physicians to refer patients by certifying a life expectancy of

six months or less of life with normal disease progression (Kolbe, & Dwyer, 1986).

Kolbe and Dwyer (1986) defined gatekeepers as the general practitioners who determine eligibility and initiate the order for hospice referrals. Research is needed to determine the HCPs' behavioral intentions behind such underutilization. This was the focal perspective of this capstone project.

Problem Statement

Connecting patients and families to hospice services during their time of need can be an intricate process. The aging consumers are beginning to demand better care at the end of life (Keehan et al., 2008; Knickman & Snell, 2002). There are many ways the hospice referral process can be initiated. Other than the provider introducing the concept, hospice could begin through a desire of the patient/family member, an evaluation from nursing or a recommendation by those with knowledge of hospice services. The order for the referral must be made by the HCP, and this is a challenge that prevents the referral process from transitioning smoothly or occurring. Healthcare access in rural areas have long been a standing issue, but when dealing with healthcare professionals who have established connections with eligible hospice patients, the avenue for reaching the root of "why" referrals are not made can be mystifying. According to the Theory of Reasoned Action, behavioral intention is the result of one's attitude, knowledge, and social norm. When the HCPs' knowledge-base, attitudes, beliefs, and barriers to hospice services are addressed on the forefront, this could evolve into a positive change in social norm and a point of successful improvement with referrals, or at least intentions to do so. Therefore, if the intentions of these HCPs are addressed, then their awareness is heightened, potentially in hospice access for many more eligible terminally ill patients. No peer-

reviewed articles exist that examine the behavioral intention HCPs have toward hospice care for patients, specifically in rural areas. As with the case of many rural areas, the identified rural county has high rates of obesity, hypertension, chronic kidney disease, and other debilitating diseases, which are leading causes of life limiting illness (Robert Wood Johnson (RWJ) & The University of Wisconsin Population Health Institute, 2014; WECT, 2013), yet there are only a few patients being referred to hospice care services (James, Cossman, Cossman, Campbell, & Blanchard, 2004; Lynch, 2012). The lack of hospice referrals in the unhealthiest county in North Carolina, for the past four years, is a concern and serves as justification for this capstone project.

There is no known statistical data for the low referral rates in the county, but there have been professional transparent discussions about this issue. In paraphrasing the CEO of the largest serving hospice agency in the county, “There are concerns with low hospice referrals in (identified) County... providers feel they will lose their patients and this is not true...they need further education on this issue” (L. Bystrom personal communication October 2, 2013). The interim CEO of the local hospital in this rural county indicated an appreciation for hospice and shared that a palliative program may benefit the hospital (D. Erwin personal communication, October 7, 2014). Despite the low hospice referral rates, there is also a complexity of how one approaches the HCPs about this issue.

Justification of Project

As previously mentioned, this project focused on a rural county in the southeastern region of North Carolina. The overall statistical data for this area is limited; however there have been correspondences with the CEO and VP of clinical services of the largest agency providing hospice services in the area. Since 2009, this agency has

served over 70% of the total hospice admissions in this county, with its two competitors serving 10-13% (Carolina's Center for Hospice and End of Life, 2012). The VP of clinical services of the largest serving agency shared that the providers are either not making referrals at all or other families are choosing alternative locations of care, such as regional medical centers (G. Whitley, personal communication, November 12, 2013). The specialist and regional medical centers are making contact with the hospice agencies resulting in late referrals and unnecessary financial burdens for the patients, family, specialists and healthcare facility (G. Whitley, personal communication, November 12, 2013).

The financial benefits of having an appropriate hospice referral are two-fold. First, the final days of life are often the most expensive for the patient and family (Experton, Ozminkowski, Branch, & Li, 1996; Hogan, Lunney, Gabel, & Lynn, 2001). Secondly, evaluating costs from an inpatient prospective (hospital readmissions and critical care services that are eminent), suggested that early intervention saves money (Smith, Brick, O'Hara, & Normand, 2014). Hospital overhead, unnecessary testing, and physician fees accumulate simply because most hospitals are ill suited to provide palliative care in such a way that is cost neutral. The utilization of high-level care providers is very costly, especially when nursing, family members, and more cost effective providers who can work either in the home, or in a facility are more suited for end of life care. Overall, hospice services can assist the local rural hospital with lowering readmission rates. According to the Patient Protection Affordable Care Act of 2010, starting in 2015, hospitals with high readmission rates will lose up to three percent of their Medicare reimbursement (Bradley et al., 2013).

This population is in a geographic area with limited resources and lack of specialty providers (Fink et al., 2013); therefore the primary care providers (PCPs) play a key role in palliative care services, yet there is a lack of knowledge and skill to do so (Van Vorst et al., 2006) (Fink et al., 2013). Consistent with national trends (Kangovi et al., 2013), residents of this area with financial means drive approximately an hour to an urban medical center. These patients and families often feel a sense of desperation and limited understanding of the terminal stages of disease progression (Johnson. & Slaninka, 1999). According to the CEO of the largest hospice serving agency, a vast majority of the referrals come from the large medical center which can be a 55 mile one-way trip. This medical center provides this agency with over 60% of their referrals (L. Bystrom, personal communication, October 3, 2013). Weckmann (2008) noted the benefit of the family physician in the referral was important, as they are seen as the primary initiator for early hospice referrals. Patients are seeking care with specialists and in urban medical centers and being found to be hospice appropriate. If the hospice referral could be initiated by primary care or family providers in the local region, patients may be able to avoid unnecessary physical and psychosocial suffering. Fink et al. (2013) stated rural health providers perceive they are providing palliative care and yet they are not. In evaluating the needs for this capstone, the VP of Medical Services at the county medical center stated he felt “that palliative services were being provided in our hospital all the time” (R. Berry, personal communication, October 7, 2014). It is noted that there is no formal palliative services or team in this facility. This validated Kaufman and Forman’s (2005) research on the impact an educational intervention would have on nurses, physicians, and other related healthcare professional. Kaufman and Forman (2005)

concluded, “the educational intervention significantly increased the number of patients referred for hospice care” (p. 415).

Robinson’s et al. (2009) article focused on the pressing need to advance the agenda of rural palliative care associated with life limiting illness and death. Inequalities of this nature are due to the need for further education and access to care overall as issues with palliative care seems be in its infancy in rural areas (Robinson et al., 2009).

This pilot project can make a difference because there is a lack of rural research about such a topic over the past five years, and there are no palliative care programs in the hospital or among the hospice agencies within the county. Finally, the project can make a difference in the financial bottom line for the rural hospital as well as the terminally ill with a more specialized form of care at no or low cost to the patient (Cassel, Webb-Wright, Holmes, Lyckholm, & Smith, 2010). This educational intervention can:

- Improve the line of communication between HCPs and patients
- Improve symptom management more quickly
- Lower the cost of in-hospital readmissions and deaths

(Cassel et al., 2010).

Since the Affordable Care Act has heightened the awareness of health concerns, and the rural areas of the United States continue to have chronic disease issues, the need for hospice and EOL care will continue to intensify. The patients in rural areas with multifaceted chronic diseases continue to get sicker, so the initiation of hospice care is an effort to support these patients’ major needs. The project administrator chose a rural county in the state from the southeastern region of the nation for the purposes of this scholarly capstone project. As a county resident, the project administrator had a desire to

make a positive impact. Researched rationales, statistics, and dialogues with healthcare and hospice administrators revealed a low number of hospice referrals. However, there was a lack of definitive information to resolve the rural referral issue and how it impacts hospice utilization. This is the justification for beginning with healthcare providers (HCPs).

The project administrator planned to focus on all rural HCPs, identified as physicians, physician assistants, and nurse practitioners in the county. According to the National Hospice and Palliative Care Organization (NHPCO) March 4, 2013 press release in *Health Affairs*, hospice enrollment saves money for Medicare and improves care quality for Medicare beneficiaries. Hospice saves money for hospitals and other healthcare facilities, such as nursing homes and assisted living facilities. Hospice administrators have had failed attempts to initiate outreach programs to improve underutilization of hospice for this county yet the eligible patients are becoming sicker and mortality rate without hospice care increases. Hospice services should be viewed as a humane service for terminally ill patients. Many times, the lack of knowledge of hospice policies and services resulted in rash decisions that inflated the financial bottom line. This led to overall increased cost to Medicare, insurance companies, facilities, and families alike. HCPs can impact this cost as they become experts in patient advocacy for those eligible for hospice services.

Rationale for the Educational Intervention

A study by Trollor (1995) examined the need for EOL educational training for general practitioners in a rural area. Twenty percent of the physicians reported having adequate training, 61.7% felt that their present skills were adequate and a majority

preferred seminars in their own town (Wilson et al., 2006). Barnabe and Kirk (2001) conducted a needs assessment of rural physicians in Canada to determine their educational needs and learning preferences (Wilson et al., 2006). Forty-one percent had never received any formal palliative care education (Barnabe & Kirk, 2001). The knowledge gaps were bereavement, psychosocial aspects of dying, and interdisciplinary communication. Their preferred form of education was case studies, lectures, and self-directed learning in settings close to home and over the weekend. In another study, half felt evening meetings would be best (Wilson et al., 2006). This capstone project was designed to (re)educate HCPs about hospice care in hopes of connecting eligible patients with a needed service. Participating in this educational intervention added to or enhanced the HCPs' current knowledge-base, addressed specific attitudes, and perception, while releasing barriers, all to improve behavioral intentions for hospice referrals.

Potential Barriers to the Capstone Project

The project administrator addressed the behavioral intention of making a hospice referral by initiating a pre-test-educational intervention-post-test survey to pinpoint specific areas of content held by the rural HCPs. A major challenge posed by the project administrator's research was to understand the culture of the healthcare providers (HCP), meaning receptiveness. There was no Institutional Review Board (IRB) or any known research being implemented in the local hospital; therefore the receptiveness to engage in the capstone project was a concern. Another challenge was the rural HCPs' receptiveness to follow through and complete this capstone project from beginning to end. In a research article by Brodaty et al. (2013), lack of time was the overwhelming reason general practitioners did not participate in research. Motivating factors included a need to update

knowledge and desire for continuing medical education (CME) points Brodaty et al. (2013).

Statement of Purpose

The purpose of this capstone project was to examine the self-reports of behavioral intentions of healthcare providers toward making hospice referrals in regards to their attitudes, knowledge, and beliefs about hospice services along with perceived benefits of and barriers to hospice care.

Project Questions

The project administrator sought to answer one key research question:

Did the hospice educational intervention impact the rural HCPs' behavioral intention toward hospice referrals?

Upon completion of the hospice education intervention:

1. Was there a significant impact on rural HCPs' attitude about hospice services?
2. Was there a significant impact on rural HCPs' knowledge about hospice policies and services?
3. Was there a significant impact on rural HCPs' beliefs about hospice policies and services?
4. Was there a significant impact on rural HCPs' knowledge of benefits about hospice referrals?
5. Was there a significant impact on rural HCPs' knowledge of barriers to hospice referrals?

Definition of Terms

The following terms are defined as points of clarification for the reader:

- End of Life (EOL): The Center for Advanced Palliative Care (2014), defined EOL as recognition of the inability to reverse a life-limiting medical condition(s) that will result in death.
- Hospice care: is a specific entity of palliation for patients with a terminal illness. It is an interdisciplinary philosophy of collaborative care for those living with a life-threatening illness while placing emphasis on the patient's end-of-life care quality. Medicare defines hospice eligibility as a chronic illness in which the patient has six months or less to live (Christakis & Escarce, 1996). The primary goals included pain management, comfort, and palliative measures. ("What is Hospice?," 2013) (Center for Advanced Palliative Care, 2014)
- Palliative care: A broad extension of hospice care. A specialized form of care to relieve pain, stress, or alleviate a symptomatic issue for patients with serious illnesses. There are three major types of palliation: *those with curable disease process*, such as a with leukemia, receiving a bone marrow transplant with a 70% success rate; *those with the initial onset of a serious illnesses* such as Chronic Obstructive Pulmonary Disease (COPD) or Dementia that could last for several years; and finally hospice care for *those with progressive incurable diseases* with a prognostication of six months or less, such as metastatic cancer. This later would be an eligible hospice patient, yet all three groups of patients can benefit from palliative care (Agency for Healthcare Research and Quality [AHRQ], 2013) (Center for Advanced Palliative Care, 2014).

- Prognostication: prediction of future outcomes (Merriam-Webster 2015)
- Rural: Federal government has defined rural as those areas not designated as parts of metropolitan areas by the Office of Management and Budget. The Center for Advanced Palliative Care's (2014) rural tool kit documented the difficulty in defining this word; therefore, the project administrator specifies rural as outside the realms of urban and suburban sites that involve people with challenging socioeconomic circumstances and limited overall access, specifically to healthcare. For the purpose of this capstone project, rural will be defined as an area that is more than five miles but less than or equal to 25 miles from an urbanized area (Office of Management and Budget, 2000).

Summary

Over the last three decades, hospice care services for eligible patients and their families have grown on the national level, yet there is a lack of utilization in rural areas. Improving the status quo for eligible patients in rural areas to receive hospice services is essential. The assessment and evaluation of the thought process of rural HCPs is a step toward addressing this issue. This capstone project focused on the behavioral intention of HCPs to make hospice referrals based on their attitudes, knowledge-base, and the benefits and barriers about hospice policies and care, for this is an avenue to improve access to care for eligible patients.

CHAPTER II

Research Based Evidence

The focus of this literature review was constructed around the capstone project “Rural Healthcare Providers’ Behavioral Intentions with Hospice Care: Attitudes, Knowledge, Beliefs, Benefits and Barriers.” The purpose of this literature review was to examine available literature regarding variables relating to the capstone project. This chapter will discuss the capstone project’s theoretical framework and analysis of literature.

Review of the Literature

Despite rural hospice services being in great demand, review of the literature indicated a limited amount of information pertaining to healthcare providers’ attitudes, knowledge or perceived benefits or barriers of hospice services. A review of the literature was conducted through a variety of databases and search engines. These included Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, PubMed, Sage Premier, Medical Literature On-Line (Medline), and EBSCO databases. The project administrator also utilized the search engine Google scholar as an additional alternative to accessing detailed research information. Key terms for the search included hospice, hospice care, hospice services, access to hospice, rural, referrals, palliative, palliative care, palliative services, hospice referrals, palliative referrals, advanced practitioners, health care providers, general practitioners, physicians, providers’ knowledge, providers’ attitude, benefits and providers’ barriers to hospice and/or palliative referrals. There were also searches to include the theory of reasoned action with these key terms or similar information integration.

Identifying the Need for Palliative Care

Claessen et al. (2013) conducted a qualitative interview with 20 (n=20) General Practitioners (GPs) in the Netherlands. The GPs were recruited by snowball sampling until data saturation occurred, and recruitment ceased (Claessen et al., 2013). The research utilized Lynn and Adamson's model to implement palliative care during the early stages of a terminal disease (Claessen et al., 2013). The research questions included how GPs recognize a need for palliative care, the trajectory of the disease and determining if there is a difference between cancerous and non-cancerous patients in the timing and nature for needing palliative care. The interview dialogue began with discussing when the GPs thought palliative care should begin and this varied according to disease processes but one main consensus was that this care should not begin upon initial diagnosis, which is congruent with what the Lynn and Adamson's model recommend (Claessen et al., 2013). The GPs recognized the need for palliative care when their patients had changes in self-care, and/or were not improving in social norms related to health (Claessen et al., 2013). Additional results found a variation in GP's recognition for palliative care based on disease process and progression (Claessen et al., 2013). The GPs identified the prognostication of cancer issues a moot point as these referrals processed without delay. Those patients with chronic obstructive pulmonary disease (COPD) or heart failure were not so easily predicted and needed additional involvement of family or the medical specialist (Claessen et al., 2013). The results concluded that the GPs did not support early implementation of Lynn and Adamson's Palliative Care Model (Claessen et al., 2013).

Barriers to Hospice Referrals

A descriptive exploratory pilot study by Upchurch & Thornton (2012) explored factors that impact a physician's decision to admit eligible hospice patients with Alzheimer disease (AD) along with reasons why the referrals are not made. Additionally, this study not only looked at factors physicians used for making referrals, but it also delved into physicians' knowledge and understanding of hospice admission criteria as well as for prognosticating (Upchurch & Thornton, 2012). The results indicated that 50% of the 12 research participants were aware of facilities that offered hospice care (Upchurch & Thornton, 2012). Also, after examining the physicians' barriers to referring a patient to hospice, the authors' determined family influenced it, as they were allowed to decide. The specific reason was not clear as the article identified this as a need for further investigation (Upchurch & Thornton, 2012).

Ache, Shannon, Heckman, Diehl, and Willis (2011) conducted a study comparing the attitudes toward hospice referrals considering the personal experiences a physician's ethnicity has with a palliative model of care, specifically the African American and white American primary care provider (PCP). The results indicated a difference based on race, but further validation was needed for specific insight into a curriculum focus during medical education (Ache et al., 2011). The questionnaire was reviewed by professionals of the Scottsdale, Arizona and Rochester, Minnesota Mayo Clinics as well as the Mayo Survey Office. The initial intent was to look at all PCPs, resulting in the survey being sent electronically to the physicians and residents working for the Mayo Clinics in Florida, Arizona and Minnesota via Mayo's intranet (Ache et al., 2011). Additionally the Mayo's Midwest PCPs had the printed version with a two-week follow up (Ache et al.,

2011). Once the authors decided to change their focus to exclude other ethnicities, the final tallied responses was 167 white Americans and 46 African Americans (Ache et al., 2011). The initial responses yielded 22 respondents who were not African or white American, eight African American and 167 white American (Ache et al., 2011). The authors then had the challenge of balancing the underrepresented African American responses, so they distributed 100 additional surveys during a minority meeting at the 2007 National Medical Association conference in Hawaii (Ache et al., 2011). This yielded an additional 38 African American responses (Ache et al., 2011). The results, “suggest that certain attitudes toward hospice referral may differ between African American and white American PCPs” (Ache et al., 2011, p. 547).

The 17-question survey revealed an analysis of five statements with a significant statistical difference (Ache et al., 2011). This included statements about the patients’ or family members’ feelings and reluctance to discuss hospice, relying on intuition to help determine if patient or family is ready for hospice, correlating patient’s race with hospice resistance and making referrals for spiritual or religious preferences (Ache et al., 2011).

Brickner et al. (2004) surveyed physicians in a not-for-profit Health Maintenance Organization (HMO) and focused on hospice referral, particularly the physicians’ knowledge about hospice services, as well as knowledge and attitude about making the qualified referrals (Brickner et al., 2004). One hundred twenty-five physicians from two departments within the HMO had an 89% response rate of 91 staff physicians and 20 residents (Brickner et al., 2004).

The highlights of the demographics section revealed that one third of those who replied had a personal experience with hospice, meaning a family member or close friend

as a hospice patient (Brickner et al., 2004). The mean number of practice time with the HMO was 8.9 years with 71.2% of the physicians practicing in clinic-base areas (Brickner et al., 2004). As for the physicians' knowledge of hospice and making qualified referrals, 78% of the respondents considered themselves adequately trained to discuss death with patients, while 74% would like to have the presence of a hospice staff member during office visits to discuss making such referrals (Brickner et al., 2004).

Interestingly, physicians younger than 30 years and practicing fewer than six years considered hospice an underutilized option and 82% of this group tended to respond to making more referrals. Ninety-five percent of their counterparts shared they made appropriate hospice referrals (Brickner et al., 2004). Forty-two percent of physicians shared the most common rationale for making the hospice referral was to allow hospice staff to guide the patient and family along the dying process, but other responses also included pain control, nursing support and psychological support (Brickner et al., 2004). This study found that family/patient requests, issues with family coping, and access benefits were less of a concern (Brickner et al., 2004).

Ogle et al. (2002) initiated the groundwork for the previous article with a focus on hospice referral barriers with physicians by examining their attitudes toward knowledge about and perceptions of benefits and barriers to hospice care. The authors were aware of the advantages and even growth hospice care was having, but the concern was in underutilization of the services (Ogle et al., 2002). This article spent time explaining the formation of the questionnaire based on literature reviews, pilot testing small groups of physicians outside the researched community, and dialoguing with hospice professionals (Ogle et al., 2002).

The surveys were collected by mail and the surveys were sent to the same groups as the 2003 article, with the same response rate of 72 percent. The questionnaire consisted of five sections: the first section had five demographic questions; the next section was a 13-item five-point Likert scale survey about physician attitudes (Ogle et al., 2002). The third section responses evaluated knowledge about hospice and the participants were asked to “agree,” “disagree,” or state they were “not sure.” This data was converted into “correct,” “incorrect,” or “not sure” answers. The final two-part sections had eight leveling (“very beneficial, somewhat beneficial and not beneficial”) questions about specific benefits while the second part had nine questions on specific barriers (Ogle et al., 2002).

In a comparison of this and the next article, the exact same questions were utilized for both students. It is the project administrator’s belief that the exact survey was conducted and researched from a different perspective focus. Mail survey was the method of data collection (Ogle et al., 2002). The demographic profile revealed the group with the largest age range was 41-50 years of age. Over a third of the respondents had more than 20 years of practice; 56 % were family physicians with 20% percent being internists. More than half of those surveyed practiced privately or had university residence and more than 25% had not discussed or recommended hospice to a patient or family (Ogle et al., 2002).

With questions related to attitudes about hospice, 80% endorsed the positive questions and depending on the question, 20% or less endorsed the negative attitude questions (Ogle et al., 2002). As for the physicians’ knowledge about hospice, 96% were aware that hospice services were available to terminally ill patients other than cancer

patients; only 7% knew that palliative radiation and chemotherapy did not exclude a patient from hospice care (Ogle et al., 2002). With demographical comparisons, the younger physicians were more knowledgeable than the older physicians. The latter group rated lack for familiarity with local hospice services and patient/family unwillingness to elect hospice services as strong barriers (Ogle et al., 2002).

Ogle et al. (2003) addressed the attitudes, knowledge, and barriers to hospice by specifically using primary care physicians as their focal point of reference. The purpose of this article was to examine primary care physician's (PCPs) attitudes and knowledge about hospice as well as researching any barriers and/or benefits to hospice care (Ogle et al., 2003). Of the 264 physicians compiled using hospital staff listings, insurance panels, and local medical rosters, there was a 72% response rate and of these 69% were either internists or family physicians for a quantitative value of 131 PCP respondents (Ogle et al., 2003). The researcher admitted to lacking a specific number of PCPs (Ogle et al., 2003). The primary author developed the physician's questionnaire using pilot testing with physicians outside the community along with primary care residents and hospice professionals, both within the community (Ogle et al., 2003). Results of the 13 attitude questions revealed the nine positive questions were endorsed by at least 80% of the PCP respondents with strong agreements for hospice for terminally ill patients and for effectiveness of hospice care (Ogle et al., 2003). These physicians felt comfortable facilitating hospice referrals for patients and family members (Ogle et al., 2003). There were four negative attitude survey questions and 20% or fewer agreed with these results (Ogle et al., 2003). In comparing the positive and negative attitude questions, there was

no significance between the internal medicine and primary care providers as well as no significance in the physicians' age or years in practice (Ogle et al., 2003).

As for determining the PCPs' knowledge base about hospice, these eight questions were answered using the agree/disagree/not sure method (Ogle et al., 2003). Over half of those surveyed indicated they were not sure instead of giving a correct response (Ogle et al., 2003).

There was only one difference in the individual knowledge item scores that achieved statistical significance between the two specialties. In reference to the statement that "The patient must be given a prognosis of six months or less to be eligible for hospice," 55% of the family practitioners were correct, as compared to 85% of the internists (Ogle et al., 2003, p. 45).

The survey used a three-point scale (1=not beneficial; 2=somewhat beneficial; 3=very beneficial), to evaluate the eight benefits and barriers of hospice. All but one of the questions had a response of very beneficial. The one outlier, related to financial benefits from the patient and family from hospice referrals, revealed more cautious responses with little difference between family practice and internal medicine physicians (Ogle et al., 2003). An additional financial issue revealed less than one third of the internists were not certain about the type of services covered under Medicare hospice benefits as compared to over half of the family practice physicians (Ogle et al., 2003). The perceived barriers to hospice referrals revealed over 67% who had no hospice discussions had a rationale based on lack of knowledge with hospice services (Ogle et al., 2003).

Friedman et al. (2002) compiled both qualitative and quantitative research that focused on barriers and enabler issues hospice experts had with hospice referrals in two

phases. This was a collaborative effort between Harris Interactive (global Internet-based healthcare research firm) and Robert Wood Johnson Foundation (RWJF) (2013) with 30 hospice experts from across the nation. Visits were made to four different hospice programs (Friedman et al., 2002). Phase one consisted of exploratory interviews that focused on generating an overview of current best practices of the physicians along with their attitudes about resources from hospice (Friedman et al., 2002). Two professional moderators and two executive interviewers completed 30 telephone interviews using a detail-focused questionnaire. These 60-90 minute recorded interview sessions, along with the site visits, gave analytical insight into how hospice referrals can be encouraged along with factors that create barriers to hospice referrals (Friedman et al., 2002).

Friedman's et al. (2002) research identified several barriers with hospice care access. Some examples included physician and other hospice professionals' lack of education to patients and families being misinformed. The results of this funded research instigated the convening of an expert panel that made several recommendations to facilitate hospice referrals and absolve the enabler issue. Some of these ideas continue to exist today. For example, this included educating physicians who did not make hospice referrals, focusing on their practicing styles and reaching out to educate consumers of these services (Friedman et al., 2002).

Theory of Reasoned Action (TRA)

The Theory of Reasoned Action is a theory based on the social psychological context that separates a behavioral intention from the actual behavior. Several research articles validated the link between the TRA with healthcare. The overall goal was to view

one's behavioral intention. The project administrator was able to find articles that linked the TRA with healthcare.

In Brown's (2012) pilot study, the TRA was utilized to complete a non-experimental cross-section quantitative survey. The article was used for the purpose of exploring misconceptions and increasing awareness that African Americans have with organ donation.

The survey examined five general areas of reluctance associated with organ donation and this group (Brown, 2012). The author chose a non-random convenience sample of clergy, members with the Union American Methodist Episcopal Church Conference, and members of an African American sorority to send 70 on-line surveys via invitation only. A representative of the church and sorority served as the group spokesperson. This was also the contact person who shared an introductory letter about the survey, which contained login access (Brown, 2012).

Fifty-five participants (n=55) completed the ten-item online survey, as this yielded a 78.6% return rate. The responses focused on the following five areas: "(1) lack of awareness, (2) lack of trust by the medical profession, (3) fear of premature death, (4) discrimination, and (5) religious beliefs and misconceptions" (Brown, 2012, p. 1). There were a total of ten questions. The first nine quantitative questions included responses based on the five-point Likert scale. The tenth open-ended question left the participant with an opportunity to add comments (Brown, 2012). Results revealed most of those surveyed reported having reservations with organ donation and "many" of the participants reported issues with medical profession mistrust (Brown, 2012).

A majority of those surveyed did not believe in religious reasons being a rationale for a person to be an organ donor, with 52.7% strongly disagreeing, and 5.45% agreeing (Brown, 2012). The second question revealed that 40% strongly disagreed that after death, the body should be intact, while 37.7% disagreed and 21% were undecided (Brown, 2012). When questioned about the medical profession and organ donation, the respondents results revealed 20.37% strongly agreed, 38.89% agreed, 25.93% were undecided, 9.26% disagreed and 9.26% disagreed to having mistrust.

The fourth question, which was met with mixed responses, asked if being an organ donor minimizes African Americans' chances of survival should there be an accident or if one becomes chronically ill. Of the participants, 16.36% strongly disagreed, 36.6% disagreed, 23.64% were undecided, 20% agreed with the statement and 3.64% strongly agreed. (Brown, 2012, p. 31)

The remaining questions also contained inquiries about knowledge of organ donation and its process; family participation and influence, which included allowing a loved one's organs to be donated; self-disclosure about becoming a donor; and there was an inquiry about having a family member on the organ donor list (Brown, 2012). On the last question, 24 participants shared open-ended comments and the results varied with support, no support, or ambivalence for organ donation (Brown, 2012).

The author chose TRA to correlate with the perceptions African Americans have with organ donation. The TRA provided a framework on why people make certain decisions along with how performance is related to the behaviors (Brown, 2012). Brown (2012) inductively researched this topic using TRA as a way to convey predictable

behavior intentions with subjective norms, or social pressures. The actual behavior was not addressed but rather methods to influence change discussed.

The strength of Brown's (2012) article resides in the knowledge gained for applying this research to future educational interventions. The presentation of knowledge gained could dispute myths and build awareness about organ donation within the African American community (Brown, 2012). This survey can also be a framework for dialoguing about organ donation amongst a variety of groups, such as race, education, and socioeconomic status.

The author addressed that since this was a pilot study it was limited. Additionally, with the pilot study approach, the research lacked demographics to consider information such as age and educational background, and the ability to correlate the results of the survey with those features.

Enguidanos, Kogan, Lorenz, and Taylor's (2011) created a hospice informational brochure with role modeling stories to improve the attitudes and knowledge of hospice among African Americans aged 65 and older. This quantitative research was based on two theoretical frameworks: the social learning theory with the role modeling brochure, and the pre-test-post-test extension relative to the TRA. This article used a pilot study to determine sample eligibility and recruitment, which included racial and age demographics and the requirement that the participants must have two or more chronic disease conditions such as hypertension, diabetes, and/or heart disease (Enguidanos et al., 2011).

Seventy-one participants (n=71) ranging from age 63-91 were interviewed (Enguidanos et al., 2011). There was a variety of demographics including: 73% retired,

80.3% female, 33.8% married, and 28.2% divorced with 45.1% having completed some college and 60% knowing someone who received hospice services (Enguidanos et al., 2011).

The pre and post tests were a series of 21 questions focusing on knowledge, attitudes, and intentions toward hospice enrollment (Enguidanos et al., 2011). The knowledge questions were nine true-false and the 12 Likert scale and were from a previously adopted study (Ogle et al., 2002) to identify myths about hospice in general (Enguidanos et al., 2011). The results revealed a “significant improvement in the knowledge of and attitude toward hospice” (Enguidanos et al., 2011, p. 165). With the pre-test, brochure reading, and post-test comparison results, the article revealed improvements in recognizing the primary site of hospice care, and the behavioral intentions of hospice enrollment.

The knowledge questions provided the most improvement from the pre-test. There was a 75% improvement with knowledge of hospice covering the cost of medications and 59% improvement on hospice services (Enguidanos et al., 2011). Statistical improvement with attitudes was demonstrated with a 41.1 at pretest and 46.29 at post-test (Enguidanos et al., 2011). Participants’ attitudes improved after reading the role model brochure. And finally, the behavioral intentions improved from 84.5% at pretest to 92.9% for the post-test. As previously stated, the respondents intentions for seeking hospice care for themselves or a family member improved (Enguidanos et al., 2011).

The article suggested avenues for future research, which included physician communication with patients about hospice services; engaging in hospice conversations;

and the timing, relative to disease promotion with hospice discussions (Enguidanos et al., 2011). Finally, this study identified its own limitations to include limited geographic location of the sample, small sample size, lack of comparison group, and the type of study design (Enguidanos et al., 2011).

The final critique by Whisenant and Woodring (2012) is a quantitative randomized controlled pre-test-post-test study using two theoretical approaches, the TRA and the Precede-Proceed model. The TRA was the framework for understanding the student nurses' attitudes and knowledge related to organ donation, and assisted with the development of the curriculum for the educational intervention (Whisenant & Woodring, 2012).

One hundred eighty four (n=184) volunteer junior baccalaureate level nursing students were randomly placed into two groups using color coded cards, with an equal number of both colors (Whisenant & Woodring, 2012). Each student was assigned to either the control or the experimental group based on the color he/she chose. Initially, both the control and experimental groups completed the same pre-test together. A one-hour educational intervention which included a PowerPoint lecture and digital videodisk (DVD) presentation was given to the experimental group. The control group did not benefit from the educational intervention, but instead received a list of suggested reading/video resources related to organ donation. Two weeks later, both groups received the post-test (Whisenant & Woodring, 2012). The results of the study failed to demonstrate a correlation between demographics and the level of knowledge or presence of positive attitude with organ donation and transplants (Whisenant & Woodring, 2012).

The mean knowledge score results supported the hypothesis that the educational intervention would increase the knowledge level of the participants in the experimental group and the control groups' "knowledge level remained less than adequate" (Whisenant & Woodring, 2012, p. 9). In terms of attitudes toward organ donation and transplantation, females had a higher overall support for organ donation with self and family, during the pretest than males, but the posttest revealed an equal stance (Whisenant & Woodring, 2012).

Interestingly enough a statistical difference between the pre and post-tests of both groups was found with knowledge and attitude (Whisenant & Woodring, 2012). There was however a positive relationship between an educational intervention and changes in the knowledge and attitudes of these nursing students (Whisenant & Woodring, 2012). This article has the ability to take the attitudes and knowledge variables, merge them with the two previously stated theories, while maintaining the research focus and hypothesis.

Gaps in Literature

A review of the literature surrounding the topic was limited and often not current. One similar article by Kaufman and Forman (2005) researched and determined that an educational intervention in a rural community increased awareness and availability of hospice care. No other articles that linked an education intervention with rural healthcare providers' behavioral intentions to make hospice referrals were found.

No specific articles were found that linked Fishbein and Ajzen's Theory of Reasoned Action with the healthcare providers' attitudes and knowledge about making hospice referrals. One study focused on the attitude and knowledge concepts (Hu et al., 2003), yet never addressed Ajzen and Fishbein. This article aimed at determining the

predictors of willingness district nurses had with providing palliative care in rural communities of Taiwan (Hu et al., 2003). What was revealed is hospice referrals have been a concerning issue and the approach to peer-reviewed information has varied, with a majority of the findings revealing a focus on hospice referrals only from the physicians' perspective.

In Upchurch and Thornton's (2012) research there was no theoretical basis for the topic. A limitation of the study was the small sample size and region therefore data was not analyzed for validity and reliability.

Strengths and Limitations of Literature

Although there were peer-reviewed articles that discussed physicians making hospice referrals, (Brickner et al., 2004; Friedman et al., 2002; Melvin, 2008; Ogle et al., 2002; Ogle et al., 2003) these publications lacked any type of theoretical basis.

Claessen et al. (2013) discussed the lack of prior with their topic and explained this interview was initiated to begin professional research. The authors also addressed the lack of external validity and generalizability of qualitative research (Claessen et al., 2013). Strengths of this study were comparing the GP's palliative care focuses with Lynn and Adam's model, creating the interview as an initial step for more research on this topic, and discussing the implications for research and practice. This topic can benefit future research by making more comparisons with other disease processes and not just cancer.

In Upchurch and Thornton's (2012) research included the study having such a limited number of participants even for a pilot study with a convenience sample. Also of concern, was the approach the authors had to engaging the participants in the research;

the participants were invited to participate via various approach styles, including phone calls to office managers asking for appointments, hand delivery of the questionnaire, wait and take of the questionnaire, personal approaches, and actual office time appointments. Another limitation was the need to include nurse practitioners and physician assistants in the study (Upchurch & Thornton, 2012). A final limitation included discussion about the need for more comprehensive studies of HCPs' understanding of hospice admissions and referrals of patient with AD (Upchurch & Thornton, 2012).

Ache's et al. (2011) limitations included the research being a pilot study and the need for overall research validation, especially with the low African American results. Due to a small number of African American participants, the researcher had additional minorities added to the study and these results could have assisted with validation of the racial prospective. Meaning, at times some of the results, although valid as a barrier with past research, may not have had anything to do with race, but yet another demographic piece. The strength of the study was the approach to creating a questionnaire based on hospice referrals, as this could be replicated without reference to racial context and be approached from a different angle, such as the project administrator's perspective. The most relevant barrier to hospice referrals, cited by 37% of physicians, was difficulty in accurately making the six-month or less prognostication (Brickner et al., 2004). Additional barriers included lack of time to discuss hospice issues, having a curative mindset, and lack of a financial interest for the physician (Brickner et al., 2004). The authors documented limitations such as omission of data collection that entailed more specific entities of hospice care (Brickner et al., 2004). The authors shared that the hospice referral focus from an HMO perspective was groundbreaking. Of the 19

references, this article had both recent (within five years) literature references as well as four that were outdated, and went back to 1982.

In Ogle's et al. (2003) research, the PCPs had very positive attitudes and values toward hospice care and a majority of the gaps came with the PCPs not knowing that hospice and long-term care facilities can co-exist free of charge to patients without resources or insurance. A concern for the PCPs was communication with the patient and family, as this also became the most identified issue in significant barriers to early referrals (Ogle et al., 2003). The overall result that the groups were "strikingly similar" and the findings of the stated differences could be mainly attributed to difference in level of experience with hospice (Ogle et al., 2003).

A limitation discussed in Ogle's et al. (2002) article included possible physician biases to hospice care. Another was having professional interactions with the primary author as well as the research focusing on one community area. This article had limitations that were similar to the Ogle, 2003. However, the one difference was that the authors did not define the older, middle-aged, and younger cut-off ranges when they discussed the difference in demographics of hospice knowledge and barriers.

Friedman's et al. (2002) research article did not identify limitations and strengths. Yet, the strengths of this article included the interview process that created a standardized questionnaire for the qualitative piece, as well as with the researchers' insight into interviewing various perspective/representatives of the hospice profession.

Theoretical Framework

According to Ajzen and Fishbein's (1980) *Theory of Reasoned Action*, the two major concepts that predict behavioral intention are attitudes and subjective norms

(Glantz, Rimer, & Viswanath, 2008; Hu et al., 2003; Park & Lee, 2012; Vallerand, Deshaies, Cuerrier, Pelletier, & Mongeau, 1992) and these variables are used to predict behavioral intent (Glantz et al., 2008).

Attitudes

According to the theory, this is a learned response based upon an action or object, leading to positive or negative results (Ajzen & Fishbein, 1980). The attitudes toward behavior are influenced by beliefs about a favorable or unfavorable act or object (Park & Lee, 2012). Two components of one's attitude towards a certain behavior are the belief strengths and past exposures (Ajzen & Fishbein, 1980). The beliefs are based on simple true or false responses. The evaluation involves the values or "judgments of worth" one has placed on a certain position (Benoit & Benoit, 2008).

Subjective Norm

This was a concept focusing on the usual beliefs for a given person and that person's expectation of others (Benoit & Benoit, 2008). These subjective norms dealt with what one thinks as well as how one is motivated (Benoit & Benoit, 2008). This also included how influential a peer can be in a given situation (Vallerand et al., 1992). When the concept of subjective norm is the sum of one's normative beliefs, one may easily succumb to social pressure (Park & Lee, 2012).

When one's attitude suggested a persuasive thought, but the social norms dictated we should do something else, the researcher had found that this is where both concepts intersect with behavioral intent. According to the model the immediate determinate for one's behavior is based upon these two variables, the attitudes, and subjective norms (Terry, Gallois, & McCamil, 1993).

Theoretical/Conceptual Framework

The Theory of Reasoned Action (TRA) will serve as the theoretical framework for this project. This theory was originally developed in 1967 by Fishbein to clarify how humans responded based on attitudes (Glantz et al., 2008; Park & Lee, 2012). The original research was known as the information integration theory which focused on the predictions of one's attitude. By 1980 the theory was given specific components and further developed by Ajzen and Fishbein. The final focus was one's behavior using attitudes toward behavior and subjective norms as they relate to one's behavioral intention (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975; Vallerand et al., 1992).

This theory was based on determining a person's action by looking at how behavioral intention arises, with the understanding that the intention is a factor influenced by attitude and subjective norm (Ajzen & Fishbein, 1980; Park & Lee, 2012). There are four major conceptual focuses for the TRA. These concepts are attitudes (A), subjective norm (SN), behavioral intentions (BI), and the behavior itself (Ajzen & Fishbein, 1980; Glantz et al., 2008; Hu et al., 2003; Park & Lee, 2012; Vallerand et al., 1992). When the results focus on the actual behavior, Ajzen and Fishbein found that prior to a behavior, there must be an intention to perform or react. This is called behavioral intention (Ajzen & Fishbein, 1980; Park & Lee, 2012). When one's attitude suggested a persuasive thought, but the social norms dictated another option, the researcher had found that this is where both concepts intersect with behavioral intent. According to the model the immediate determinate for one's behavior is based upon attitudes and subjective norms (Terry, Gallois & McCamil, 1993). As a summation, these two variables correlate with

one's behavior (Benoit & Benoit, 2008) and the behavior is predetermined by the intention.

Application of Theory to Practice

The TRA was applied in the practice setting through the evaluation of the behavioral intention of a HCP to make a hospice referral. Although not incorporated into this specific capstone project, the family members' decision to place a loved one on hospice services, or an eligible patient's receptiveness to hospice care could be utilized. These three entities focused on the attitudes, which included: the person's beliefs; evaluation of behavior; and one's subjective norms. This is the internal and external self-evaluation of one making finite decisions. The behavioral intentions were based upon one's personal desire and what previous HCPs have chosen in the past. If questioned, "Should your patient be referred to hospice?" or "Would your patient be interested in hospice services?" and either or both answer are "yes", then one has a desire to make the referral. A HCP's behavioral intention is validated by their subjective norms. But if the answer is "no", one has no desire to make the hospice referral. This would be based on personal beliefs, such as one's knowledge base, exposure, and/or beliefs about hospice services (Benoit & Benoit, 2008).

According to TRA, attitude is a learned response (Ajzen & Fishbein, 1980). An example of applying the independent variable of attitudes from the TRA within the clinical setting is evaluating how HCPs attitude or personal perception of hospice. As a result, there will be two major components that influence the outcome of the HCPs' attitude: how strongly the negative or positive thought is placed on the consciousness of the HCP, and how past experiences have played in the picture. Concluding that if the

HCP is pleased with what hospice has to offer, the likelihood of making a referral will increase.

The subjective norm is an independent variable that focuses on outside motivational factors. These factors are the HCPs thoughts such as, “What do I believe others would want me to do or expect me to do when it comes to a hospice referral?” Another could be, “How important is it to do what others expect of me when making a hospice referral?” or “Would I be surprised if this patient was dead six months from now?” The HCP can internally acknowledge the terminal illness; prognosticate that no other life-saving medical services are available; and that a patient has a life expectancy of less than six months. Yet, the behavioral intention to make the referral will not be fulfilled unless the HCP has such outside motivating factors that have strong influences, such as an educational intervention.

People’s health decisions are often influenced by how they view the actions they are considering as well as by the impact others have on their motives (Butts & Rich, 2011). So attitudes and social norms must jointly work together to produce a behavioral intention, the dependent variable. An example of this includes the HCP having a positive attitude about hospice services based on past beliefs or even the experiences of colleagues. This type of variable strongly influences the dependent variable of the HCP’s behavioral intention to make a hospice referral. Using the TRA with the hospice referral process can be a health promotion concept for the terminally ill patient.

According to Butts and Rich (2011), scientific theories are multidimensional and yet provide HCPs with the ability to “predict” behaviors. TRA proposes individuals perform a certain act based on their attitude and outside motivating factors. Therefore as

one is exposed to new elements of life, a change in a person's attitude which can be influenced by society can occur resulting in an ever-changing projection of behavioral intentions. The rural HCPs' adherence to interventions in the educational setting will have a substantial effect on increasing future referrals. See Figure 4 below.

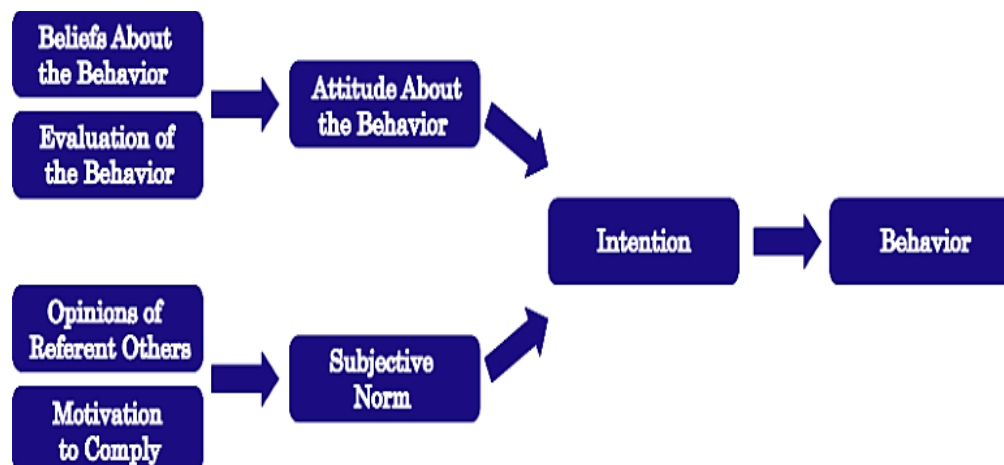


Figure 4. Fishbein and Ajzen's Theory of Reasoned Action

<http://www.soc.iastate.edu/sapp/FAModel.jpg>

The TRA was chosen as a theoretical framework for this capstone over the Theory of Planned Behavior (TPB) due to the focus on an education intervention with pre-intervention surveying. This survey can positively persuade the behavioral plans of the HCPs. Therefore, the TRA's major focus is not the actual conduct of making a change, but more of the thought of doing so, or the intent. For this reason, the study is not attempting to predict whether or not HCPs will make hospice referrals but rather, modify any necessary attitudes and social norms to influence the HCPs behavior intent. Figure 5 below illustrates the Conceptual, Theoretical, and Empirical (C-T-E) linkages for this capstone project.

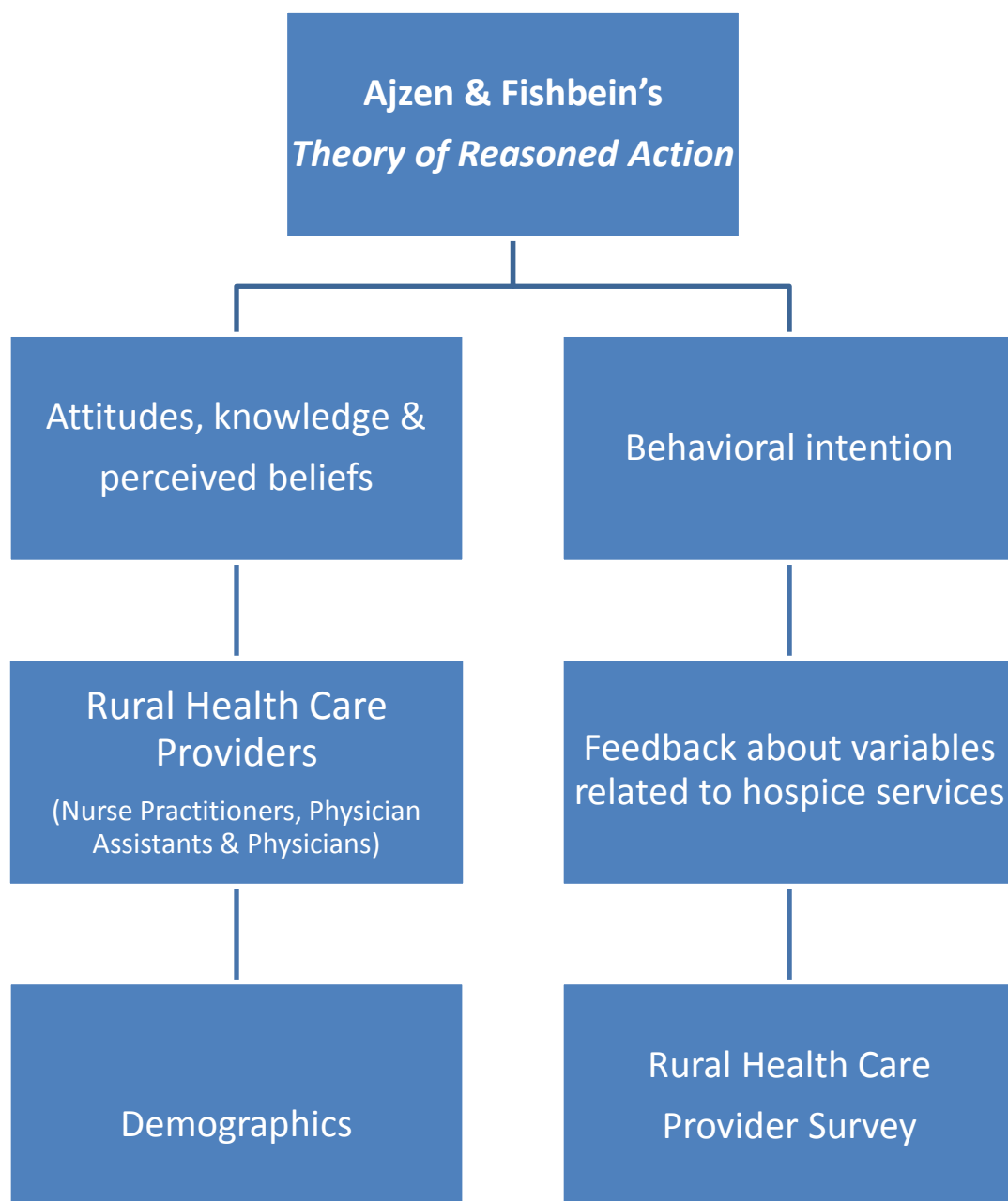


Figure 5. Conceptual – Theoretical – Empirical Framework

Summary

After completing a review of the literature, one can inductively see a need to examine HCPs' behavioral intention with hospice referrals in rural areas. The TRA has been utilized in healthcare models that focused on health prevention or making changes relative to this, (Glantz et al., 2008) but the researcher has not found a correlation between using the TRA and HCPs making hospice referrals in a rural setting. The three critiqued articles above have served as an example of how one can see a correlation between the health-related articles and Fishbein and Ajzen's Theory of Reasoned Action. In summary, the project administrator has provided a review of the theory of reasoned action, while giving the reader a brief synopsis of how this theory converges with three health related peer reviewed articles. This review of the literature identified provided the reader with an expansion of information related to the knowledge, attitudes, benefits, beliefs, and barriers healthcare providers have about hospice services.

CHAPTER III

Project Description

Underutilization of hospice services is a constant challenge in the United States (Ogle et al., 2003). The underutilization in a rural setting can be even more challenging. This capstone project examined rural healthcare providers' behavior intentions about making hospice referrals based on attitudes and knowledge about hospice care as well as the providers' beliefs, benefits, and barriers to hospice service. The project administrator used the *Healthcare Provider Survey* (Appendices A & B) to review the rural HCPs' perspective of hospice services based on knowledge, attitudes, benefit, beliefs, and barriers utilizing a pre- and post-test design. This chapter provided a detailed explanation of methodologies/procedures used to accomplish the completion of this rural hospice referral capstone project.

Project Implementation

The project administrator conducted a rural hospice referral capstone project by means of an approved survey tool for all HCPs in a specified rural county. For purposes of this study, HCPs included nurse practitioners, physician assistants, and physicians in a specified rural area. This tool utilized quantitative quasi-experimental approach to evaluate outcomes using the pre-/post-test classic approach. The pretest-posttest questionnaire method was the most practical approach to assessing the impact of the project administrator's educational intervention. This questionnaire/survey tool was originally entitled, "Physicians' Survey Tool". This survey focused on the attitudes, knowledge, benefits, and barriers to hospice services, policies, and referrals (Ogle et al., 2002; Ogle et al., 2003). The project administrator had permission from the original

author, Dr. Karen S. Ogle (Appendix C), to disperse the tool and to make modifications as necessary. Therefore the survey tool title was changed to the *Healthcare Provider Survey*. The capstone project initially began with verbal public announcements during the September and October medical staff and department of medicine meetings. Over the past three quarterly medical staff meetings prior to the actual educational intervention informal dialogue and information about the upcoming education session was shared with the rural HCPs from the VP of medical services, interim hospital CEO and project administrator over the three months leading up to the event.

After approval from the Institutional Review Board of the University, the project administrator continued collaboration with the interim hospital CEO and VP of medical services. No formal IRB is in place at the hospital but permission to implement the project was obtained from the interim hospital CEO (Appendix D).

The hospital administrative assistant and physical liaison were instrumental in notifying potential participants of the upcoming educational intervention via email. Once approved, the project administrator collaborated with the interim hospital CEO, VP of medical services and South East Area Health Education Center (SEAHEC) to solidify a date. Then the project administrator created a dual-sided flyer announcing the educational intervention. With the interim CEO's approval, flyers were placed in the break room boxes of each HCP and on the display board in the providers' lounge. A personal hand-delivery system was used for HCPs who worked outside of the facility of four facility satellite offices for the hospital. To cover all the bases of outreach, the project administrator forwarded the flyers and reminder announcements to the hospital physician liaison and the CEO's administrative assistant. These hospital staff members assisted the

project administrator in making sure the flyer and all other electronic announcements about the capstone project were emailed to all affiliated HCPs. Mass emails were forwarded to the HCP database four weeks, two weeks and three days prior to the educational intervention. The subject line of the email stated: *Participants needed (physicians, NPs & PAs only) Free CME and Meal!* The content area said: *Please read the attached document.* Page one of the flyer (Appendix E) had a brief note to the HCPs introducing the project administrator, explaining the purpose and focus of the capstone project. The second page was a colorful flyer summarizing the note of the reverse side. The purpose of the colorful flyer is to create an eye-catching summary that included the date and time of the sessions along with the incentives for participation. The flyer and emails to the HCPs included a summarization of the project. The word of mouth and hand deliveries was a relaxed way to introduce the project administrator and answer any brief questions the HCPs may have about the project.

In order for the participants to receive CME credit the project administrator had to follow SEAHEC's guidelines for approval to be an educational session. The project administrator was connected to SEAHEC's CME director and nursing director for the continuing education department. The project administrator met with this team two months prior to the educational intervention to discuss the objective and logistics of having a course for CME credit for the rural HCPs affiliated with the specified rural hospital. The staff was receptive and considered this a win-win situation in order to connect with more of the HCPs in the identified county for the future. The project administrator completed SEAHEC's office of continuing medical education's application and planning guide for CME educational activity credit on October 9, 2014 (Appendix

F). Since a physician had to be the course director, the local hospital's VP of Medical services agreed to be this designee. The application was identified at event # 45120 and one credit for PAs and physicians were to be awarded through the American Medical Association and one credit for NPs would be awarded through American Nurses Credentialing Center's Commission on Accreditation. This educational session was identified as a joint effort with SEAHEC, the University and the local rural hospital. A *Continuing Education Joint Providership/Co-Provider Agreement* (Appendix G) was also signed by the project administrator and the director of continuing education. The VP of Medical Services also had to sign a *Course Director Agreement* (Appendix H). Upon approval from the University, the educational intervention and scheduled implementation was finalized with SEAHEC continuing education representative and the hospital interim CEO. Multiple stakeholders were involved in the planning and hosting of the educational intervention. Key representatives from the hospital clinical liaison, administrative assistant, information technology office, and hospital maintenance were coordinated to implement the project.

Setting

As previously stated, the setting of the project was in a rural county in the southeastern region of the United States. This location was chosen based on past research that identified this area as having major chronic health conditions and a need for hospice referrals. The actual educational intervention took place in the educational department of the local hospital.

Sample

The project administrator originally began compiling the location of a majority of the HCPs in the identified area using the local phone book. Through email correspondences and casual conversations during medical staff meetings, it was noted that the hospital's administrative assistant had a point of contact for all HCPs affiliated with the local hospital. This sample collection was compared with the project administrator's past phone book search resulting in a database of all of the rural HCPs for the county. The database included information such as the names, work addresses, phone numbers, and email addresses of the HCPs. Two fee-for-service methods of participant collection were available. One was through the state board of nursing, to identify practicing nurse practitioners in the area and other was the state medical board to identifying PAs and physicians who may be practicing in the identified area. These options were deemed costly for this capstone project. Without charge, the largest hospice provider in the rural area gave the project administrator a list of the practicing physicians within the county, but this list lacked hospitalists (physicians, PAs and NPs) who worked for the rural hospital. The best method for identifying all of the rural HCP was through the administrative assistant's database at the local rural hospital. This option was free. It should be noted based upon no specific evidence the anesthesiologists, radiologist, nurse anesthetists, ophthalmologists, chiropractor, and dentists were excluded based upon their reduced likelihood of making a referral and after dialogue with the VP of medical services.

The rural HCPs surveyed were providers with the authority given by the state BON and/or medical board to practice medicine with privileges to make hospice

referrals. In order to increase the sample size, the capstone project involved doctors of osteopathy, medical doctors, and also include nurse practitioners and physician assistants. Finally, these HCPs must have been actively practicing in the identified rural area. Additional demographic information included gender, years of practice, practice setting, specialty, and whether the HCP relocated specifically to practice in the area or was originally from the area.

Convenience sampling was used for the recruitment of qualified participants. The participants were recruited through convenience sampling of selected rural healthcare providers in a rural county of the southeastern area of North Carolina. There were 67 providers affiliated with the local rural hospital. This included the physicians, nurse practitioners, and physician assistants. Based on recommendations for the VP of medical services, providers who provided limited chronic care or did consultations outside of the county were omitted from the invitation. This included radiology, podiatry, urology, pathology, anesthesiology, ophthalmology, psychiatry, chiropractic and dental services. This resulted in an opportunity to invite 36 potential participants. Since this is a pilot study, the project administrator was interested in having full participation of at least 14 rural HCPs, at least 40% of the group. Vetting participation was a multi-prong approach as stated above. An additional way to enhance participation was by offering continued medical education (CME) credit through a collaborative effort with the local South East Area Health Education Center (SEAHEC). The sample was obtained on a volunteer basis.

The project administrator had several email correspondences as well as telephone and personal meetings with administrative members of SEAHEC. These members were

stakeholders who voiced the importance of the educational intervention. In collaboration with the University, SEAHEC and the local rural hospital, the project administrator implemented the educational intervention, and participants were awarded one CME credit.

Project Design

The design of the educational intervention was a multi-prong approach, with the first phase leading to an intention and the second to actual behavioral change.

Phase One

Phase one was the actual educational intervention as well as the recruitment of the qualified participants. The design of the intervention involved the setting and the educational intervention. The setting for the lunch session (November 18, 2014 at noon) was in the hospital administration's board meeting room. This was a change in venue due to an admitted oversight by a member of the education department who had initiated an all-day class at the same location. The setting for the dinner session (November 18, 2014 at 6pm) was in the large educational room of the hospital. To enhance provider knowledge and improve practice outcomes, Bordage, Carlin, and Mazmanian (2009) recommended the use of multimedia instruction and exposure. The project administrator used a PowerPoint program as the primary guide to present the hospice information (Appendix I). The instructional exposures included:

- a folder with a printout of the PPT slides which included an area to take notes,
- reading of a story about a dying provider who chose hospice,
- demonstrating the use of hospice eligibility applications,
- the use of CME,

- the pre-survey/post survey questions themselves,
- open discussion about hospice care and services.

Three hospice agencies were invited to display additional information about their agency and hand out general hospice information to healthcare providers and the general public in the main foyer of the hospital. Participants attending the educational intervention were asked to register with names, title, email address, and were provided informed consent to participate in the activity. The educational session began with the VP of medical services introducing the project administrator. The project administrator began each session with reviewing the disclaimers, according to SEAHEC guidelines, followed by a consent form for the participants. The project administrator then asked the participants to open the numbered folder in front of them to find the green survey labeled *Healthcare Provider Pre-Survey* (Appendix A) with the same number in the top right hand corner as the folder. The participants were given approximately 12 minutes to complete the pre-survey and place their results in a locked box labeled surveys. The project administrator was the only person in charge of the anonymous surveys as indicated to the IRB.

The project administrator facilitated the educational session utilizing PowerPoint (PPT) slides (Appendix I). The environmental educational culture was one of a collegial manner in which the participants dialogued about topics presented and discussed relevant the case studies that some participants had experienced. The objective was to:

- Differentiate palliative and hospice care.
- Discuss the basic requirements for hospice eligibility.
- Review state and local statistics.

- Examine how hospice benefits the providers.
- Recall the process connections for making a referral.
- Review challenges related to prognostication.

An area of particular focus will be the participants' open dialogue about their behavioral intention to make a referral based upon the given case studies. The key question which ended the introduction of each case will be asking participants, "Would it be a surprise if this patient were to die within six months" (Lorenz et al., 2008, p. 150).

Once the PPT slides were 75% complete, the project administrator turned the session over to the VP of medical services. He shared personal experiences about hospice care and services in our county. Some key points about the educational intervention were:

- The providers' fear of losing the connections with their patients after the hospice admission (Weckmann, 2008). It was imperative to inform the providers about the referral process and what happens to their patients after hospice admissions.
- To close the PPT session with an introduction to two hospice mobile applications (App) entitled, *VITAS*[®] and *Hospice in a Minute*.

The *VITAS*[®] App assisted the participants with eligibility criteria, allowed the participants to review specific qualifying diagnoses and also had a body mass index calculator. *Hospice in a Minute* App was introduced to the participants to increase their comfort, competence, and knowledge regarding hospice and referrals. This App provided the participants with the types of hospice services offered, admission criteria, local hospice locator, and suggestions on discussing hospice care with patients.

Once the PPT slides were completed the participants were thanked and asked to complete the post-survey. The post-survey was pink with the same number in the right hand corner as the green pre-survey. Once the survey was complete the results were placed in the locked box controlled by the project administrator.

The second and final phase of the educational session was the project administrator asking the participants to be sure they placed their name and email address on the SEAHEC paper provided. Each participant provided an email address. The project administrator scanned and emailed the sheet to SEAHEC as a means to evaluate the effectiveness of the educational session.

During this final phase and four weeks post educational session, SEAHEC agreed to allow the project administrator to ask the participants how many hospice referrals had been made in the past month.

This data from the surveys and SEAHEC evaluations were compiled, compared, and contrasted for the analysis of the results. Frequency analysis was used to generate descriptive statistics for categorical variables. Analysis of variance (ANOVA) was used to compare means of continuous variables grouped across categorical variables. The timeline in Table 2 below provides more specific sequential details about the capstone project.

Table 2

2014 – 2015 Timeline and Estimated Budget

Timeline						
June - July	Aug- Sept	Oct	Nov-Dec	Jan-Feb	March	April
Initial Introduction/consent form created Permission to use survey tool	Work on proposal Submit SEAHEC application for CME	Work on Educational Intervention & IRB Approval	Pre-Survey Implement Educational Intervention Post-Survey Search for statistician	1-month behavioral question Data Analysis Finalize Statistics with statistician	Write full capstone project	Oral Defense Thank you notes to (SEAHEC, hospital CEO, administrative assistant and provider liaison, HCPs through emails left, University IRB, Chair and committee members, statistician)
			Budget			
	Purchase green and pink paper \$10	Handout Flyers \$20		Statistician and data analysis \$300	Editor \$150	TOTAL EXPENSES \$480

Protection of Human Subjects

The protection of participants was addressed by requiring participants to read a consent form. The form stated that participation was voluntary. Information gathered was anonymous and kept confidential. Patients did not disclose identifiable information during data collection. Next, the consent form explained the risk of participating in the

educational session as minimal to none without ethical implications. The incentives for participation were an optional free meal and one free CME credit. There was no penalty for declining to participate; however, participants gained insightful knowledge.

It is important to note, there were a small number of HCPs who knew the principle administrator personally. This could have been a potential for ethical concern of the statistical results of this capstone project. Additionally, some participants may have recognized the principle administrator as an employee of a hospice agency and misinterpret the project as promotion of this agency. All participants were informed of this connection. All known issues of such ethical concern were addressed after reading the project disclaimer and informed consent (Appendix J).

Participant surveys were maintained confidentially in locked box within the locked office of the project administrator. Upon completion of the project, de-identified data will on file at the University. There were no major risks for the participants in this research. Participation in the study was voluntary and remained confidential. The participants had the option to opt out of the study at any point, with no repercussions. Participants could have enjoyed a meal and educational session without participating in the surveys. Participants who fully participated in the entire capstone project were given CME credit through SEAHEC after the final evaluation of the session.

Instruments

The project administrator's capstone project focus was to examine the HCPs' behavioral intentions for making hospice referrals. The data collection involved modifying an existing Physicians' Survey Tool with permission from the original author. The tool was a pen/paper pre-post-survey that questioned the theory of reasoned action's

theoretical concepts of attitudes and social norms that lead to behavioral intention for referring patients to hospice care.

The original authors pilot-tested this questionnaire by using small groups of academic and private practice physicians in other communities as well as primary care residents in the same community (Ogle et al., 2002). This led to subsequent revisions prior to the implementation of the final product. This will be noted as a limitation to the project. The project administrator estimated that the strength of this capstone project to be replicated is high and the questionnaire has accurate measurement intentions. Upon research of the survey tool, the project administrator found no reliability or validity. The project administrator found no survey tools related to healthcare of this kind yet found another similar tool as well as the use of this tool in at least two peer-reviewed articles.

Data Collection

Data was collected using a pre-educational intervention survey, educational intervention, and post-educational intervention survey. This survey determined if the HCPs' dependent variable of "behavioral intention" for hospice referral influenced the independent variables: attitudes and social norms about hospice care. The data was quantitatively analyzed to determine the significance of the educational intervention on hospice services and care. Several variables were analyzed such as comparison of totaled scores from the pre-survey and post-survey, age, current residence, years of practice, and hospice education. The surveys consisted of five sections. These sections were broken into nine sections separating each entity of the survey to certain area. See Table 3 below.

Table 3

Summation of Correlation Pre and Post Surveys Questions

Pre Survey Question Numbers	Section	Post Survey Question Numbers	Four Weeks
1 – 10	Section # 1 – Demographics		
14 – 27	Section #2 – Attitude	2 – 15	
28 – 40	Section # 3 – Knowledge	16 – 28	
41 a – e	Section # 4 – Beliefs	29 a – e	
43 a – g	Section # 5 – Benefits	30 a – g	
44 a – j	Section # 6 – Barriers	31 a – j	
12	Section # 7 – Behavioral Intention	1	
11 & 13	Section # 8 – Actual Behavior		Independent Question
42	Section # 9 - Belief		

The first section focused on demographics and practice variables (Ogle et al., 2002). The second section surveyed the HCP's attitudes utilizing a five-point Likert scale, ranging from strongly agree to strongly disagree. The third section focused on hospice knowledge and the possible responses were "agree," "disagree," and "not sure" (Ogle et al., 2002). The fourth and ninth sections focused on hospice beliefs. The fourth section's response was one question reduced to sub-questions about hospice beliefs which included "Very Important, somewhat important to not important" (Ogle et al., 2002). The fifth section focused on hospice benefits ranging from "very beneficial" to "somewhat beneficial" to "Not beneficial" (Ogle et al., 2002). The sixth section inquired about barriers to utilizing hospice. This area had sub-categorical questions with answers ranging from "strong barrier" to "moderate barrier" to "negligible barrier" (Ogle et al., 2002). The seventh section was a pre and post question inquiring about the HCPs' behavioral intention (how likely are you to consider) to make a hospice referral. The eighth section inquired about the actual number of referrals made in the past four weeks.

Upon completion of the educational intervention, participants were asked to complete the post-survey followed by reading the debriefing statement. (Appendix K)

Summary

This capstone project surveyed rural hospice-referring HCPs in a county in the southeastern part of the United States. The expectation of this project was to establish the following: (a) a correlation between the HCPs' attitude and social norms of hospice services with the behavioral intention of making a hospice referral, and (b) and to implement an intervention to enhance the hospice services in an underserved area. Both the pre and post surveys examined the variables of knowledge base, attitudes, and social norms according to the TRA, as they impact the behavioral intention for making a hospice referral.

Thirty-six participants were invited to the educational intervention. Fifty percent of those who were invited, eighteen participants (n=18) consented to participate in this capstone. These participants consented to participate in this capstone project and completed the pre and post survey tools without difficulty or emotional distress. No participants contacted the project administrator, the committee chairperson, or the contact person for the IRB to ask for removal of data from the project. Subsequently, 18 surveys were reviewed and statistically analyzed for comparisons and improvements.

CHAPTER IV

Results

This capstone project utilized a quantitative pre-test, educational intervention, posttest approach to determine rural HCPs' behavioral intention for hospice referrals. Appendix A and B included the questions presented to each participant to measure the significance of the project. Each area of the survey was divided into nine separate sections. Data reported included results of a pre and post survey for various healthcare providers practicing as physicians, nurse practitioners, or physician assistants. The surveys included the demographic information, and the completed survey questions.

Statistical Methods

Descriptive statistics were utilized to calculate all variables. For comparative analyses, nonparametric statistical methods were used as the survey data were ordinal and not normally distributed. Pre- and post-score totals for sections 2-8 were compared using the Wilcoxon signed-rank test for paired data. Pre-test scores were compared against demographic variables using the Wilcoxon rank sum test for categorical variables and Spearman correlations for ordinal variables (i.e., age range and years of practice). SAS® Enterprise Guide® 6.1 was used for all analyses. A p-value of 0.05 was considered statistically significant.

Sample Characteristics

Eighteen (n=18) rural health care providers participated in the capstone project. There was an equal distribution of physicians (DO & MD) and advanced practice providers (NP & PA). These HCPs have the professional ability to initiate hospice referral orders. The practicing demographics of each participant are indicated in Table 4.

Table 4

Distribution of Participating Rural Health Care Providers

Provider Type	Frequency	Percent
DO	2	11.11
MD	7	38.89
NP	7	38.89
PA	2	11.11
TOTAL	18	100

Major Findings

The educational intervention focused on hospice care and services can impact the behavioral intention of rural healthcare providers (HCPs) to make an eligible hospice referral Table 5 compares pre and post score totals using the Wilcoxon signed rank test.

Table 5

Pre-test Posttest SAS Results

Section	Pre mean (standard deviation)	Post mean (standard deviation)	p-value
2 – Attitudes	179.7 (25.7)	178.5 (15.9)	0.9294
3 – Knowledge	179.7 (39.2)	227.5 (9.9)	<0.0001*
4 – Belief	93.6 (5.9)	94.4 (5.9)	0.2500
5 – Benefits	106.9 (13.5)	108.6 (11.9)	0.2500
6 – Barriers	143.6 (22.2)	135.6 (24.0)	0.0034
7 – Behavioral Intent	16.9 (4.3)	19.7 (1.2)	0.0156*

The total scores for sections 3 and 7 were significantly higher on the post-test than the pre-test. The project administrator's educational intervention had an impact on the rural HCPs' behavioral intention to make a hospice referral. Therefore the assumption can be made that improving the HCPs' knowledge base about hospice care impacted the behavioral intention.

The total score for section 6 (barriers) was significantly higher on the pre-test than the post-test and could have impacted the social norms of the HCPs. The total score for sections 2, 4, and 5 were not significantly different between the pre-test and the post-test.

More specifically, the only other correlations that were statistically significant are section 4 (beliefs), with age and years of practice impacting the HCPs' beliefs about hospice care on the pre-survey. The correlation coefficient for age and pre-score total is 0.52671 ($P < 0.0247$). The correlation coefficient for years of practice and pre-score total is 0.52881 ($p < 0.0240$). The pre-score total increases as provider age increases and as years of practicing experience increase. (Table 6)

Table 6

Correlation between Age and Provider Experience

Spearman Correlation Coefficients, N = 18 Prob > r under H0: Rho=0		
Section	Age-Range	Yrs-Practice
2	0.10517	0.00317
	0.6779	0.9900
3	0.38488	0.45432
	0.1148	0.0582
4	0.52671	0.52881
	0.0247*	0.0240*
5	0.38723	0.40479
	0.1124	0.0957
6	0.25518	0.19925
	0.3068	0.4280
7	0.31988	0.36790
	0.1957	0.1331

Summary

All the other correlations are not statistically significant, meaning there is no statistically significant relationship between the respective variables. Rate response to determine the significance of the actual behavior to make a hospice referral was poor. The four week data return after the educational intervention was zero out of 18.

CHAPTER V

Discussion

Although this capstone project is a modification of an original research project from over ten years ago, this was the first known project of its kind. There may be more but not in the literature which focused on a specific action to improve the quality of clinical care (hospice referral rate) through an education intervention. The project administrator found statistical significance, limitations, and implications to quality improvement of practice. In the project administrator's survey a majority of the rural HCPs had a positive attitude about hospice. During the educational intervention and on the survey, the providers positively valued hospice in general. According to the TRA, the survey itself can make an impact on social norms, but the project administrator believes the dialogue between case studies and colleagues during the educational intervention had a strong impact.

Implications of Findings

An important significance was the ability to utilize this setting to enhance the HCPs' knowledge-base of hospice. During brief conversations palliative care workers and providers must dialogue with other primary care and specialty providers about palliative and hospice care. Knowledge about an issue can improve behavioral intention as it had in this capstone project. This significant entity was consistent with past research (Brickner et al., 2004; Ogle et al., 2003; Ogle et al., 2002). There was no data during the four week follow up question about the HCPs' likeliness to consider making a hospice referral.

Application to Theoretical Framework

Azjen and Fishbein's Theory of Reasoned Action was offered as the theoretical model for influencing behavioral intentions for rural HCPs to make hospice referrals based upon: attitudes, knowledge, belief, benefits, and barriers. Each of the surveys were categorized in this manner with a specific focus of questions relating to the categorical section. The theory itself seems to work for the project, but continued modification of the survey tool and an increase in the sample size could assist with building the case. The finding of change in the actual behavior to make a hospice referral is indicative of congruency with the theoretical framework.

Limitations

The project administrator's data collection during the project was rigorous but structured. The data was collected utilizing a pre-test posttest survey method. With the progression of technology, the data collection method could have been streamlined with an electronic version. The project administrator found one specific recommendation was to implement the project earlier in the year to measure a longitudinal impact of the project and specific behavioral changes. The post survey and one month process of data collection during this DNP project, as Zaccagnini and White (2011) indicated, "...did not permit the collection of enough data points to achieve statistical significance" (p. 457).

There are several limitations with the output or immediate results. First, the educational intervention had several options for the various types of learner, but when a participant had a particular focus on one area it took away from the time allotted to another piece of the educational presentation. For example, there were interactive hospice eligibility questions embedded in the presentation that should have been held until the

end and the technology for switching back and forth was a challenge. The number of participants was not enough to make a statistical impact on the outcomes from a short or long-term perspective; therefore, the survey results did not yield much significance. Additionally the project lacked generalizability to future studies.

The project administrator failed to inquire about the usefulness of the phone apps entitled, *VITAS*[®] and *Hospice in a Minute* which were introduced to the participants during the educational session. This could have been a window of opportunity for more qualitative information about the ease or assistance used to make a hospice referral.

Despite a conglomerate of background research to improve participation, the respondent numbers were too low (n=18) to make a statistical impact. A higher number of participants could have yielded more valid and reliable responses. Considering the response rate, the project administrator would reconsider the exclusion of healthcare providers not affiliated with the local rural hospital and also include providers with their own practices within the county. The project administrator did not evaluate the associations between each of the categorical variables using chi-square (χ^2) testing. Although not needed, due to the limited significance, it would have been an option to evaluate the knowledge section of the surveys to see if there was a particular area that changed. Therefore further evaluation of data with a larger population may have yielded more significant results.

Implication for Nursing

These findings are significant to the quality of patient care in several ways. First, the project demonstrated that nursing leadership can have a major role on impacting colleagues with the same or similar clinical practicing privileges. Having this educational

session has begun to improve the access rural patients need to hospice care as well as impacting the quality of care providers implement. Second, with a rural residence of one of the unhealthiest counties in the state, nursing practice impact health outcomes through research and the implementation of projects based upon chronic diseases of such rural areas. There is a need for increased hospice education within this facility. This educational intervention can serve as a guide for the hospital's education department to share during orientation of novice and seasoned providers.

A comprehensive literature review identified survey tools for like content that was outdated. A replication of this project with a focus on each survey question within each category would be most beneficial. The implementation of further projects of this nature could continue to validate the current tool and make improvements wherever needed.

There was discussion with SEAHEC CME director about how to improve evaluations during phase two of the project. At this time, there were no recommendations, but improving response rates once the participants have dispersed can be a topic for future research or a capstone project.

Recommendations

The major lesson learned was to take clear advantage of technology whenever the opportunity arises. Since each participant connected with the rural hospital had an email account, the project administrator would reconsider using an electronic survey form instead of the pen and paper approach.

Though each participant completed the surveys, in the future, the project administrator would collaborate with other experts in the field to pilot test and reduce the number of questions to include those of most significance. Doing so would assist with

improving post-secondary clinical education about hospice and facilitate the development of a valid survey tool. This tool could be universal and not just for rural health.

Considering HCPs are just one entity of obtaining a hospice referral, this project was an initial study for the project administrator to review and evaluate why hospice referrals are low in the area. The project administrator is now interested in focusing on the patient and family member's point of view about hospice care and services.

Additionally, with some additional modifications of the survey itself, this capstone project could be reapplied in a different practice setting, a group of potential or eligible hospice patients and even family members to assist decision to place a loved one on hospice services, all to determine receptiveness or behavioral intention for pursuing hospice care.

Conclusion

In conclusion, the educational implementation and results of this capstone project improved rural HCPs' knowledge about hospice which positively impacted rural HCPs' behavioral intention to make hospice referrals. If validated, further insight into this issue could have a global effect on hospice referral implementation and practice. Finally, future research is needed to focus on behaviors one has towards hospice care.

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Appendices

Appendix A

Health Care Provider Survey

Pre-survey

Section 1 Demographics: This is a four-part survey consisting of questions about your professional background and experience. Please check the correct answer(s) to the following questions.

1. Healthcare provider type or your specific degree to practice is: *(Check one)*
 - a. Doctor of Osteopathy
 - b. Medical Doctor
 - c. Nurse Practitioner
 - d. Physician Assistant
2. Gender: *(Check one)*
 - a. Female
 - b. Male
3. Your current age: *(Check one)*
 - a. 30 years or less
 - b. 31 to 40 years
 - c. 41 to 50 years
 - d. 51 to 60 years
 - e. 61 years or >
4. How many years have you been in practice since completing formal training? *(Check one)*
 - a. < 1 year
 - b. 1-5
 - c. 6-10
 - d. 11-15
 - e. 16-20
 - f. 21 years or >
5. Where you born in this county? *(Check one)*
 - a. Yes
 - b. No
6. Do you currently reside in this county? *(Check one)*
 - a. Yes
 - b. No
 - c. If so, specify _____ month(s) _____year(s)
7. How many years have you been practicing in this county? *(Check one)*
 - a. < 1 year
 - b. 1-5
 - c. 6-10
 - d. 11-15
 - e. 16-20
 - f. 21 years or >
8. Current primary practice area: *(Check one)*
 - a. Family practice
 - b. Internal medicine
 - c. Emergency medicine
 - d. Hospitalist
 - e. Pediatrics
 - f. Other (please specify) _____

9. Current primary practice site: (Check one)
- Private
 - Community Health
 - Hospital
 - Other (please specify) _____
10. Which of the following best indicates the number of patients and/or families with whom you have discussed or recommended hospice as an option in care during the last three (3) months? (Check one)
- _____ None
 - _____ 1 – 5
 - _____ 6 – 10
 - _____ 11 – 15
 - _____ > 15

11. Prior to this educational session, how likely are you to **consider** making a hospice referral? (Circle One)

Highly Likely	Undecided	Not Likely
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12. In the past month, how many hospice referrals have you made?
- 0-3
 - 4-7
 - 8-11
 - 12 or more

Section 2 Please respond to the statements in Section 2 of this survey by indicating the extent you agree or disagree

	A. Strongly Agree	B. Somewhat Agree	C. Not sure	D. Somewhat Disagree	E. Strongly Disagree
13. When there is no longer a realistic hope for cure for a patient and life expectancy is limited to months rather than years, hospice should always be included in patient/family discussions regarding treatment options.					
14. Discussion of hospice gives patients and families a sense of "hopelessness"; i.e., a sense that "nothing more can be done".					
15. Hospice is a more cost-effective model of terminal care than that provided by hospital, nursing home, or at home with home health services.					
16. Hospice patients, in general, require less skilled care than patients who receive terminal care at the hospital, nursing home, or at home with home health services.					
17. Hospice services should be discussed with patients prior to the terminal stage of their disease.					
18. When hospice services are used, the primary/referring provider loses control over management of care.					
19. Hospice services require more of your time for paperwork than home health services.					
20. Hospice personnel have the clinical expertise to provide all services and support necessary for terminal care in the home.					

21. Determining who is responsible for medical management and decision making is difficult when hospice is involved.					
22. Hospice is a valuable alternative for the provision of terminal care as compared to hospital, nursing home or home health services.					
23. Hospice is effective because of its interdisciplinary approach.					
24. The healthcare provider is the most appropriate person to introduce the concept of hospice to the patient and family.					
25. I am comfortable discussing a hospice referral with patients and families.					
26. When patient care goals change from rehabilitation to palliation and support, transfer from home health services to hospice should be facilitated.					

Section 3 Please indicate in Section 3 whether you agree or disagree with each of the following statements

	A. Agree	B. Disagree	C. Not Sure
27. A patient must have a family member or significant other(s) as caregiver(s) 24 hours per day to be eligible for home hospice referral.			
28. Patients receiving radiation therapy and/or chemotherapy for palliation of symptoms are not candidates for hospice referral.			
29. For patients receiving hospice services, all proposed diagnostic tests or changes in therapy must first be approved by hospice.			
30. All adults and children who are terminally ill are candidates for hospice care, not just those with a cancer diagnosis.			
31. If a referral to hospice has been made, someone from hospice team must be present at the time of patient's death.			
32. If a terminally ill patient lives beyond the six month prognosis, hospice services must be terminated.			
33. A provider must be present to pronounce a patient dead.			
34. Hospice referral may be made for social work, chaplain services, and volunteer services, even when skilled nursing care is not required.			
35. A patient may reside in a nursing home and receive hospice coverage.			
36. The provider can be reimbursed for revisions in the plan of treatment and telephone contacts when a patient is receiving hospice services.			
37. Patients can drop hospice benefits and resume them at a later date if they desire.			
38. Patients must have health insurance to receive hospice services.			
39. The patient must be given a prognosis of six (6) months or less to be eligible for hospice services.			

Section 4 Please answer each question in Section IV as indicated. Any comments, where designated in the area below.

40. When making a referral to hospice, please indicate the importance of each of the following reasons for the referral(s). (Check on box for each, indicating level of importance)

	A. Very Important	B. Somewhat Important	C. Not Important
a. Anticipated need for pain/symptom management and skilled nursing care.			
b. Immediate need for pain/symptom management and skilled nursing care.			
c. Anticipated need for psychosocial support for the patient and/or family.			
d. Immediate need for psychosocial support for the patient and/or family.			
e. Patient and/or family were requesting help.			

Comments:

41. In the "ideal" hospice care delivery model, a patient should receive care for: (Please check one)

- a. _____ less than 2 weeks
- b. _____ 2 to 4 weeks
- c. _____ 5 to 8 weeks
- d. _____ 2 to 4 months
- e. _____ 5 to 6 months
- f. _____ 7 to 8 months
- g. _____ Other: _____ (please specify)

42. What do you perceive to be the benefits of hospice referral in this community? (Check one box for each)

	A. Very Beneficial	B. Somewhat Beneficial	C. Not Beneficial
a. Expert pain and symptom management.			
b. Financial benefits to patient and family.			
c. Skilled care of the terminally ill.			
d. Availability of trained interdisciplinary team of health care professionals.			
e. Availability of trained hospice volunteers			
f. Allows patients to die at home.			
g. Other (Please specify):			

Comments:

43. What do you perceive to be the barrier to hospice referral in this community? (Check one box for each)

	A. Strong Barrier	B. Moderate Barrier	C. Negligible Barrier
a. I am not familiar with hospice services in this community.			
b. I have been dissatisfied with hospice services patients have received in the past.			
c. Patient/families are unwilling or not ready to elect hospice services.			
d. I am uncertain of the length of coverage under the hospice benefit.			
e. I am uncertain of the types of service covered under the hospice benefit.			
f. I do not wish to change care providers if the patient is already established with a home health agency.			
g. I do not feel response to referrals is timely.			
h. I do not wish to lose contact and management of patients in the terminal stage of care.			
i. I feel there is a lack of timely communication between myself and hospice providers.			
j. Patients or families are reluctant to have strangers in their home.			
Other (please specify):			

Comments:

44. Please offer suggestions regarding how hospice services might improve to better serve the needs of your patients.

Thank you for your assistance!

Appendix B

Health Care Provider Survey

Post survey

Section 1 **Demographics:** This is a four-part survey consisting of questions about your professional background and experience. Please check the correct answer(s) to the following questions.

1. At the completion of the educational session, how likely are you to **consider** making a hospice referral?
(Circle One)

More Likely	Undecided	Not Likely
-------------	-----------	------------

2. In the past month, how many hospice referrals have you made?
- a. 0-3
 - b. 4-7
 - c. 8-11
 - d. 12 or more

Section 2 Please respond to the statements in Section 2 of this survey by indicating the extent you agree or disagree

	A. Strongly Agree	B. Somewhat Agree	C. Not sure	D. Somewhat Disagree	E. Strongly Disagree
3. When there is no longer a realistic hope for cure for a patient and life expectancy is limited to months rather than years, hospice should always be included in patient/family discussions regarding treatment options.					
4. Discussion of hospice gives patients and families a sense of "hopelessness"; i.e., a sense that "nothing more can be done".					
5. Hospice is a more cost-effective model of terminal care than that provided by hospital, nursing home, or at home with home health services.					
6. Hospice patients, in general, require less skilled care than patients who receive terminal care at the hospital, nursing home, or at home with home health services.					
7. Hospice services should be discussed with patients prior to the terminal stage of their disease.					
8. When hospice services are used, the primary/referring provider loses control over management of care.					
9. Hospice services require more of your time for paperwork than home health services.					
10. Hospice personnel have the clinical expertise to provide all services and support necessary for terminal care in the home.					
11. Determining who is responsible for medical management and decision making is difficult when hospice is involved.					

12. Hospice is a valuable alternative for the provision of terminal care as compared to hospital, nursing home or home health services.					
13. Hospice is effective because of its interdisciplinary approach.					
14. The healthcare provider is the most appropriate person to introduce the concept of hospice to the patient and family.					
15. I am comfortable discussing a hospice referral with patients and families.					
16. When patient care goals change from rehabilitation to palliation and support, transfer from home health services to hospice should be facilitated.					

Section 3 Please indicate in Section 3 whether you agree or disagree with each of the following statements

	A. Agree	B. Disagree	C. Not Sure
17. A patient must have a family member or significant other(s) as caregiver(s) 24 hours per day to be eligible for home hospice referral.			
18. Patients receiving radiation therapy and/or chemotherapy for palliation of symptoms are not candidates for hospice referral.			
19. For patients receiving hospice services, all proposed diagnostic tests or changes in therapy must first be approved by hospice.			
20. All adults and children who are terminally ill are candidates for hospice care, not just those with a cancer diagnosis.			
21. If a referral to hospice has been made, someone from hospice team must be present at the time of patient's death.			
22. If a terminally ill patient lives beyond the six month prognosis, hospice services must be terminated.			
23. A provider must be present to pronounce a patient dead.			
24. Hospice referral may be made for social work, chaplain services, and volunteer services, even when skilled nursing care is not required.			
25. A patient may reside in a nursing home and receive hospice coverage.			
26. The provider can be reimbursed for revisions in the plan of treatment and telephone contacts when a patient is receiving hospice services.			
27. Patients can drop hospice benefits and resume them at a later date if they desire.			
28. Patients must have health insurance to receive hospice services.			
29. The patient must be given a prognosis of six (6) months or less to be eligible for hospice services.			

Section 4 Please answer each question in Section IV as indicated. Any comments, where designated in the area below.

30. When making a referral to hospice, please indicate the importance of each of the following reasons for the referral(s). (Check on box for each, indicating level of importance)

	D. Very Important	E. Somewhat Important	F. Not Important
f. Anticipated need for pain/symptom management and skilled nursing care.			
g. Immediate need for pain/symptom management and skilled nursing care.			
h. Anticipated need for psychosocial support for the patient and/or family.			
i. Immediate need for psychosocial support for the patient and/or family.			
j. Patient and/or family were requesting help.			

Comments:

31. In the "ideal" hospice care delivery model, a patient should receive care for: (Please check one)

- a. _____ less than 2 weeks
- b. _____ 2 to 4 weeks
- c. _____ 5 to 8 weeks
- d. _____ 2 to 4 months
- e. _____ 5 to 6 months
- f. _____ 7 to 8 months
- g. _____ Other: _____ (please specify)

32. After this educational intervention, I am more likely to initiate hospice referrals for eligible patients.

- a. Yes
- b. No

33. What do you perceive to be the benefits of hospice referral in this community? (Check one box for each)

	D. Very Beneficial	E. Somewhat Beneficial	F. Not Beneficial
h. Expert pain and symptom management.			
i. Financial benefits to patient and family.			
j. Skilled care of the terminally ill.			
k. Availability of trained interdisciplinary team of health care professionals.			
l. Availability of trained hospice volunteers			
m. Allows patients to die at home.			
n. Other (Please specify):			

34. What do you perceive to be the barrier to hospice referral in this community? (Check one box for each)

	D. Strong Barrier	E. Moderate Barrier	F. Negligible Barrier
k. I am not familiar with hospice services in this community.			
l. I have been dissatisfied with hospice services patients have received in the past.			
m. Patient/families are unwilling or not ready to elect hospice services.			
n. I am uncertain of the length of coverage under the hospice benefit.			
o. I am uncertain of the types of service covered under the hospice benefit.			
p. I do not wish to change care providers if the patient is already established with a home health agency.			
q. I do not feel response to referrals is timely.			
r. I do not wish to lose contact and management of patients in the terminal stage of care.			
s. I feel there is a lack of timely communication between myself and hospice providers.			
t. Patients or families are reluctant to have strangers in their home.			
Other (please specify):			

Comments:

35. Please offer suggestions regarding how hospice services might improve to better serve the needs of your patients.

Thank you for your assistance!

Please place your completed questionnaire in the envelope provided. Your feedback will remain confidential.

If you would like a copy of the results, list your name along with your specified route of contact below.

Your Name: _____

Specified point of contact:

If you are interested in attaining CME credit for attending this session, please provide your email address below.

Appendix C

Permission to use Survey Tool

From: Karen Ogle <Karen.Ogle@covenanthospice.org>
 Sent: Sunday, January 19, 2014 7:36 PM
 To: Meki Jacobs Graham
 Subject: RE: Survey tool...

Consider this permission.

Karen S. Ogle, MD
 Covenant Hospice
 2001 Palafox Street
 Pensacola, FL 32501
 Phone 850-202-0840
 Fax 850-202-1170
 Karen.ogle@covenanthospice.org
 www.covenanthospice.org

To: Karen Ogle <Karen.Ogle@covenanthospice.org>;
 Cc: Dr Anna S. Hamrick;

Hi Dr. Ogle,
 My school requires that I obtain permission. Thank you so much.
 Respectfully,

Meki Jacobs Graham, MSN/Ed., APRN, NP-C
 Gardner-Webb Doctor of Nursing Practice Student

From: Karen Ogle <Karen.Ogle@covenanthospice.org>
 Sent: Tuesday, January 14, 2014 6:49 PM
 To: Meki Jacobs Graham
 Subject: RE: Survey tool...

Meki, I apologize for this rushed note, but I am on jury duty with work hanging over me all evening this week. I have not had a chance to look at your changes, but there is no need to have my approval of them -- whatever you have decided for your work is entirely up to you. Best wishes, KO

Karen S. Ogle, MD
 Covenant Hospice
 2001 Palafox Street
 Pensacola, FL 32501
 Phone 850-202-0840 <tel:850-202-0840>
 Fax 850-202-1170 <tel:850-202-1170>
 Karen.ogle@covenanthospice.org <mailto:Karen.ogle@covenanthospice.org>

From: Karen Ogle [<mailto:Karen.Ogle@covenanthospice.org>]
 Sent: Monday, June 03, 2013 1:14 PM
 To: Meki Graham
 Subject: RE: interest in research

Instrument attached -- unfortunately the only file I have is a copy with coding notes on it.

Best wishes for your work.

KO

From: Karen Ogle [Karen.Ogle@covenanthospice.org]
Sent: Monday, June 03, 2013 10:50 AM
To: Meki Graham
Subject: interest in research

Meki,

I received a message that you have some interest in previous research I did - I am guessing it is about the survey of physicians about attitudes and knowledge re hospice.

If you would like to use that instrument in your own work, I am happy to send you a copy of it.

I have experienced an incredible amount of interest in this paper ever since it was published and I regret that I have had to limit what I can offer in terms of individual conversation about it. Just to give you a sense of this, I have had four such requests in the last three weeks.

I am sorry that I am unable to offer you more support.

Best wishes in your work,

Karen Ogle

Appendix D

Rural Hospital Interim CEO Permission

To: Meki Graham; Duane L. Erwin <derwin@crhealthcare.org>;
 Cc: meki.graham@lcfh.org; Dr Anna S. Hamrick;

• You replied on 8/4/2014 4:12 PM.

Meki,

Duane has given you clearance to proceed.

I wish you well in your endeavors.

Thank you,

Rachel N. Dunbar, BS

Executive Assistant to:
 Duane Erwin, Interim CEO
 Terry Beasley, CNO
 Carl Biber, CFO
 Columbus Regional Healthcare System
 (910) 642-1771 (o) 910-642-9305 (f)
www.crhealthcare.org

Hi Rachael,

I enjoyed talking with you last week. Please let me know if you have any more questions about hospice or palliative care.

As a Columbus County native (all of my life), I work in the realm of hospice and palliative care as a nurse practitioner. I'm also a graduate student at Gardner-Webb University with an interest in educating others about what hospice is and how it all works. My research focus is on rural healthcare providers' knowledge, attitudes, barriers and beliefs about hospice care and services. I will be surveying every healthcare provider (Physician, NP and PA) in Columbus County who has the authority to write a referral for hospice care. In a nutshell, my research will consist of a pre-test to get an initial idea of the providers' knowledge base. This will be followed by with an educational intervention. I would also be most appreciative if I could present at one of the medical staff meetings. Once the intervention is complete, I will conduct a post-test, then compile my data, and present to my chair and faculty for publication.

Since Columbus Regional Healthcare System is such a rural hospital without a research department or an internal review board (IRB), I am emailing to ask permission from the CEO to conduct this research. My survey questions are attached.

After attending a few medical staff meetings, my thoughts are that the task of doing the survey online for some providers affiliated with CRHS may be challenging and time consuming; therefore, I would like to additionally have the survey available prior to a few of the medical staff meetings.

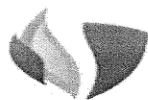
I could go on and on about hospice services, and my research. If Mr. Hawthorne has the time and so desires, I am willing to share the benefits/revenue the hospital could have with a palliative care program. Please feel free to contact me. Thank you for your time.

In closing, this email is to ask permission for a graduate student to survey (electronically & paper/pen) all of the healthcare providers affiliated with CRHS.

Respectfully,

Meki Jacobs Graham, MSN/Ed., APRN, NP-C
Gardner-Webb Doctor of Nursing Practice Student

Appendix E: Educational Intervention Invitation Flyer



GARDNER-WEBB
UNIVERSITY

Dear Colleague:

Hospice Care is growing in great strides. However there is a lack of access to hospice care for eligible patients in rural areas. Our patients tend to miss out on the opportunity to have hospice services entirely or could be referred much earlier into their disease process.

Over the past decade hospice care experts have been researching why healthcare providers do not make referrals for their patients. There is no study that addresses this issue in our county.

Therefore, for AMA CME credit, I am asking you participate in an educational session and complete the pre and post surveys. The survey is entitled *Healthcare Provider Survey* and will review knowledge-base and attitudes about hospice care along with benefits and barrier to hospice services. The pre-survey can be completed in less than ten minutes. Responses to this survey are anonymous. Once the pre-survey is completed, you will need to attend an educational intervention lasting 60 minutes followed by a post-survey lasting about five minutes. Including answering of questions and any additional volunteer dialogue, the session should last about one hour and thirty minutes.

Please contact me if you have any questions or concerns about this study.

Thank you for your contribution to this study.

Sincerely,

Meki Jacobs Graham, APRN, MSN/Ed, ANP-C
DNP Student, Gardner-Webb University
mgraham2@gardner-webb.edu
910.599-8113

Anna Hamrick, DNP, FNP-BC (Capstone Chair)
Gardner-Webb University School of Nursing
ashamrick@gardner-webb.edu
704.406.2460



GARDNER-WEBB
UNIVERSITY

Hunt School of Nursing

FREE CME CREDIT

Participants (*Physicians, NPs and PAs ONLY*)

needed for an

Educational Capstone Project

Examine Behavioral Intention to Make Hospice Referrals

The purpose of this educational project is to increase rural health care provider's knowledge about the hospice care, and services with a specific focus on the hospice referral process. Participants will be asked to fill out a pre-survey, attend an educational session, followed by a post-survey. The surveys will take approximately five to ten minutes each and the scheduled educational session will take 60 minutes of your time.

To participate in this capstone project you must be have an affiliation with Columbus Regional Healthcare System with qualifications to practice as a nurse practitioner (NP), physician assistant (PA), medical doctor (MD), or doctor of osteopathy (DO).

Participants will enhance their knowledge of the hospices referral process, and receive free CME credit.

This educational class will be held at Columbus Regional Healthcare System 500 Jefferson Street Whiteville, NC 28472. Thursday, December 4, 2014 in educational session in classroom B from 11:30am-12:30pm or Thursday, December 4, 2014 in hospital cafeteria from 6:30pm-7:30pm

This educational project is being conducted by Mēki Jacobs Graham, a doctoral student at Gardner-Webb University's Hunt School of Nursing.

To learn more about this project, contact Mēki Jacobs Graham via email at mgraham2@gardner-webb.edu.

Appendix F: SEAHC Application



South East Area Health Education Center
Office of Continuing Medical Education
Application and Planning Guide
CME Educational Activity

Date: 10-09-14

Part I: General Information

Activity Title:	Making a Hospice Referral: How Optimistic Are You?		
CASCE # (SEAHEC will complete this section)	Event # 45120	Session #	
Activity Date/Location:	Start Date: November 18th	Start Time: 12noon and 6pm End Time: 1 hour session	Site: Columbus Regional Healthcare System hospital City, State: Whiteville, NC
Will there be Exhibitors:	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Separate room Room name: <u>Hospital Foyer Entrance</u>		
Location:	Note: Exhibitors must be located in a different room/venue from the area where speaker presentations are made.		
Type of Activity: Criterion 5	<input type="checkbox"/> Regularly Scheduled Series (RSS) <input type="checkbox"/> Performance CME (quality) <input type="checkbox"/> Annual Program/Activity <input type="checkbox"/> Enduring Materials <input checked="" type="checkbox"/> One Time Program/Activity		
Credit Type Requested (Double click on all credit types to be requested / applied for)	<input checked="" type="checkbox"/> American Medical Association Category 1 (AMA/PRA) <input checked="" type="checkbox"/> Nursing <input type="checkbox"/> Allied Health <input type="checkbox"/> Mental Health <input type="checkbox"/> Other: (please list) Contact hours		
Number of Category 1 CME Hours requested:	1.0	Number of Other Credit Hours requested:	1.0 CNE
Activity Director and contact information	Dr. Richard G. Berry, MD	Phone #: 910-642-0300 Fax: 910-640-3327 Email: Goshen@webInk.net	
Activity Coordinator and Contact Information	Meki Jacobs Graham Gardner-University Graduate Student	Phone #: 910-599-8113 Fax: 910-642-0223 Email: mgraham2@gardner-webb.edu	
Sponsorship (Double click on correct type of sponsorship)	<input type="checkbox"/> Directly Provided (SEAHEC CME or other SEAHEC department working alone or in collaboration with an outside organization(s)) <input checked="" type="checkbox"/> Jointly Provided (SEAHEC CME works with a Non-accredited provider) (If this is to be a jointly provided program a contract must be developed between SEAHEC and the joint organization) Organization's Name: _____		
Planning Committee Members and their affiliations	All persons with control over the content of the program, including planning committee members must complete financial disclosure and attestation forms. Name: _____ Affiliation: _____		
	Meki Jacobs Graham Dr. Anna S. Hamrick, DNP, FNP-C, ACPNP Dr. Richard G. Berry, MD Ashley Bell, MHA Cindy Grant, BSN, RN-BC	Gardner-Webb University Gardner-Webb University Columbus Regional Healthcare System SEAHEC SEAHEC	

All materials may be sent to the attention of:

Part II: Educational Planning

<p>Who will identify speakers and topics: Criterion 7 (Double click on choice(s))</p>	<p><input type="checkbox"/> Physician Activity Director x Activity Coordinator <input type="checkbox"/> Planning Committee <input type="checkbox"/> Other: List name(s) & address(es)</p>
<p>Were any employees of a pharmaceutical company and/or medical device manufacturer involved with the identification of speakers and/or topics? x NO <input type="checkbox"/> YES, please explain: _____</p>	
<p>Summary of Professional Practice Gap (learning needs)</p>	<p>The professional practice gap is defined as the difference between how a professional currently practices and how he/she should be practicing. It is the basis for defining the learning needs of the target audience.</p> <p>1. What is the problem that will be addressed by this activity? There is a pressing need to advance the agenda of rural palliative care associated with life limiting illness and death. This type of care is called hospice services and it is still in its infancy in rural areas. There is a lack of research that pinpoints why hospice is underutilized in rural areas. Statistics show that there is a steady decline of hospice patients served in Columbus county from 2010-2012. There are no palliative care programs in the hospital or amongst the hospice agencies within the county. This could be due to geographic inequalities due to access of care or other issues. These challenges include healthcare providers' knowledge, attitudes, beliefs and barriers about hospice care and services.</p> <p>2. How are we sure it is a gap for our learners? Rural health providers perceive they are providing palliative care and yet they are not. Key gaps for our learners include:</p> <ul style="list-style-type: none"> • Time consuming process • Hesitant due to pt/family resistance • Stigma of the word, "Hospice" • Prognostication with end of life can be challenging <p>3. What is the activity designed to change?</p> <p><input checked="" type="checkbox"/> Competence (To give new abilities and strategies) <input checked="" type="checkbox"/> Performance (To help modify practice) <input type="checkbox"/> Patient Outcomes (To help improve patient outcomes)</p> <p>4. How will we evaluate this change? Competence – post survey Performance – post survey and follow up with Coastal Connect Health Information Exchange.</p>

Part III: Needs Assessment and Educational Design

<p>Check the core competencies that will be addressed (select 1 at minimum) CME activities should be developed in the context of desirable physician attributes. Please indicate which American Board of Medical Specialties (ABMS/Accreditation Council for Graduate Medical Education (ACGME) or Institute of Medicine (IOM) core competencies will be addressed in this activity. Criterion 6 (Double click on all that apply)</p>	
<p>x</p>	<p>Patient Care: that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health in this activity.</p>

All materials may be sent to the attention of:

X	Medical Knowledge: established and evolving biomedical, clinical, and cognate sciences and the application of this knowledge to patient care.			
X	Practice-Based Learning and Improvement: involves investigation and evaluation of one's own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care.			
X	Interpersonal and Communication Skills: that result in effective information exchange and teaming with patients, their families and other health professionals.			
X	Professionalism: commitment to carrying out professional responsibilities, adherence to ethical principles and sensitivity to a diverse patient population.			
X	System-Based Practice: actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value.			
<p>Needs Assessment Data and Sources (select 2 at minimum) Please indicate the sources used to identify the deficiencies/quality gaps or needs. Select all that apply and provide/attach supportive documentation. (C = Competence; P = Performance; O = Patient Outcomes) Criterion 2 (Double click on all that apply)</p>				
	<table border="1"> <tr> <td> New methods of diagnosis or treatment - (C) Availability of new medication(s) or indication(s) - (C) Development of new technology - (C) Experts regarding advances in medical knowledge - (C) Literature review - (C) Data from outside sources: e.g. public health stats - (C) Survey of target audience - (C) Quality assurance/audit data - (O) Professional society requirements - (C) </td> <td> X X X X X X X X X </td> <td> External requirements such as: National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare (JCAHO) or Health Plan Employer Data and Information Set (HEDIS). (C, P & O) Continuing review of changes in quality of care as revealed by medical audit or other patient care reviews (P & O) Referral patterns (C & P) Legislative, regulatory, or organizational changes effecting patient care - (C, P & O) Joint Commission Patient Safety Goal/Competency: _____ Other: _____ </td> </tr> </table>	New methods of diagnosis or treatment - (C) Availability of new medication(s) or indication(s) - (C) Development of new technology - (C) Experts regarding advances in medical knowledge - (C) Literature review - (C) Data from outside sources: e.g. public health stats - (C) Survey of target audience - (C) Quality assurance/audit data - (O) Professional society requirements - (C)	X X X X X X X X X	External requirements such as: National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare (JCAHO) or Health Plan Employer Data and Information Set (HEDIS). (C, P & O) Continuing review of changes in quality of care as revealed by medical audit or other patient care reviews (P & O) Referral patterns (C & P) Legislative, regulatory, or organizational changes effecting patient care - (C, P & O) Joint Commission Patient Safety Goal/Competency: _____ Other: _____
New methods of diagnosis or treatment - (C) Availability of new medication(s) or indication(s) - (C) Development of new technology - (C) Experts regarding advances in medical knowledge - (C) Literature review - (C) Data from outside sources: e.g. public health stats - (C) Survey of target audience - (C) Quality assurance/audit data - (O) Professional society requirements - (C)	X X X X X X X X X	External requirements such as: National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation of Healthcare (JCAHO) or Health Plan Employer Data and Information Set (HEDIS). (C, P & O) Continuing review of changes in quality of care as revealed by medical audit or other patient care reviews (P & O) Referral patterns (C & P) Legislative, regulatory, or organizational changes effecting patient care - (C, P & O) Joint Commission Patient Safety Goal/Competency: _____ Other: _____		

Part IV: Additional Information

Target Audience	Select all that apply (at least 1 box from provider type and specialty must be selected) Criterion 4
------------------------	--

All materials may be sent to the attention of:

Provider Type: <input checked="" type="checkbox"/> Primary Care Physician <input checked="" type="checkbox"/> Specialty Physician <input type="checkbox"/> Pharmacists <input checked="" type="checkbox"/> Physician Assistants <input checked="" type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Other (specify: _____)	Specialty: <input type="checkbox"/> All specialties <input type="checkbox"/> Anesthesiology <input checked="" type="checkbox"/> Cardiology <input checked="" type="checkbox"/> Dermatology <input checked="" type="checkbox"/> Emergency Medicine <input checked="" type="checkbox"/> Family Medicine <input checked="" type="checkbox"/> General Medicine <input type="checkbox"/> Neonatology <input checked="" type="checkbox"/> Neurology	<input checked="" type="checkbox"/> Ob/Gyn <input checked="" type="checkbox"/> Oncology <input checked="" type="checkbox"/> Orthopedics <input checked="" type="checkbox"/> Pediatrics <input checked="" type="checkbox"/> Primary Care <input type="checkbox"/> Psychiatry <input checked="" type="checkbox"/> Radiology <input type="checkbox"/> Radiation Oncology <input checked="" type="checkbox"/> Surgery <input type="checkbox"/> Other (specify): _____
<p>What patient groups are cared for by the proposed attendees? All patient populations served in Columbus county. Target group are those with chronic diseases who are eligible for hospice services.</p> <p>What is the estimated physician attendance per session? @ 10 _____</p> <p>What is the estimated non-physician attendance per session? @15 _____</p>		
Content (Double click on the one(s) that apply)	<p>The content should be based on the target audience and the gap being addressed.</p> <input checked="" type="checkbox"/> This will be new content for the target audience <input type="checkbox"/> This will be a review for the target audience	
Learning Objectives:	<p>Briefly list the proposed learning objectives for this educational program.</p> <ul style="list-style-type: none"> • Differentiate between palliative and hospice care • Identify the basic requirements for hospice eligibility and examine state and county statistics for eligibility and referral • Understand how hospice benefits the providers and review the process for making a hospice referral • Review the challenges associated with prognostication 	
Educational Design / Methodology Criterion 5	<p>The activity should be structured to achieve the stated learning objectives. Please indicate the educational method(s) that will be used to achieve the stated objectives. (Select all that apply.)</p> <input checked="" type="checkbox"/> Didactic lecture (Knowledge) <input checked="" type="checkbox"/> Panel discussion (Knowledge) <input type="checkbox"/> Roundtable discussion (Knowledge) <input checked="" type="checkbox"/> Q & A session (Knowledge) <input type="checkbox"/> Quality Initiative in the workplace <input checked="" type="checkbox"/> Case Presentation (Knowledge & Competence) <input type="checkbox"/> Simulation/Skills Lab (Competence & Performance) <input type="checkbox"/> Other:	
Evaluation Strategy and Outcomes	<p>How will you measure if changes in knowledge, competence, performance or patient outcomes have occurred? All outcomes measurement methods must be approved by SEAHEC. Check all that apply. C11 (Double click on all that apply)</p>	
Knowledge / Competence		
<input checked="" type="checkbox"/> Evaluation form for participants (required) <input type="checkbox"/> Audience Response System (ARS) <input checked="" type="checkbox"/> Customized pre- and post-test	<input checked="" type="checkbox"/> Physician and/or patient surveys and evaluations <input type="checkbox"/> Other: Explain	
Performance		

All materials may be sent to the attention of:

<input checked="" type="checkbox"/> Adherence to guidelines <input checked="" type="checkbox"/> Case-based studies <input type="checkbox"/> Chart audits <input type="checkbox"/> Direct observations	<input checked="" type="checkbox"/> Customized follow-up survey/interview focus group about actual change in practice at specified intervals <input type="checkbox"/> Other: Describe
Patient/Population Health	
<input type="checkbox"/> Change in health status measure <input type="checkbox"/> Change in quality/cost of care <input type="checkbox"/> Measure mortality and morbidity rates	<input type="checkbox"/> Patient feedback and surveys <input type="checkbox"/> Other: Describe

Part V: Financial

<p>Commercial Support: Will this activity receive commercial support (financial or in-kind grants or donations) from a company such as a pharmaceutical or medical device manufacturer? Note, exhibit fees are not considered commercial support.</p> <p><input checked="" type="checkbox"/> NO YES - if yes I have read and agree to abide by the ACCME Standards for Commercial Support</p> <p>PROJECTED BUDGET: We strongly encourage you to either work with SEAHEC/OCME on the projected budget or if you have your own template, please ensure that all income and expenses are listed in detail. FINAL BUDGET: If using your own template, at the conclusion of the activity a final budget must be given to the Office of Continuing Medical Education for the activity's files.</p> <p><input type="checkbox"/> Yes - projected budget is attached and a final budget will be presented to the OCME after all revenues have been received and all expenses have been paid. <input checked="" type="checkbox"/> No - budget is not attached, will develop with SEAHEC/OCME</p>

You may submit the application packet by mail or email to:

SEAHEC
 Ashley Bell, MHA
 CME Director
 2511 Delaney Avenue
 Wilmington, North Carolina 28403

All materials may be sent to the attention of:

<input checked="" type="checkbox"/> Customized pre- and post-test	
Performance	
<input checked="" type="checkbox"/> Adherence to guidelines	<input checked="" type="checkbox"/> Customized follow-up survey/interview focus group about actual change in practice at specified intervals
<input checked="" type="checkbox"/> Case-based studies	<input type="checkbox"/> Other: Describe
<input type="checkbox"/> Chart audits	
<input type="checkbox"/> Direct observations	
Patient/Population Health	
<input type="checkbox"/> Change in health status measure	<input type="checkbox"/> Patient feedback and surveys
<input type="checkbox"/> Change in quality/cost of care	<input type="checkbox"/> Other: Describe
<input type="checkbox"/> Measure mortality and morbidity rates	

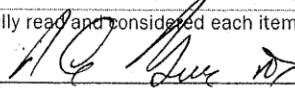
Part V: Financial

Commercial Support: Will this activity receive commercial support (financial or in-kind grants or donations) from a company such as a pharmaceutical or medical device manufacturer? Note , exhibit fees are not considered commercial support.
<input checked="" type="checkbox"/> NO YES – if yes I have read and agree to abide by the ACCME Standards for Commercial Support
PROJECTED BUDGET: We strongly encourage you to either work with SEAHEC/OCME on the projected budget or if you have your own template, please ensure that all income and expenses are listed in detail. FINAL BUDGET: If using your own template, at the conclusion of the activity a final budget must be given to the Office of Continuing Medical Education for the activity's files.
<input type="checkbox"/> Yes – projected budget is attached and a final budget will be presented to the OCME after all revenues have been received and all expenses have been paid.
<input checked="" type="checkbox"/> No – budget is not attached, will develop with SEAHEC/OCME

You may submit the application packet by mail or email to:


SEAHEC
Ashley Bell, MHA
CME Director
2511 Delaney Avenue
Wilmington, North Carolina 28403
Email: Ashley.Bell@SEAHEC.net
or
Beth.Mixon@SEAHEC.net

This page has been signed and emailed to SEAHEC.

I have carefully read and considered each item in this form and completed it to the best of my ability.	
	<u>10-23-14</u>
Physician Course Director or Designee Signature	Date

THANK YOU!

CME OFFICE USE ONLY

Date Application Received:	Date Application Approved:	Approver's Signature	Directly Provider	YES/NO
	11/3/2014		Joint Providership	YES/NO

Approval of the OCME Application Date:

Appendix G: SEAHEC Continuing Education Provider Agreement



South East Area Health Education Center
Continuing Education
2511 Delaney Avenue • Wilmington, NC 28403
Phone: 910.667.9330 • Fax: 866-734-4405
www.seahec.net

Continuing Education Joint Providership / Co-Provider Agreement

This joint providership/co-provider agreement is between New Hanover Regional Medical Center d/b/a South East Area Health Education Center (SEAHEC) and Memory Matters for the purpose of providing one continuing education event.

Program Title: Making a Hospice Referral: How Optimistic Are You?
Program Date: 11/18/2014
Program Location: Columbus Regional Healthcare System, Whiteville, NC
Joint-Provider: Meki J. Graham MSN/Ed., APRN, NP-C, Gardner-Webb University Doctor of Nursing Practice Student


SEAHEC agrees to:

- Work collaboratively with the Meki Graham to implement the continuing education activity; Ashley Bell will be point of contact.
- Offer applicable and appropriate continuing education credits.
- Provide online, electronic copies of all speaker-provided handouts (if made available) within 10 business days of receipt.
- Disperse electronic evaluation forms to all participants and provide Meki Graham a summary of all feedback within 14 days of program completion.

Meki Graham agrees to:

- Involve Ashley Bell and the SEAHEC Education Team in the planning process of topic and speaker presentations in order to award credit.
- Provide SEAHEC with required information of program material so credits can be determined (program description, agenda, objectives, and speaker information/résumés).
- Complete CME/Nursing Application and Course Director Agreements and return to SEAHEC before program occurs.
- Provide SEAHEC with information of program, including program description, agenda, speaker topics, and speaker information, so that marketing material can be sent out through SEAHEC database.
- Marketing Material - Will work with SEAHEC to design brochure; SEAHEC must approve prior to marketing to ensure accuracy and compliance.
- Onsite management: sign in registration and disclosure and credit statements will be managed by Meki Graham on the day of the event.

Financial Agreement:

South East Area Health Education Center

 2511 Delaney Avenue Wilmington NC 28403 910 343-0161 fax 866-734-4405
www.seahec.net
 Medicine

In affiliation with the University
at Chapel Hill School of

Appendix H: SEAHEC Course Director Agreement



Office of Continuing Medical Education

Ashley Bell, MHA 910-667-9268, Ashley.Bell@seahec.net , Director, CME
 Beth Mixon, BS 910-667-9337, beth.mixon@seahec.net , Project Specialist, CME

Fax to (866)734-4405

Course Director Agreement

Course directors are responsible for assuring that the educational activity is educationally sound, free of commercial influence and fiscally responsible.

I, Richard G. Berry, MD, Course Director for Making a Hospice Referral: How Optimistic Are You?
Course Director's Name Name of Event or RSS

agree to carry out the following responsibilities:

- Select faculty and verify their competency in the subject area
- Oversee curriculum development and assure that the format supports the educational goals of the activity
- Faculty should be made aware of the course objectives and needs of the target audience
- Assure that Faculty relationships with industry are disclosed to participants prior to the educational activity. Make sure conflicts of interest do not exist and resolving them if they do exist.
- Inform Faculty that they must disclose experimental and off-label uses to participants
- Ensure that all presentations are free of commercial bias, both of trade names and products with which the faculty have a commercial interest. It is encouraged that Faculty use generic names and that any mention of trade or brand names should include all products within a class of pharmaceuticals or devices. In addition, Faculty may not promote products, books, or publications in which they have a commercial interest.
- Assure that there is no marketing or other sales activity in the room in which the activity is conducted.
- Commercial interests are not permitted to participate in the curriculum planning activity or faculty selection. The commercial entities are permitted to submit a list of potential speakers but it is the responsibility of the course director to select course faculty on the basis of their academic, educational and clinical credentials.
- Confirm that all commercial support is reported to SEAHEC's Office of CME
- Assure that all budget assumptions and honoraria payments are reasonable and comply with all organizational policies. Any honoraria over \$3000 must be justified in writing and is subject to review.
- Provide feedback to the Director of Continuing Medical Education regarding services rendered.

Richard G. Berry, MD
Course Director's Name (Printed)

Richard G. Berry
Course Director's Signature

10-24-14
Date

Appendix I: Educational Intervention

Be sure you have completed the
Pre-Survey
it takes about 10 minutes

Making a Hospice Referral: How Optimistic Are You?

Meki Jacobs Graham, APRN, MSN/Ed., NP-C
Graduate Student at Gardner-Webb University

SEAHEC


GARDNER-WEBB
UNIVERSITY

Disclaimer

- Meki Jacobs Graham, is a graduate student at Gardner-Webb University
- Commercial support has not been provided for this activity
- Any reference to a commercial product is for example purposes only and does not reflect endorsement
- Area vendors are located outside the classroom with additional palliative/hospice information

Participant Consent Form

A Provider's Perspective on Death & Dying



http://www.scenicreflections.com/files/dying_smc_30allpages...y11.jpg

Objectives

- Differentiate palliative and hospice care
- Identify the basic requirements for eligibility
- Examine state and county statistics
- Understand how hospice benefits the providers
- Examine the challenges with prognostication
- Review the referral process

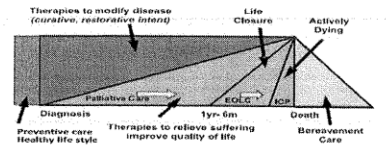
Palliative & Hospice Care

- Palliative Care
 - Initiated as soon as pt is diagnosed with chronic illness
 - A means to keep the patients we serve in our county
 - Assists providers with lowering return ED visits
 - Not an alternative but a concurrent service
 - A gateway to discussing goals of care – including advanced directives
- Hospice Care
 - The chronic illness is becoming terminal
 - When life-sustaining options are no longer an option. (pain & symptom management)
 - HCP can f/u on pt's care at home on a weekly basis
 - Full team approach: Nurse Practitioner, Registered Nurse/Case Manager, Aide, Social Worker, chaplain, volunteer

The Continuum of Palliative Care

(Macklin)

Modified from:
<http://dopts.washington.edu/pallcare/training/bpt.html>



Chronic Illness for Hospice Eligibility

(Top List of Diagnoses)

- Cancer
- Emphysema / COPD
- Congestive Heart Failure
- End-Stage Renal Disease
- Cirrhosis or End Stage Liver Disease
- Neurodegenerative Diseases (MS, ALS, etc.)
- Dementia (Vascular/Lewy Bodies, etc.)
- Alzheimer's Type Dementia
- HIV/AIDS

Decline in Status Shortcuts

- High Overall Burden of Illness
- Clinical Status
- Poorly Controlled Symptoms
- Signs
- Dependence in 2 or > ADLs

High Overall Burden of Illness

- Chronic Ischemic Heart Disease
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure
- Dementia
- Diabetes Mellitus
- HIV/AIDS
- Liver Disease
- Neoplasm
- Neurologic Disease (CVA, ALS, MS, Parkinson's)
- Refractory Severe Autoimmune Disease
- Renal Failure

Clinical Status

- >2 hospitalizations in past month for same issue
- >2 ER or physician visits
- Recurrent infections (UTI, pneumonia or sepsis)
- Progressive weight loss
- Dysphagia leading to recurrent aspiration
 - G-Tube placement not an option
 - Pt/Family choice
 - Recovery risk

Poorly Controlled Symptoms

- Respiratory complications
 - Dyspnea, increased respiratory rate, cough
- Nausea, vomiting, diarrhea
- Pain requiring increasing doses of analgesic

Signs

- SBP < 90 or progressive postural hypotension
- Ascites, edema, effusions
- Changed level of consciousness
- Progressive stage 3-4 pressure ulcers
- Albumin < 2.5

ADL Dependence in 2 or >

- Feeding
- Ambulation
- Continence
- Transfers
- Dressing
- Bathing

Hospice Care:

- Provides relief from pain and other distressing symptoms;
- Affirms life and regards dying as a normal process;
- Does not intend to hasten or postpone death;
- Incorporates the psychological and spiritual aspects of patient care;
- Uses a team approach to provide a support system for patients and their families;
- Enhances quality of life, and
- May also positively influence the course of illness.

<http://www.schs.state.nc.us/SCHS/pdf/SBps.pdf>

Deaths Served by Hospice

	2004	2005	2006	2007	2008	2009
North Carolina	34.20%	35.78%	38.26%	39.96%	40.42%	43.07%
Columbus county	33.21%	31.69%	39.31%	42.30%	40.73%	37.81%

Why Make the Referral?

- Quality of life versus quantity of life
- Studies have shown patients have lived longer with these services
 - Lung cancer, survival that was prolonged by approximately 2 months (see article provided)
- Improvement in pt mood and family dynamics
- Conversations about EOL & resuscitation
- More appropriate care at the end of life, reducing the costs toward hospitals and CMS

Further Considerations

- Pt/Family needs help with
 - Complex decision-making
 - Determination of goals of care
- Frequent visits to emergency department
 - More than one time/month for same issue
- > one hospital admission in last 30 days
- Hospitalized > 5 days without improvement
- Extensive stays in ICU with poor prognosis

(CAPC, n.d.a)

Also consider . . .

- Providers would postpone discussions until the patient became:
 - symptomatic, failed disease-directed treatment, or even might never conduct these discussions unless initiated by the patient or family
- Providing active care of patients with advanced, progressive, and incurable diseases

<http://www.schs.state.nc.us/SCHS/pdf/58j.pdf>

How Does Hospice Benefit the Provider?

- Not enough time in the office to
 - Discuss advanced directives (DNR or MOST form)
 - Concerned about eligibility
 - Unsure about how pt/family would feel about discussing hospice.
- Staying better informed about their patients
- Reducing pressure from hospitals related to re-hospitalization

Technology Assistance Options

- Beneficial technology app with prognostication and referral
 - VITAS app 
 - Hospice in a Minute App 

Collaborative Efforts with Providers:

- Pain
- Respiratory Distress & Anxiety
- Infections (Respiratory, Urinary)
- Nausea/Vomiting
- Restlessness
- Keep the patient comfortable and pain-free
- Palliative surgical consults
- Measure pt's comfort level
 - to make sure that medication, therapies, and procedures are designed to achieve the goals outlined in the patient's care plan.
 - The care plan is reviewed frequently to make sure any changes and new goals are in the plan.

Hospice Staff Collaborate with Providers

- What is expected of me if I refer?
- Would I be the primary care provider if I make the referral?
- Am I going to get bombarded with paperwork and phone calls?

How to Make a Referral?

- Have a nurse or administrative assistant
 - Review the guidelines for a particular chronic illness
- Write an order for a palliative care consult or hospice consult to the hospice agency
 - Reduces the need for providers having extensive, time consuming conversations about the hospice or palliative care process
 - Admission is confirmed once both pt and provider agree
- Introduce the topic of palliative care
 - F/u about goals of care
 - Allows family/pt make the referral

Case Study Approach

- Exam prognostication
- Key questions
 - Would you be surprised if this patient died in the next 6 months?
 - Would you make a hospice referral on this patient?



Discussion

- VP of Medical Services
- Open Panel Discussion
- Discussion r/t different experiences/perspectives

Summary

- Terminal chronic illness
- Quality of life
- Patient satisfaction
- Reduced caregiver burden
- More appropriate referral to and use of hospice
- Reduced use of futile intensive care

Hospice Providers in Columbus County*

- **Community Home Care and Hospice** 
333 Jefferson Street Whiteville, NC 28472
Phone: (704)664-2876
- **Liberty Home Care and Hospice** 
44 McNeill Plaza Whiteville, NC 28472
Phone: (910)641-4095
- **Lower Cape Fear Hospice and Life Care Center** 
206 Warrior Trail Whiteville, NC 28472
Phone: (910)642-9051

*As of September 2014

Prior to leaving please ...

Be sure you have completed the
Post-Survey
it takes about 5 minutes

- Leave email address in order to receive the course evaluation for CME credit



References

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- What is hospice? (2009, August 10). Retrieved from <http://www.nhpco.org/resources/facts-and-figures/hospice-care-in-america.pdf>

Thank you

- Meki Jacobs Graham
- DNP student
- Gardner-Webb University
- mgraham2@gardner-webb.edu

Appendix J: Participant Informed Consent

Study Title: Rural Healthcare Providers' Behavioral Intentions with Hospice Care: Attitudes, Knowledge, Benefits and Barriers

Project Administration: Mēki Jacobs Graham

Dear Participant,

As part of the requirements for the Doctor of Nursing Practice, I am conducting a study about the behavioral intentions of rural health care providers (NPs, PAs, MDs and DOs) to make hospice referrals. You are being invited to take part in this study. Before you decide to participate, it is important that you understand why the study is being done and what it will involve. Please take the time to read the remaining information carefully.

The purpose of this study is to determine if an educational intervention will improve the behavioral intention for rural health care providers to make hospice referrals. Your expected time commitment for this study is 60 minutes. You will be asked to complete two surveys, one before and one after the educational presentation. Please provide the most appropriate responses to each question using your best judgment.

Participation in this study is completely voluntary. If you do not want to be in the study, you may choose not to participate. You may withdraw your participation at anytime. You have the right to skip any question or section that you do not feel comfortable answering.

The risk of this study is minimal. Your responses will be anonymous and confidential. You may decline to answer any or all questions and you may terminate your involvement at any time if you choose to do so. There may be risks that are not anticipated. In addition, every effort will be made to minimize any risks.

The direct benefit for your participation includes a meal and free CME credit. There is no monetary compensation to you for your participation in this study.

Please do not write any identifiable information on your questionnaire. Should you have any questions about the capstone project or any related matters, please contact the project administrator, Mēki Jacobs Graham at mgraham2@gardner-webb.edu or the chair of my capstone project, Dr. Anna S. Hamrick, DNP at ashamrick@gardner-webb.edu.

By completing the survey, I the participant confirm that I have read and understand the information. I understand that my participation is voluntary and that I am free to withdraw at any time.

Appendix K: Debriefing Form

Debriefing Form to Improve Behavioral Intention with Hospice Referrals Gardner-Webb University

Thank you for your participation in our study! Your participation is greatly appreciated.

Purpose of the Study:

The general purpose of the study is to determine if this educational session would improve your intention to make a hospice referral.

Confidentiality:

The information we have collected from you is completely anonymous. The risk of this study is minimal. Please do not disclose research procedures and/or hypotheses to anyone who might participate in this study in the future as this could affect the results of the study.

The benefits of your participations are CME credit options. Additionally, the project administrator hopes that the information obtained from this study will provide you with knowledge that can be used to make more eligible hospice referrals. There is no monetary compensation to you for your participation in this study.

Final Report:

If you would like to receive a copy of the final report of this study (or a summary of the findings) when it is completed, please feel free to contact us.

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, please free to contact the project administrator, Meki Jacobs Graham. Should you have any questions about the research or any related matters, please contact the project administrator at mgraham2@gardner-webb.edu or the chair of the project, Dr. Anna Hamrick, DNP, FNP-BC ashamrickr@gardner-webb.edu.

*****Please keep a copy of this form for your future reference. Once again, thank you for your participation in this study!*****