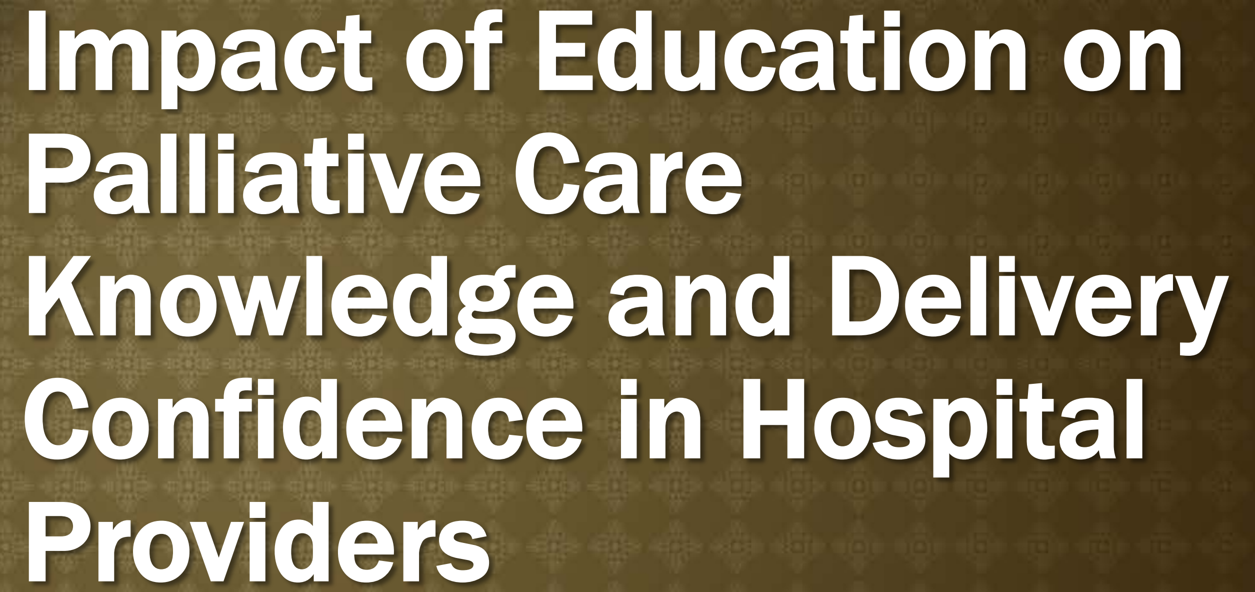
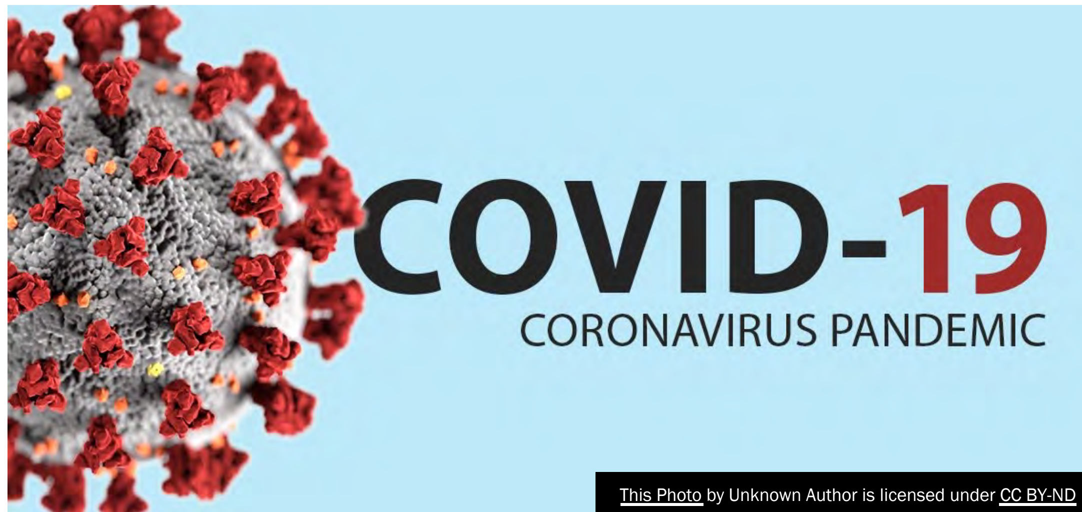


Impact of Education on Palliative Care Knowledge and Delivery Confidence in Hospital Providers

Jennifer Rice, MSN, APRN, AGNP-C

Introduction



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- March 11, 2020- WHO declared coronavirus disease 2019 (COVID-19) a global pandemic
- Categorized as severe respiratory syndrome coronavirus 2 (SARS-CoV-2)
- First emerged in Wuhan, China in late November 2019
- Case fatality rates varied initially across regions of China
- Caused severe and life-threatening illness for some patients
- Highest risk- older patients and patients with comorbid chronic conditions

Introduction

- Multiple COVID-19 case surges in U.S. throughout 2020
  - Severe cases monopolized hospital systems
  - Hospital systems pushed to brink of resource allocation
- As of April 10, 2021, 557,093 U.S. citizens dead due to COVID-19
- Estimated mortality rate from 0.4% to 16.3%
- Elderly, co-morbid, and vulnerable patient populations at higher risk of severe illness
  - requiring hospitalization
  - Increased risk of death
  - Most common symptoms of severe COVID-19- breathlessness/dyspnea and agitation
  - Palliated by relatively small doses of opioids and benzodiazepine

Introduction

- Acute need to manage severe symptoms
- Acute need for serious goals of care conversations
- Increased need for palliative care in hospitalized COVID-19 patient populations
- Need for palliative care services arose rapidly
- Limited palliative care specialty staff
- Hospital clinicians and palliative care teams swiftly adapted

Problem Statement

- Lack of palliative care equity among hospitalized adult patients with severe COVID-19 illness
- Quality measures outlined by the Institute of Medicine's report *Crossing the Quality Chasm* (2001)
  — efficiency, effectiveness, timeliness, equity, and patient-centeredness.
- Reliance solely on the palliative care consult team not feasible
- Palliative care inequities exacerbated by pandemic within JMCGH
- Evidence supports benefit of early palliative care involvement for seriously or terminally ill patients
- Palliative care needs not uniformly and systematically assessed

Purpose

- The purpose of this project was to develop, implement, and evaluate a brief asynchronous primary palliative care education module and a validated palliative care resource pocket card available through the Centers to Advance Palliative Care (CAPC) for hospital providers.

Objectives

Describe	Describe the current palliative care continuing education and resources available to providers in a single hospital setting.
Assess	Assess clinician knowledge, attitudes, perceived barriers, and confidence in delivering palliative care with an online pre-test.
Develop	Develop primary palliative care education PowerPoint module based on providers' knowledge, attitudes, perceived barriers, and confidence
Evaluate	Evaluate the effect of provider education and evidence-based resources on provider understanding and confidence in delivering primary palliative care among the COVID-19 patient population through posttest.
Disseminate	Disseminate findings through doctoral project presentation and final project paper.

Background

- "It is neither sustainable nor desirable that palliative care specialists manage all the palliative care needs of all seriously ill patients" (Weissman & Meier, 2011, p.17).
- Workforce shortages and tenuous funding limit growth and sustainability of new and existing palliative care programs
- COVID-19 pandemic surges of seriously ill patients further exacerbate the limits of specialty palliative care

Background

- JMCGH
  - only tertiary hospital between Memphis and Nashville
  - serves a 19-county area of rural West Tennessee
  - total residential patient population of 400,000.
- Average daily inpatient census is around 540 patients
- Last COVID-19 surge in December 2020
  - 140-150 of those were COVID-19 positive per day
- Hospitalized COVID-19 patients benefit from palliative care
  - either through symptom management or goals of care discussions
- Increased patient volume
  - limited specialist palliative team (3 full time providers- 1 MD, 2 NPs)
  - primary palliative care responsibility of treating providers

Concepts

- The primary concepts within this project were:
  - palliative care as a care modality
  - palliative care clinical practice guidelines as an evidence base for palliative care clinical practice

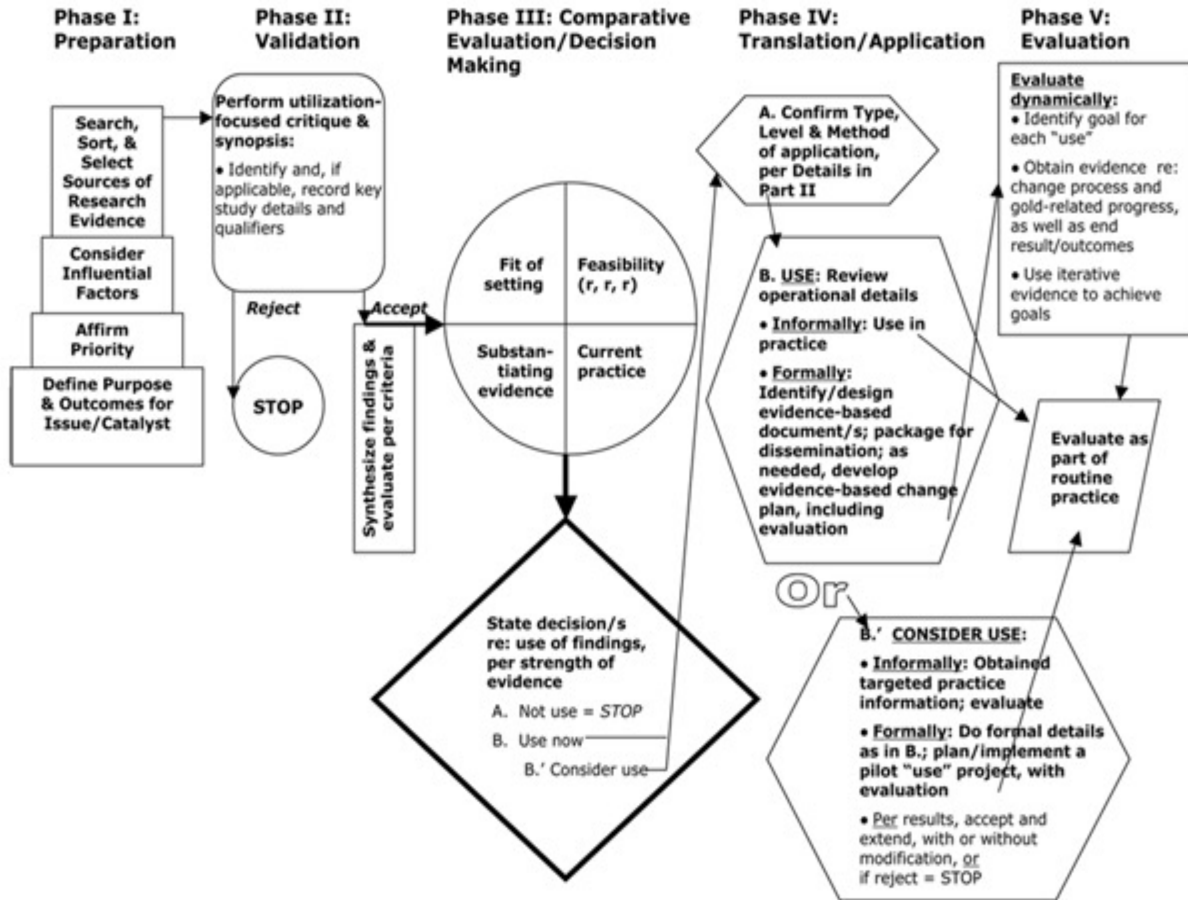
As defined by National Census Project for Quality Palliative Care (NCP) (2018), palliative care is patient and family-centered care performed by an interdisciplinary care delivery team seeking to anticipate, prevent, and manage suffering experienced through physical, psychological, social, and spiritual distress in the seriously or terminally ill patient.

Concepts

- National Consensus Project for Quality Palliative Care (2018) clinical practice guidelines, now in the 4th edition
- The NCP (2018) guidelines include eight domains:

1. Structure and processes of care
2. Physical aspects of care
3. Psychological and psychiatric aspects
4. Social aspects of care
5. Spiritual, religious, and existential aspects of care
6. Cultural aspects of care
7. Care of the patient nearing the end of life
8. Ethical and legal aspects of care

Framework



This project used the Stetler Model of Evidence Based Practice which is a practitioner-oriented framework for translating evidence into practice

- Phase I: Preparation
- Phase II: Validation
- Phase III: Comparative Evaluation/ Decision Making
- Phase IV: Translation/ Application
- Phase V: Evaluation

Synthesis of the Evidence: Evidence Search

- PICOT:

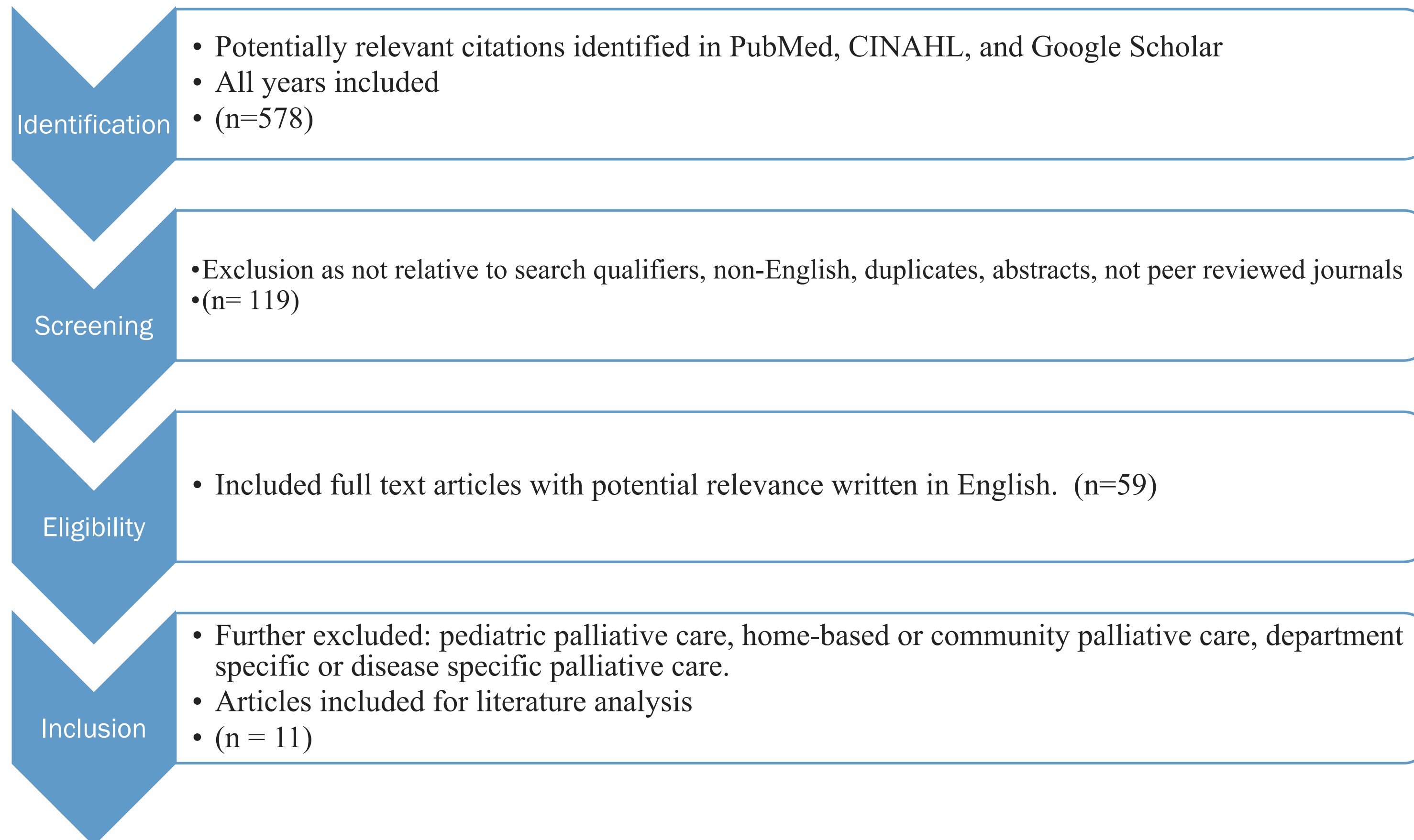
In hospital providers (P) does implementation of a primary palliative care education module coupled with distribution of a COVID-19 symptom management and communication prompt pocket card (I) as compared with usual education (C) increase primary palliative care knowledge and delivery confidence (O) over a four-to-six-week period (T)?

Synthesis of the Evidence: Evidence Search

- Literature review conducted using PubMed, CINAHL, and Google Scholar
- Spring 2020 and again January 2021
- Search terms included:
  - palliative care, referral, barrier, education, inpatient, provider education, knowledge deficits
  - “primary palliative care,” “inpatient palliative care,” “palliative care consults,” “palliative care and COVID-19,” “palliative care education,” “barriers to palliative care,” “COVID-19 symptom management,” and “improving palliative care delivery”

Synthesis of the Evidence: Evidence Search

Figure 1. Evidence Search Flow Diagram



Synthesis of the Evidence

- Levels of Evidence
  - Three randomized controlled trials (RCT)- evidence level II
  - Four descriptive studies- evidence level VI
  - Two retrospective cohort studies- evidence level IV
  - A case series report- evidence level VII
  - A consensus report- evidence level VII
- The level of evidence ranged from high to low.

Synthesis of the Evidence

- Major theme:
  - increased need for primary palliative care education among clinicians participating in day-to-day patient care due to the increase in patients requiring palliative care, especially during the pandemic, with limited availability of specialty palliative care clinicians (Fausto et al., 2020; Lovell et al., 2020; Lopez et al., 2021; Vuong et al., 2019; Weissman & Meier, 2011)

- Secondary theme:
  - need to standardize approaches to identify patients with potential unmet palliative care needs (Hauser et al., 2015; McDarby & Carpenter, 2019; Vuong et al., 2019; Weissman & Meier, 2011).

Synthesis of the Evidence

- Strength:
  - need for primary palliative care education initiatives among nonpalliative clinicians (Fausto et al., 2020; Lovell et al., 2020; Lopez et al., 2021; Vuong et al., 2019; Weissman & Meier, 2011
- Weakness:
  - lack of availability of meta-analyses or systematic reviews
  - Questionable generalizability- single site implementation or small sample size
- Gaps:
  - How to best implement primary palliative care within a hospital setting.
  - More robust palliative care education within graduate training/ curricula

Methods

- **Project Design**
  - Quality Improvement
- **Setting**
  - single hospital in West Tennessee
  - Jackson-Madison County General Hospital (JMCGH)
- **Participants**
  - hospital-based physicians and advanced practice providers caring for COVID-19 patients and/or patients with serious illness
  - recruited via email and word of mouth
  - Received $5.00 Starbucks gift card for participation

Methods

- **Intervention**
  - Pre-test/posttest questionnaire accessed via REDCap link
  - 23-minute PowerPoint primary palliative care education module with content reviewed by the palliative care team
  - Handout COVID-19 dyspnea symptom management/ communication prompts pocket cards

Data Collection and Analysis

Study data was collected and managed using REDCap

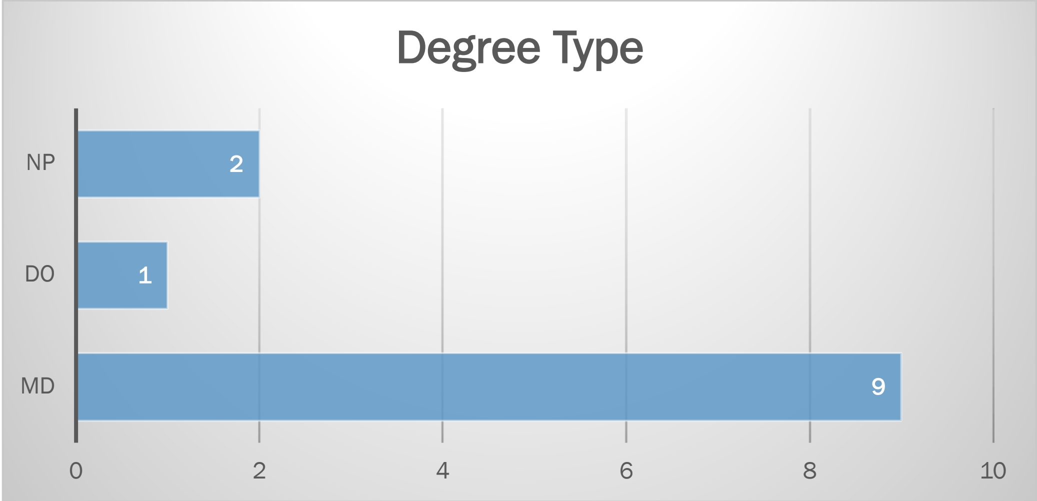
Data collection took place during the project implementation time period

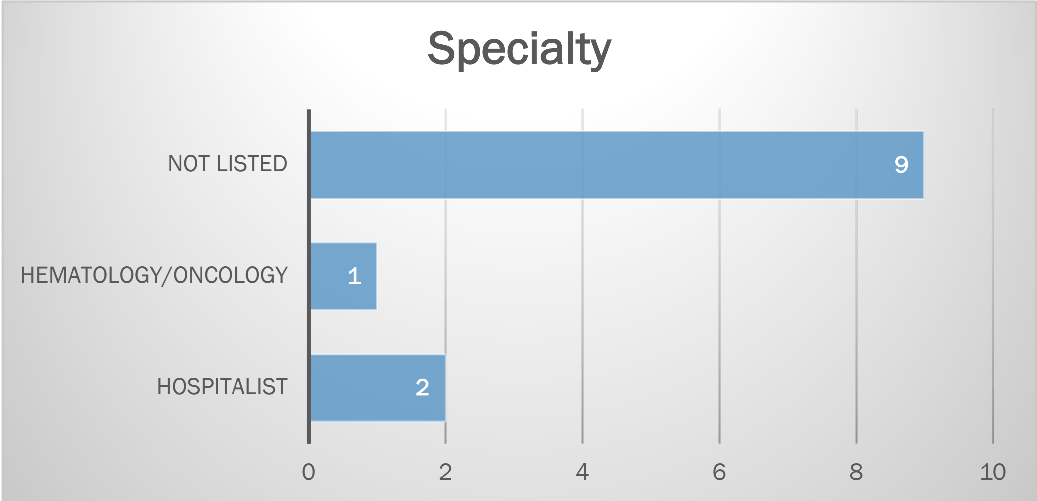
Descriptive statistics for quantitative data

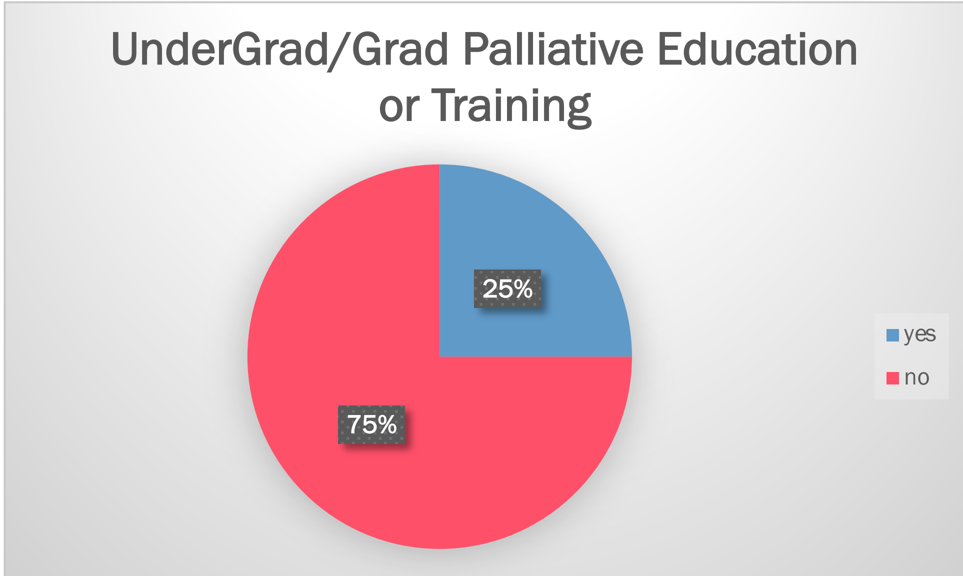
Qualitative data was analyzed by three content experts

Results

Participant Demographics







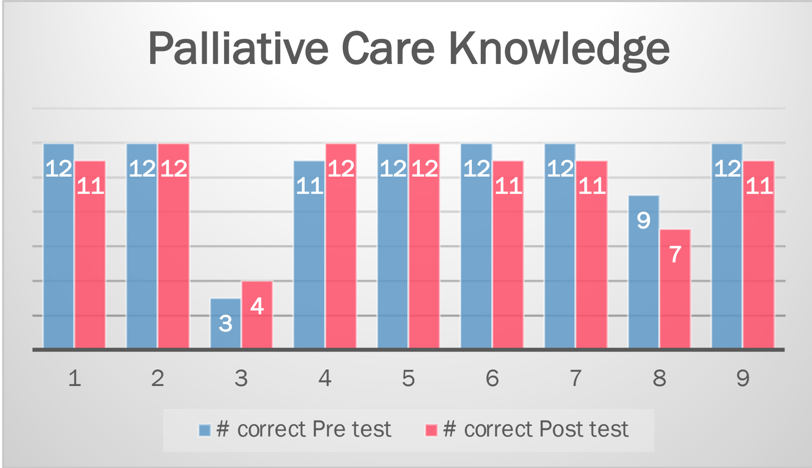
Results

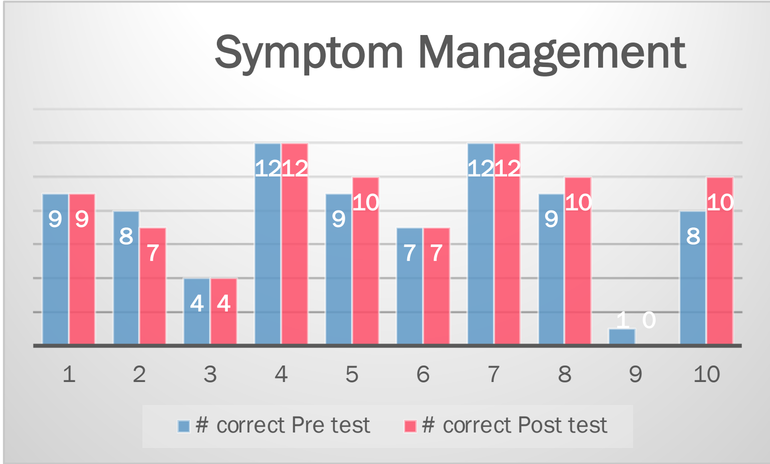
Qualitative

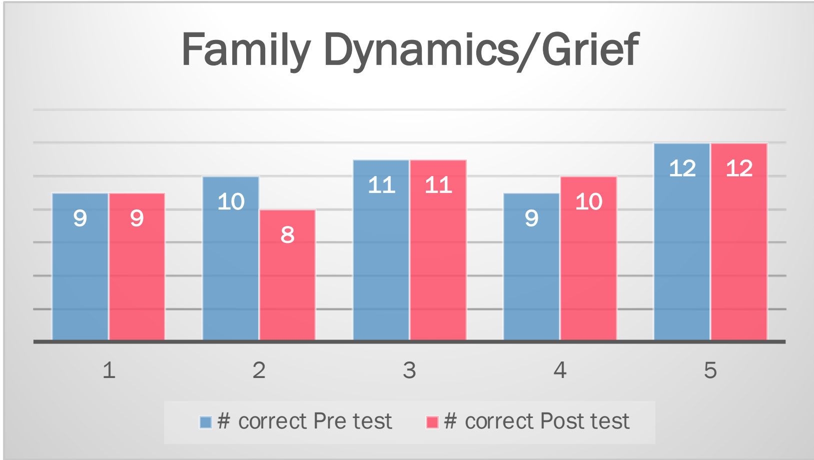
Type of Provider	Direct Provider Quotes
NP	“lack of time; discomfort in discussing the subject”
MD	“Providers’ understanding of the appropriateness of consulting palliative care and providers’ understanding that palliative care can consulted before imminent death.”
NP	“lack of communication”
MD	“Provider and patient/family reluctance”
MD	“Limited knowledge training”
MD	“Lack of understanding regarding the need for palliative care”
MD	“Logistics”
MD	“Patient bias. When offered a palliative care consult, patients often decline because they think that palliative is only hospice care or admitting that they are at ‘end of life’ stages.”
MD	“Lack of education”
MD	“Rotating physicians, making it hard to make connection with patient or family for goals of care talk.”

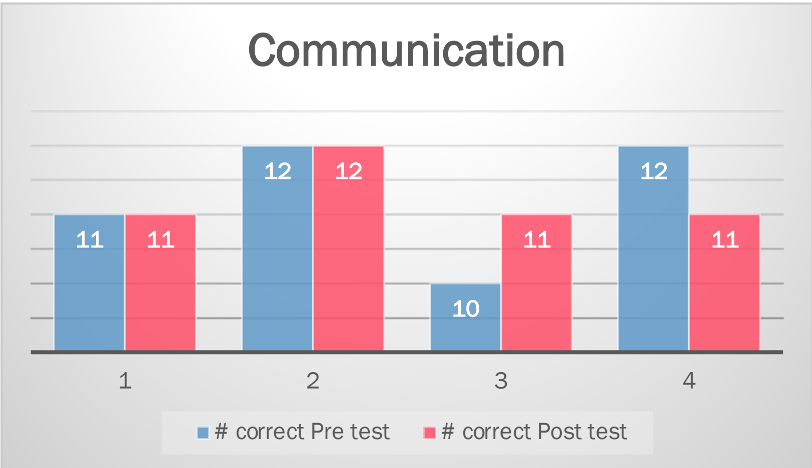
Results

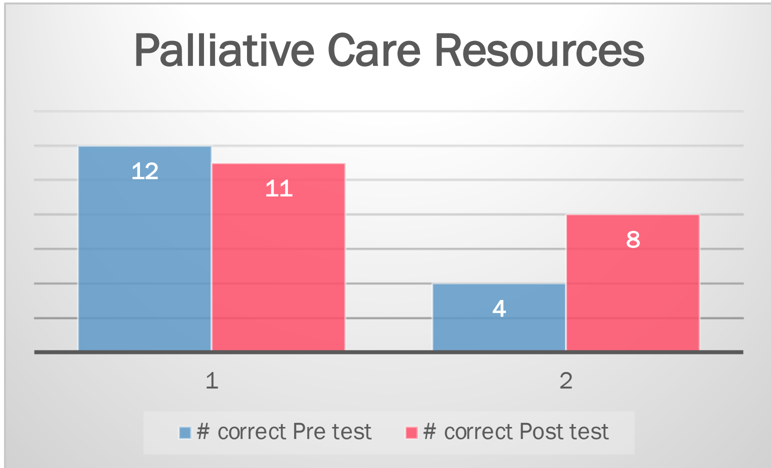
Quantitative











Discussion

- 10 out of 30 (33%) questions received lower number of correct responses
  - Did not show quantitative improvement
- N=12 (100%) participants self-reported increased knowledge and confidence with plans to incorporate into daily patient encounters
- Strengths
  - Ease of access
  - Self-paced
- Limitations
  - Small sample size
  - Short implementation period

Implications for Practice

- Project allowed for insight- in providers' own words
- Barriers to basic/primary PC identified
- Continued education can improve knowledge and confidence
- Expansion of PC education module
  - Potential to positively impact quality and consistency of patient care
  - Allows for more equitable PC distribution

Conclusion

- Specialty PC limits highlighted during COVID pandemic
- Hospitalized seriously ill patients benefit from early PC
- Implementing basic PC continuing education will increase nonpalliative care clinician knowledge and confidence delivery
  - Ultimately improving the quality of patient care
  - Equitably distributes palliative care

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