

Palliative Care: Improving Eligible Patient Identification to Encourage Early Intervention

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Norman Eugene McMurray

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Abstract

Palliative care (PC) encompasses a holistic way of caring for patients and families with chronic disease or life-limiting illness through optimal symptom management. Individuals in need of PC has reached 20 million annually world-wide. Many patients in need of this service never receive a consultation, or if they do, it comes late in the disease process. Some health care specialists see PC as incongruent with treatment, while others have a lack of understanding of what this service provides. Additionally, many providers have few or no resources to guide in the recognition of PC needs. This practice improvement project emphasized identification of chronically ill patients in need of PC through the use of the Supportive and Palliative Care Indicators Tool (SPICT), coupled with a thorough assessment by a nurse practitioner (NP) in an outpatient clinic in Yuma, Arizona. The project used a mixed-method design with qualitative data obtained through face-to-face interviews with the NPs and a questionnaire. Quantitative analysis occurred through comparison of the number of PC candidates with and without the use of the SPICT tool. Results showed that the SPICT tool, coupled with a thorough assessment, increased the NP's recognition of PC needs by 34%, and guided them in initiating a PC discussion with the patient and family. A thorough assessment, coupled with the SPICT screening tool can assist the practitioner in recognizing chronically ill patients in need of PC, thus increasing the potential for referral in a timely fashion. This may positively impact symptom management and quality of life.

Palliative Care: Improving Eligible Patient Identification to Encourage Early Intervention

Palliative care (PC) is described by the World Health Organization (WHO) as a means to prevent or relieve suffering for those with life-limiting illnesses (Cameron & Johnston, 2015). However, the term *Palliative Care* was not coined until 1974 by French-Canadian physician, Balfour Mount. He introduced this concept into teaching hospitals in Canada as a holistic way to care for patients and families with chronic disease or life-limiting illness (Hennessey, Lown, Landaazt, & Porter-Williamson, 2013). PC has evolved to include the care of those who struggle with symptom management and to improve quality of life (QOL). PC is no longer confined to those facing imminent death. PC also encompasses excellent communication with the patient and family and among health professionals (Hennessey et al., 2013). This important communication should include discussions regarding the nature of the illness, the prognosis, treatment, and even hopes and goals (Hennessey et al., 2013). Palliative care interventions can be most effective through early patient identification so as to intervene with the end goal of optimal symptom management, thus improving QOL for the patient and family (Cameron & Johnston, 2015).

Problem Description

There is a great need for PC knowledge and services world-wide (Yang, Nelesen, Montross, Whitmore, & Ferris, 2013). In low to moderate resource countries patients present for care with advanced symptoms due to the fact that these patients have not had the opportunity for PC treatment (Yang et al., 2013). Moreover, it is estimated that of the 20 million people globally requiring PC each year, the majority of them live in these underserved countries. The barriers to receiving this type of care in these countries are many, with an important one being inadequate economic resources due to money being allocated for immediate diseases such as malaria, tuberculosis, and HIV/AIDS (Yang et al., 2013). Resources are also severely lacking for provider

education and training (Rosa, 2017). The under-use of PC services in the United States is in large part due to the fact that it is still a relatively new sub-specialty with a sparse number of trained specialists as well as a lack of providers' awareness of the value of this intervention (Rosa, 2017). One of the results of this lack of awareness is that providers do not have the training necessary to recognize when a patient could benefit from PC and therefore, they fail to begin the conversation surrounding this option (Orchard, King, Kahlili, & Bezzina, 2012). There is also no structured method to determine a patient's candidacy, therefore, difficult discussions might be delayed or impaired (Orchard et al., 2012). Providers also avoid discussing life expectancy for fear of destroying the patient and family's hope or marring therapeutic relationships (Orchard et al., 2012). Additionally, patients and families demonstrate variances in their readiness for discussion of life expectancy (Hennessey et al., 2013). This variance is, in large part, due to the patient and family's lack of exposure to these types of discussions and their adjustment to the disease process (Walczak et al., 2015). The result is that many patients who could benefit from PC are never offered this service, or are offered it very late in the disease process (Hennessey et al., 2013). The stark reality is that the majority of PC discussions first occur when the patient is near death, with acute hospital admissions (Walczak et al., 2015). While many patients at the end of life would prefer to die at home, not be a burden to their loved ones, have little to no pain, and avoid artificial life support, 50% of all deaths in the United States (annually) occur in hospitals (Hennessey et al., 2013). This suggests that patients and families have not had adequate time or information to make an informed decision, in part due to healthcare providers having not recognized the need for PC and having not initiated these difficult conversations (Hennessey et al., 2013). Therefore, while PC is increasing in the United States most patients still receive this

intervention during the end stages of a disease, and some not at all (Berry, Castallani, & Stuart, 2016).

At a local level, PC treatment is affected by culture and requires an understanding and sensitivity to that culture. Yuma, Arizona's population is 62.8% Hispanic, which calls for increased awareness of the unique needs of this group (United States Census Bureau, 2016). Often, this Hispanic population faces difficulty in accessing and utilizing healthcare due to socio-cultural and economic barriers (Najet-Hajem, Carrion, Ell, Hamilton, & Palinkas, 2013). This region also has two American Indian reservations that comprise 2.3% of the population (United States Census Bureau, 2016). Many Native American cultural beliefs present some difficulties in the discussion of PC and end of life. The local tribes, the Quechan and Cocopah, are reluctant to discuss future events as their belief is that this will lead to the actual occurrence of the event (Najet-Hajem et al., 2013). The Native American culture also relies on the passage of time to make big decisions, which may lead to PC at a later stage in the illness trajectory (Marr, Neale, Wolfe, & Kitzes, 2012). Additionally, Yuma, Arizona has a severe shortage of PC specialists, with just one medical doctor (MD) and one Nurse Practitioner providing PC to this community. When a patient is a candidate for PC there is a long waiting list to receive care. In this paper I will describe an intervention designed to address the root of the local problem, which is identifying patients who are eligible for palliative health care services.

Available Knowledge

A literature search was conducted with the following clinical question: Will the implementation of a screening tool better identify patients with chronic illness that meet criteria for palliative care? The overall search strategy was identified, and studies were assessed that were pertinent to the clinical question. Searches were also conducted surrounding the general

topic of interprofessional communication and collaboration, as a lack of communication and collaboration add to the problem of missed identification of patients eligible for PC. Using the search terms *palliative care*, *communication*, and *collaboration*, with the limits of English language, less than 12 years old, and full text available, 607 articles were revealed in the Cumulative Index of Nursing and Allied Health Literature (CINAHL) and SAGE Publishing. The search was then narrowed by adding the key words: *early intervention*, *referrals*, and *screening tools*. A total of 86 articles was revealed. Abstracts were reviewed for 45 of those articles, and the full text reviewed for 15. The final number of articles retained was five. Studies retained focused specifically on interprofessional communication and collaboration, along with those that showed successful utilization of screening tools to identify PC needs. Results indicated that few studies have been conducted in the United States in relation to collaborative training for healthcare providers in order to improve communication skills for PC and end-of-life issues. Additionally, there are few PC screening tools that have been created, tested, or fully implemented.

Oishi and Murtaugh (2014) studied Interprofessional collaboration (IPC) through the use of a systematic review and narrative synthesis. The aim of the review was to discover evidence related to the views on the provision of PC by primary care providers and to also reveal any gaps in the evidence. The authors concluded that effective IPC is necessary to deal with the uncertainty of PC provision and to maintain coordinated care. Further research is needed to develop a model for effective interprofessional work for the benefit of those patients needing PC.

Beernaert et.al., (2014) created focus groups consisting of 20 physicians and 12 nurses in Belgium, and also interviewed their patients in order to determine barriers of early identification of PC needs. This was a qualitative study with a thematic design to discover those barriers. The

main obstacles discovered related to communication styles, the perceived role of the family physician (FP), and continuity of care. It was also noted that FPs focused more on acute needs and also that patients were hesitant to discuss non-acute care needs in this setting. It was also discovered that FPs paid most attention to PC needs only during the terminal phases of a patient's illness, rather than earlier in the disease trajectory. While these findings are subjective, they can lend understanding to the physician and nurse roles in relation to communication and assessment of PC needs.

Waller, Girgis, Currow, and Lecathelinais (2008) developed a needs assessment tool to be used with advanced cancer patients and caregivers, that might prompt early intervention. This study utilized a convenience sample of 103 health care providers who viewed videotaped consultations with a simulated patient and caregiver interacting with a health professional. They then completed the Palliative Care Needs Assessment Tool (PC-NAT) and gave feedback on its clarity, content, and acceptability. The methodology employed was one of a single non-experimental study. While the results show that the tool demonstrates ease in use, and demonstrates content validity, it is over 10 years old and no updated studies with the PC-NAT have been conducted.

The Sheffield Profile for Assessment and Referral for Care (SPARC) was developed in order to better reach those patients who could benefit from PC. The SPARC is a self-assessment questionnaire where patients are asked a series of questions related to their physical symptoms, psychological issues, and independence and activity, among others. Ninety-nine consumer and self-help support groups were recruited from the United Kingdom (UK) to review the tool and respond via a questionnaire. Thirty-eight groups participated and answered questions related to the tool's acceptability, relevancy, and their perception of its usefulness. The majority of

respondents (93%) found the tool easy to understand and useful. A small minority (12%) found the tool to be “too sensitive” in its subject matter, and hard to understand. The findings suggest that the SPARC tool is a relevant and acceptable tool to identify those patients with PC needs. Limitations include the fact that this tool has not been tested clinically, with actual patients, and is based on opinion of self-help groups alone (Hughes et al., 2013).

The Supportive and Palliative Care Indicators Tool (SPICT) was first developed in 2010 as a collaborative project between the National Hospital System (NHS) Lothian, and the University of Edinburgh Primary Palliative Care Research Group in Scotland (www.spict.org.uk). (See Appendix A for the SPICT tool). This tool was designed to provide practical, evidence-based guidance to help clinicians recognize when their patients might be at risk of dying and likely to benefit from PC in addition to ongoing management of their advanced conditions. Highet, Murray, Crawford, and Boyd (2013) conducted a mixed-methods study that used a participatory research method to retest and refine the SPICT tool from 2010. The tool was updated to include easily identifiable general indicators relevant to patients with an advanced illness, and disease-specific indicators for advanced conditions. PC specialists, primary care clinicians, hospital clinicians, and a senior social scientist, as the project researcher, were included in the refinement of the SPICT. An international, electronic mailing list was used to communicate with the 30 participants from the UK, Europe, United States, Canada, New Zealand, Australia, and Africa. Email alerts were sent to all participants to seek input on updates to the 2010 version of the SPICT until no further changes were proposed. Simultaneously, the SPICT was tested in an acute care facility in Scotland (Highet et al., 2013). One-hundred and thirty patients with advanced disease were identified as candidates for PC with the use of the tool following an unplanned hospital admission. Findings suggest that the SPICT can augment

clinical judgment when identifying patients who are at risk for deteriorating and/or dying. The updated SPICT is a simple tool to support better identification of patients with un-met PC needs (Highet et al., 2013). Additionally, the SPICT provides clear indicators that can be useful in initiating conversations with patients and families about their preferences for different treatment and care options. Lastly, the SPICT can promote effective communication between providers and care teams.

Based on the findings from these three screening tools, the SPICT was chosen for this practice improvement project as it was tested in a clinical setting, and relies heavily on thorough assessment skills to recognize PC needs. The SPICT is available for all practitioners to use without permission, and all users are encouraged to visit the website frequently to note any updates (www.spict.org.uk). Additionally, the SPICT is not a series of boxes to check, but rather a guide for the clinician in determining PC recognition, and suggests prompts for communication surrounding PC. This project aimed to provide a direction for practice change by communication with patients and families through the use of the SPICT, resulting in an increased recognition of candidates for PC.

Rationale

While Yuma County, Arizona is becoming more urban and less rural, it is still considered a medically underserved area (Arizona Department of Health Service, 2015). Despite advances in increased knowledge and availability of PC, many rural dwelling people still lack access to healthcare services, including PC (Tasseff, Tavernier, Watkins, & Neill, 2018). Additionally, medically underserved areas experience a shortage of physicians and nurses, which adds to the lack of access (Tasseff et al., 2018). The Rural Nursing Theory is centered on how rural dwelling people define health in the context of productivity and capability, rather than as the absence of

disease (Tassef et al., 2018). This theory was developed by Long and Weinert (1999) and the premise is that rural dwelling people have different definitions of health and illness. For example, rural people often delay seeking health care until grave illness sets in or they become incapacitated (Long & Weinert, 1999). This means that health care services must be modified to suit the life-styles and preferences of rural citizens and must include family and community help during times of illness or injury (Long & Weinert, 1999). Nurses must address the helpers along with the patients in order to gain trust and cooperation. The underlying belief of this theory is that the formal health care system needs to adapt and acknowledge the informal helping system (Long & Weinert, 1999). This theory also comprises other key concepts, such as self-reliance and autonomy, in order for the patient to work to provide for the family's needs. Another key concept is delayed healthcare seeking behavior due to fear of missing work and a pay check (Tassef et al., 2018).

The Rural Nursing Theory provides a conceptual framework within which this practice improvement project is contained. This is because Yuma County, AZ is a medically underserved area with limited access to specialists, and has a manual-labor population that defines health according to capability and productivity rather than through the absence of disease. Thus, the definition of health by this population impacts their healthcare seeking behavior, many of them only seeing a provider when grave illness sets in. With the shortage of PC specialists in this area, it can be argued that the use of the SPICT coupled with a thorough assessment, can help all health care providers to identify and even begin treatment for those patients who can benefit from PC interventions.

Specific Aims

Increasing the identification of patients in an outpatient clinical setting who are in need of PC through the consistent use of the SPICT by providers is the aim of this practice improvement project. The overarching goal is to create a sustainable process whereby all patients are screened for PC needs. The secondary aim is to help the providers focus on patient and family-centered care for those who experience life-limiting illness and disease. This can be accomplished through early assessment and referral, thus providing optimal symptom management and an increased QOL (Hennessey et al., 2013).

Methods

Yuma County, Arizona is a medically underserved population and lacks many specialists, including sufficient PC providers. It is imperative that a universal method for identifying patients in need of PC be determined and utilized. Due to the shortage of PC providers, it is also necessary for primary care providers (PCPs) to enhance their awareness and abilities in the recognition and treatment of those patients who can benefit from PC. This practice improvement project commenced on November 5, 2018 in order to determine if the SPICT coupled with thorough assessment skills could better identify patients in need of PC.

Context

Transitional Care Services (TCS) is an outpatient clinic affiliated with Yuma Regional Medical Center (YRMC) and specializes in the care of patients with heart failure (HF), chronic obstructive pulmonary disease (COPD), and some with renal disease. Many of this patient population suffer from multi-morbidity, which is the presence of many diseases or conditions that occur simultaneously (Petrillo & Ritchie, 2016). Multi-morbidity is associated with increased mortality, increased healthcare utilization, decreased QOL, and inadequate symptom management (Petrillo & Ritchie, 2016). This inadequate symptom management leads to

symptom burden, which is a clustering of multiple symptoms and is defined as the severity of the symptoms as well as the patient's perception of the impact of those symptoms (Petrillo & Ritchie, 2016). This patient population may require a specialized level of care upon discharge from an acute care facility, and the TCS clinic ensures that adequate resources are provided to successfully manage these chronic conditions. Three NPs oversee TCS and assist in enhancing symptom management and promoting QOL for this patient population. Oftentimes patients avoid readmission to the hospital due to the care and attention to their symptoms at this clinic. The best way to promote QOL and control symptoms may be PC. The control of symptoms and enhancement of QOL can be difficult because there is no generally accepted method to assess for PC readiness (Locker & Lubbe, 2014). Due to the nature of chronic illness and multi-morbidity it was determined that many in this patient population might be candidates for PC. This was the catalyst for choosing this clinic.

Intervention

Two doctorally prepared NPs received extensive education in the form of a verbal presentation regarding current PC trends (See Appendix B for outline of presentation). The discussion included information regarding the gaps in PC as well as the benefits. A discussion including PC as a holistic way to care for patients and families with chronic disease or life-limiting illness was included. The presentation emphasized that PC has evolved to include the care of those who struggle with symptom management and QOL, and is no longer confined to those facing imminent death. It was stressed that PC also encompasses excellent interprofessional communication as well as with the patient and family. The providers were then introduced to the screening tool by reviewing the SPICT website and resources contained therein. Next, they were directed to a smart- phone application to have access to the SPICT tool

via a smart phone. Finally, the NPs were presented an educational packet that contained evidence-based articles surrounding PC with progress as well as gaps in care. A copy of the SPICT tool with literature and training information on its use was also included. Each section of the tool was discussed in detail with specific examples given. The phrase-Ask, Look, Look Again, Assess-was used to introduce each section of the SPICT tool. Section one: Ask- prompted the practitioners to ask themselves if there are clinical indicators that the health of this person who has one or more progressive conditions is deteriorating? Section two: Look- prompted the practitioners to look for two or more general indicators of deteriorating health such as poor performance status, progressive weight loss, two unplanned hospital admissions in the past six months, a new diagnosis of a life-limiting illness, two or more advanced or complex conditions, persistent or troublesome symptoms despite optimal treatment, or patient requiring progressively greater care. Section three: Look Again- prompted the practitioner to look for clinical indicators of one or more advanced conditions such as cancer, dementia/frailty, neurological disease, heart/vascular disease, respiratory disease, kidney disease, or liver disease. Section four: Assess- prompted the practitioner to review current care such as assessing current treatments and medications so as to optimize care and symptom control, discuss current and future goals with the patient and family, plan ahead if the person is at risk for loss of capacity, and consider referral for specialist assessment if symptoms or needs are complex and difficult to manage. It was emphasized that the SPICT is easy to use and prompts the healthcare provider to assess the patient in greater depth in relation to PC needs. This would be warranted if the patient presented with two or more general indicators of deteriorating health and one or more advanced conditions. It was noted that the SPICT promotes conversations regarding QOL and symptom management through conversation starter prompts as noted in section four. The presentation continued with a

discussion about how the tool could augment a thorough assessment of the chronically ill patient by addressing the four sections outlined in the SPICT.

This project was not considered research by the Institutional Review Board (IRB) for Northern Arizona University (NAU) (See Appendix C for IRB letter). However, the NPs felt that complete transparency was necessary. Therefore, a demographic form was created in both English and Spanish by the project manager, and completion of the form by the patient was considered informed consent to participate (See Appendices D and E for demographic forms in English and Spanish).

Chronically ill adult patients enrolled in the TCS clinic, who agreed to participate, were assessed using the SPICT to determine if they were candidates for PC. The SPICT was used by both practitioners from November 5, 2018 through January 5, 2019, and an individual tracking form was created and used for each patient that was screened (See Appendix F for individual tracking form). This form consisted of a patient identification number and information regarding the patient's results after assessment with the SPICT. This document also identified reasons for declination of a referral if the patient was a candidate. The NPs also utilized a data tracking sheet to keep a total of all patients screened, with results, and reasons for declination (See Appendix G for the data tracking sheet).

Specifics of the Team

The providers who used the SPICT are doctorally prepared NPs who specialize in the care of chronically ill patients, specifically those with heart failure (HF), chronic obstructive pulmonary disease (COPD), or renal failure. Luz Wiley received her Master of Science/Adult Nurse Practitioner degree from the University of Arizona in 2006, followed by a Doctor of Nursing Practice degree from the University of Arizona in 2013. Dr. Wiley is the director of

Transitional Care Services, and one of the NPs participating in this practice improvement project. Carolyn Hull received her Master of Science/Adult Nurse Practitioner degree from the University of Arizona in 2015, followed by a Doctor of Nursing Practice degree from the University of Arizona in 2016. Dr. Hull is an adult nurse practitioner at TCS and participated in this project.

Study of the Intervention

A qualitative approach along with descriptive statistics was chosen for this practice improvement project in order to formulate an understanding of PC need recognition and how it was enhanced by the use of the SPICT screening tool.

Approach for Assessing Impact

Utilization of the screening tool by the two NPs, occurred daily, from November 5, 2018 through January 5, 2019. The use of the SPICT to determine PC needs was compared to assessment alone. The NPs kept notes of their experiences and findings while using the tool. The key determination was whether using the SPICT enhanced recognition of PC needs compared to standard assessment alone.

Approach to Determine Validity of Outcomes

A retrospective chart review was conducted for August 5, 2018-October 5, 2018 to document the number of patients eligible for PC using standard assessment. This number was compared to the number of PC candidates discovered during the use of the SPICT along with assessment. This comparison, along with the reflections of the NPs assisted in determining if the SPICT increased recognition of PC needs.

Measures

The NP's reflections and thoughts regarding the use of the tool were measured to determine its efficacy through face-to-face meetings and a final questionnaire (See Appendices H and I for final questionnaires). Secondary data was also measured through number of PC candidates, number of referrals, and reasons for declination of a referral (See Appendices J and K for PC candidates, referrals, and declination of referrals).

Rationale for Chosen Measures

Interviews and questionnaires are common methods to obtain data in qualitative studies and to collect detailed descriptions of variables. Based on these findings, plans for improving health care practices can occur, and these measures can assist in determining the value of the outcomes. Interviews may consist of a set of open-ended or closed-ended questions and are often used when obtaining more personal information from the respondent (Melnyk & Fineout-Overholt, 2015). Several face-to-face interviews occurred during the project intervention, and a questionnaire was completed by both NPs at its conclusion. Through the use of these two measures the practitioners were able to articulate their experiences and determine the efficacy of the SPICT tool in enhancing recognition of PC needs.

Contextual Elements Affecting Measures

The project manager met with the NPs weekly to discuss data collection, findings, and to answer questions. The NPs stated that patients were reluctant to participate due to the following factors: the time involved in completing the demographic form; disclosing of personal information such as education and income; misunderstanding the term "palliative care", thinking it meant hospice or that it applied immediately to them. All of these factors limited the number of patients that were screened with the use of the SPICT. In retrospect, the project manager and the NPs determined that the demographic form giving consent was not necessary. The idea of

eliminating the demographic form mid-way through the project was discussed at length. However, it was decided to continue using the form for consistency as per the NPs desire. In looking at the aims of this project, it would have been acceptable to avoid the use of the form or stop its use mid-way and assess every patient. There was no harm involved to patients, the project was deemed non-research by NAU's IRB, and the assessment tool simply augmented the practitioner's expert assessment skills. The decision to use informed consent via the demographic form limited the number of patients the NPs could assess with this tool.

Completeness and Accuracy of Data

To ensure consistency in the tool's use and in the interpretation of findings a re-training and review of the process was conducted weekly. The project manager met with the NPs and reviewed the tool and addressed questions, concerns, and comments regarding the use of the tool. It was noted that both NPs used the tool in the same manner yet with some flexibility due to their own style in assessing and communicating with patients. The NPs expressed the ease in use of the tool and stated that it helped them to focus on the patient holistically, looking at their current status, potential declining health, and plans for future health needs. They both expressed that the tool directed them to ask questions that they did not always ask, but felt they should be asking. The prompts on the tool were a reminder for them to be more thorough in their assessment of PC needs. These comments were expressed equally and consistently between both practitioners.

Analysis

Qualitative and quantitative methods were used to draw inferences from the data.

Qualitative

This practice improvement project utilized qualitative measures to discover whether the SPICT tool would assist a practitioner in the identification of chronically ill patients in need of

PC interventions. The NPs participated in several face-to-face interviews during data collection, and completed a questionnaire at the conclusion of the project.

Quantitative

Quantitative methods were employed when assessing the number of patients who were recognized as a candidate for PC between August 5, 2018-October 5, 2018 with standard methods of assessment, compared to November 5, 2018-January 5, 2019, with assessment and the use of the SPICT tool. This was to determine whether the SPICT tool increased the NPs recognition of PC needs. Secondary data such as actual PC referrals and reasons for declination of a referral were collected for the intervention period.

Variation in the Data

Fifty patients were screened with the SPICT from November 5, 2018 through January 5, 2019. In completing the retrospective chart review, 50 charts were chosen for the time period of August 5, 2018 through October 5, 2018. These patient charts were chosen based on similar characteristics of the 50 screened with the SPICT, including age, sex, and health condition.

Ethical Considerations

IRB approval was sought through NAU and the project was deemed non-research. YRMC reviewed the project and final approval was granted through this institution (See Appendix L for YRMC approval letter). A demographic form was created in both English and Spanish, which was also considered the informed consent for each patient. The patients were invited to complete the form, giving consent for the practitioner to use the SPICT as part of their regular office visit and assessment. They were informed that the SPICT would better help in the identification of their health status and provide direction for treatment options, including PC, should this be necessary. The demographic form included information including age, gender,

marital status, ethnicity, geographical location, level of education, financial status and health conditions. Initially it was thought that this type of information would be important in noting patterns of those patients who would accept or decline a referral, based on The Rural Nurse Theory discussed earlier. However, as the project progressed it was determined that the usefulness of the SPICT in recognizing PC needs was the aim of the project, and not the reasons for declination. By utilizing this demographic form as a consent, the participants had full transparency and had the option to decline participation, but it was later determined that informed consent was not necessary as this project was non-research and the SPICT could be safely incorporated into every patient visit.

Results

Initial Steps of Intervention

The project manager met with a local PC physician to discuss PC needs in Yuma County in April 2018. A discussion ensued regarding the gaps in this type of care. It was found that poor communication amongst providers and with patients and families was a large gap. This led to a literature search beginning in July 2018 to discover that these types of gaps did occur, and that a lack of communication training for providers in relation to PC existed. The search also showed few tools or guidelines to enhance the provider's assessment skills in determining PC needs. It was determined that a tool to augment a thorough assessment might help the practitioner recognize patients who could benefit from PC intervention. The SPICT was chosen based on the evidence and due to the ease of its use to supplement a thorough assessment. It was determined that an outpatient clinic (TCS) affiliated with YRMC in Yuma, Arizona would be an optimal location to implement the SPICT. The project manager met with the two NPs at TCS in early August 2018 to introduce the project and determine their interest in participating. The project

focused on recognition of those patients who were candidates for PC with the use of assessment and the SPICT. It was at this point that it was decided to also track why a patient might decline a referral once deemed a candidate for PC.

In late August 2018 training for the NPs began on the use of the SPICT and discussions surrounding the creation of a demographics and a tracking system ensued. In September 2018 the IRB application was completed and the project was determined to be non-research. In late October 2018 permission to proceed was granted by YRMC.

Details of the Process Measures and Outcomes

The tracking sheet was used to summarize the results of patients screened with the SPICT. Individual patient tracking sheets were also used. Face-to-face interviews occurred between the project manager and the two NPs to receive feedback on the use of the tool with its strengths and weakness. A final questionnaire was completed by the NPs to assess overall satisfaction and usefulness of the SPICT. During a face-to-face interview mid-way through the project, one of the NPs stated: “The SPICT tool is very helpful as it outlines criteria that guides the assessment. It opens the door to a discussion of palliation.” (L. Wiley, personal communication, December 3, 2018). The questionnaire, completed by the NPs at the conclusion of the project, prompted a reflection on the usefulness of the SPICT in their clinic. One NP stated:

I found the SPICT tool very user friendly and straightforward. The tool itself did not take a lot of time to complete... I found the tool to be helpful in determining eligibility for palliative care based on more standardized characteristics... I think consistent utilization of the SPICT tool would be ideal not only in Transitional Care, but also in PCP and specialists’ clinical practices. (C. Hull, Personal Communication, February 25, 2019).

The final questionnaire also prompted a reflection on how useful the SPICT tool was in initiating difficult conversations in relation to PC and as well as end of life issues. One NP stated:

We tend to focus on the status quo because it is easier than having those difficult conversations with patients and their family members. The SPICT tool was a reminder that an aggressive approach to patient care is not always the best choice, and maybe less aggressive care really is more, as quality of life is immeasurable. Having the SPICT tool available during the patient visit (and just reviewing it before each visit) was extremely helpful in honing in on specific patient needs in terms of end of life/quality of life needs. (L. Wiley, personal communication, March 7, 2019).

The comparison of PC recognition by using standard assessment alone, and by combining assessment with the SPICT demonstrated a 34% increase in recognition with the use of the SPICT. For the period of August 5, 2018-October 5, 2018, using assessment only, 8 of 50 (16%) patients were found to be PC candidates. For the period of November 5, 2018-January 5, 2019, using the SPICT and assessment, 25 of 50 (50%) patients were found to be PC candidates. Of those 25 patients deemed as candidates for PC with the SPICT, 22 were offered a PC referral, but all declined for various reasons. The remaining three candidates were not offered a referral based on specific circumstances. One of the patients was new and a PC referral was not discussed, another patient met the criteria, but based on the clinical judgment of the NP, PC was not offered. Another patient was referred back to hospice care. The declination of accepting a PC referral by the patients was discussed at length with the NPs and it was determined that a major reason for this was hesitancy on the part of the patient and family due to their requesting further discussion with their PCP, wanting to discuss further with their spouse, or the family not being in agreement. The Rural Nursing Theory is heavily evident here as rural people often delay seeking health care until grave illness sets in or they become incapacitated. This population also relies heavily on the family structure in making health care decisions (Long & Weinert, 1999). The NPs also stated that they did not encourage PC as they would have liked to, due to the fact that there would be a waiting list for admission to this service. One NP stated:

Currently, there are limited palliative care resources in our community; therefore, it was difficult to discuss palliative care services with the patient and family. If they were

agreeable to the referral, it was questionable if the referral/ patient would be accepted.” While recognition of PC needs was increased, the referral process is still lacking, due to a shortage of PC specialists in the area, and due to the hesitancy of the patient in accepting a referral. (C. Hull, personal communication, February 25, 2019).

Contextual Elements that Interacted with the Intervention

The use of the demographic form that doubled as informed consent limited the number of participants. The small number of patients willing to participate can likely be attributed to the time involved in completion of the form and disclosing of personal information. The lack of participation may also be related to aspects of the Rural Nursing Theory that emphasizes key concepts such as self-reliance and autonomy-in order for the patient to work to provide for the family’s needs. This theory emphasizes that these people often delay seeking health care until grave illness sets in or they become incapacitated (Tasseff et al., 2018).

Observed Associations Between Outcomes, Interventions and Relevant Contextual Elements

Because TCS is a clinic that cares for patients with chronic illness, there is a greater possibility that many of these patients are candidates for PC. Therefore, the use of the tool in this environment was deemed appropriate. These NPs see many patients who are referred to hospice due to the nature of their illness trajectory. This gives the NPs the potential to intervene sooner on behalf of the patient. The SPICT has assisted the TCS NPs in earlier recognition of patients who could benefit from PC. Unfortunately, their patients might still decline a referral due to their work ethic and need for supporting of their families, according to the Rural Nurse Theory (Tasseff et al., 2018). Additionally, even with an earlier recognition, the limited number of PC specialists in the Yuma area might slow a referral. While the SPICT is helpful in recognizing PC needs, it is apparent that other factors affect PC treatment. These include the reluctance of patients and families to participate coupled with the shortage of PC practitioners.

Unintended Consequences

An unintended positive consequence occurred between the project manager and a local palliative care physician. The project manager met this physician in passing and informed her of the ongoing project. The specialist showed interest in the SPICT tool and requested a copy. She also voiced the idea that the SPICT could be used by the medical residents who oversee a primary care clinic. The NPs at TCS meet occasionally with this same PC specialist and during one visit discussed the SPICT with her. One NP made this comment in relation to a visit with this PC specialist:

We have discussed utilization of the SPICT tool with the Palliative Care Director (specialist) and she is interested in learning more. She agreed that standardized eligibility criteria would be helpful in identifying eligible patients to receive palliative care services once the service grows. (C. Hull, personal communication, February 25, 2019).

An unintended negative consequence occurred as the NPs began using the SPICT. If they found that a patient was a candidate for PC, they were hesitant to offer a referral due to the severe shortage of PC practitioners in Yuma, Arizona. This area currently has one palliative care MD and one nurse practitioner that can be referred to. The NPs noted that while some patients were candidates for PC, a referral was not always offered due to a long wait to be admitted to this service. Another unintended negative consequence occurred when an informed consent was required as was mentioned previously. This severely limited the number of participants and was later considered unnecessary due to the project being deemed not human research by the IRB.

Summary

Communication, collaboration, and using the SPICT offer the potential for patients to be recognized as having PC needs in a more timely and meaningful fashion, which could initiate a PC referral or the initiation of PC treatment by their PCP. PC treatment could positively impact patients and their families during a potentially stressful and difficult time by improving symptom management and enhancing QOL.

Key Findings

Regarding the educational component of this practice improvement project the following comment was made by one of the NPs:

The educational packet and orientation to the SPICT tool helped increase my understanding of the proposed project and the tool selected for use. I found the educational packet and orientation very beneficial. The orientation also provided the opportunity to ask questions and receive clarification. (C. Hull, personal communication, February 25, 2019).

The NPs agreed that the consistent use of the SPICT would increase recognition of TCS patients in need of PC, and the use of the SPICT in their clinic increased their recognition of patients with PC needs by 34%. Because Yuma is considered a rural, medically underserved community, there are unique characteristics of this patient population as mentioned earlier in this paper. The SPICT allowed the NPs to initiate conversations about symptom management more easily, and include the family in those conversations. Understanding that families in rural areas play a large role in the care of sick loved ones was important for the NPs. An additional key finding was the lack of PC specialists in Yuma County.

Strengths of the Project

The passion and enthusiasm of the NPs made the initiation of the project very smooth. These NPs see many patients daily who have chronic illness with exacerbations and there has not been a consistent method to determine readiness for PC. These practitioners were ready for a method to assist in this recognition and were open to the use of the SPICT in hopes that it could provide a valid way to measure PC needs. This clinic sees many patients who have co-morbidities and chronicity and thus the chosen clinic was an excellent fit for this practice improvement project. The SPICT was easy to understand and use and it had excellent prompts for conversation starters surrounding PC.

Interpretation

This project demonstrated that an evidence-based, consistent method of assessing for PC needs, such as the SPICT, coupled with usual assessment, was helpful in identifying patients who could benefit from PC interventions. This project also enhanced the recognition of the shortage of PC specialists in this community, which impedes PC referrals due to limited availability of these specialists. Finally, this project aided in the recognition of the distinct needs of this patient population in relation to the Rural Nursing Theory and provided a greater understanding of this populations' belief systems surrounding health and illness.

Comparison of Results

The results from this practice improvement project can be compared to the findings of Highet et al. (2013). In their study, the SPICT screening tool was administered by ward staff members (nurses) in a local hospital in Scotland. Their study found that 130 patients with advanced diseases including renal, liver, cardiac, and respiratory were identified as candidates for PC with the use of the SPICT. Thirty-five percent of these patients had died at six months, and 48% had died at 12 months. In this hospital-based case study of patients with advanced non-malignant illnesses, those who died prior to 12 months had a higher frequency of SPICT general indicators, especially the indicators of unplanned hospital admissions, persistent symptoms and increasing care needs, than those who survived for 12 months (Highet et al., 2013). The findings of their study can substantiate the need for this practice improvement project, as the SPICT can aid in identifying patients with advanced conditions and can then encourage clinicians to consider a review of care goals and interventions to improve QOL. The study by Highet et al. (2013) demonstrates the usefulness of the SPICT in identifying PC needs and suggests that the SPICT can be used in other healthcare settings to increase PC recognition.

Impact on People and Systems

The SPICT is a simple, one-page tool with good face validity for health care professionals working in a hospital, community or home care setting. (Highet et al., 2013). The use of the SPICT can positively impact many practitioners in the Yuma area as this gives them a more consistent method for identifying those in need of PC. The SPICT contains accessible language and concepts that can be used to initiate discussions with patients and families about goals of care and even improve communication among health care providers (Highet et al., 2013). The SPICT indicators offer guidance on which patients are at risk of deteriorating, and it describes changes in health status and care needs that can be used as a starting point for these discussions (Highet et al., 2013). These indicators, in turn, can positively impact patients by having their needs met earlier through the promotion of comfort care, increased symptom management, and an enhanced QOL. The increased recognition of patients who are candidates for PC may bring greater attention to this need in Yuma County, and these findings may emphasize to administration at YRMC the need for more PC specialists. Finally, the SPICT has the potential to be added into the electronic health records (EHR) at YRMC and become a standardized screening tool for all patients as suggested by the NPs who were included in the project.

Limitations

There are some limitations to the generalizability of this project as it was conducted in a setting that is located in a medically underserved area. The responses of the patient population in an urban location might vary from the responses found in this rural area. Additionally, locations where there are a sufficient number of PC providers could likely impact the referral pattern to their services.

Factors Limiting Internal Validity

Variations in assessment methods between the NPs may have affected internal validity due to conversation style and familiarity with their specific patients. This was minimized through extensive training and re-training with the SPICT. Additionally, the NPs' knowledge of the shortage of PC providers decreased their motivation to encourage a patient to accept a PC referral as they knew the patient would be on a waiting list. The requirement of informed consent through completion of a demographic form decreased the number of participants, which limited the NPs exposure to the SPICT.

Conclusions

The number of individuals in need of PC has reached 20 million annually, world-wide (Rosa, 2017). Utilizing a screening tool, such as the SPICT, consistently with a group of providers has proven to enhance their recognition of PC needs, so that PC interventions may be offered sooner. More widespread use of the SPICT by healthcare providers has the potential to enhance symptom management and improve QOL for patients and families.

Sustainability

The continued use of this tool in the TCS clinic is expected, given its ease of use and help it provides with identifying patients who are candidates for a PC intervention. The NPs in TCS have agreed that the tool is useful and helpful. They have expressed a desire to continue using the tool in their clinic with all of their patients. One difficulty with the continued use of the tool is the lack of PC specialists available for patient referral. One of the NPs voiced this concern: "This practice improvement project reminded me that our town and our organization lack the resource to accommodate this patient population. Having the tool as a reminder was definitely beneficial". (L. Wiley, personal communication, March 7, 2019).

Potential for Spread

The potential for the use of the SPICT in other facilities in Yuma County is high. The local PC physician has voiced a desire to become familiar with the tool and suggested that the family practice medical residents consider its use as they screen patients. It has also been suggested by the NPs at TCS that it be used by other clinics, such as PCP offices. The SPICT can be useful for all patients, including in-patients, as it guides the practitioner to look for deteriorating health and the presence of one or more debilitating illnesses. The SPICT is essentially cost-free to use and can be incorporated into the EHR as a permanent assessment tool.

Implications for Practice

Utilization of the SPICT has the potential to be far reaching in Yuma County due to the enthusiasm and response of the NPs who first used it for this practice improvement project. If the local PC specialists, PCPs, and resident physicians can recognize its value, it may become standard protocol throughout clinics and for hospitalized patients as well.

Next Steps

Discussion is underway to incorporate the use of the SPICT with the medical resident physicians in a family practice clinic in Yuma, Arizona. Another practice improvement project could take place that would involve a larger scale intervention where every patient in the clinic would be screened using this tool. The current project with the NPs in the TCS clinic demonstrated that 50% of those patients screened with the SPICT qualified for PC. It is possible that other clinics may also recognize more patients who are candidates for PC by utilizing the SPICT along with a standard assessment. The potentially high number of candidates could justify adding more PC practitioners in Yuma County, which would better serve this rural, medically underserved community and their PC needs. Communication, collaboration, and the appropriate

assessment tool offer the potential for patients and families to be recognized as needing PC earlier, and then be referred in a more timely and meaningful fashion, thus positively impacting them during a potentially stressful and difficult time. It is imperative that health care providers become cognizant, comfortable, and communicative in bringing PC to patients and families who can benefit from this service. It is also important that providers understand the needs of this rural population and the importance of including families in these important conversations.

Additionally, it is imperative that hospital public servants and county health officials be made aware of the great need for PC services in this county.

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Appendix A
SPICT



Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is used to help identify people whose health is deteriorating. Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- The person has had significant weight loss over the last few months, or remains underweight.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer	Heart/ vascular disease	Kidney disease
Functional ability deteriorating due to progressive cancer. <input type="radio"/>	Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort. <input type="radio"/>	Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health. <input type="radio"/>
Too frail for cancer treatment or treatment is for symptom control. <input type="radio"/>	Severe, inoperable peripheral vascular disease. <input type="radio"/>	Kidney failure complicating other life limiting conditions or treatments. <input type="radio"/>
Dementia/ frailty	Respiratory disease	Stopping or not starting dialysis. <input type="radio"/>
Unable to dress, walk or eat without help. <input type="radio"/>	Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations. <input type="radio"/>	Liver disease
Eating and drinking less; difficulty with swallowing. <input type="radio"/>	Persistent hypoxia needing long term oxygen therapy. <input type="radio"/>	Cirrhosis with one or more complications in the past year: <input type="radio"/>
Urinary and faecal incontinence. <input type="radio"/>	Has needed ventilation for respiratory failure or ventilation is contraindicated. <input type="radio"/>	• diuretic resistant ascites <input type="radio"/>
Not able to communicate by speaking; little social interaction. <input type="radio"/>	Other conditions	• hepatic encephalopathy <input type="radio"/>
Frequent falls; fractured femur. <input type="radio"/>	Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome. <input type="radio"/>	• hepatorenal syndrome <input type="radio"/>
Recurrent febrile episodes or infections; aspiration pneumonia. <input type="radio"/>	Review current care and care planning.	• bacterial peritonitis <input type="radio"/>
Neurological disease	• Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy. <input type="radio"/>	• recurrent variceal bleeds <input type="radio"/>
Progressive deterioration in physical and/or cognitive function despite optimal therapy. <input type="radio"/>	• Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage. <input type="radio"/>	Liver transplant is not possible. <input type="radio"/>
Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing. <input type="radio"/>	• Agree a current and future care plan with the person and their family. Support family carers. <input type="radio"/>	
Recurrent aspiration pneumonia; breathless or respiratory failure. <input type="radio"/>	• Plan ahead early if loss of decision-making capacity is likely. <input type="radio"/>	
Persistent paralysis after stroke with significant loss of function and ongoing disability. <input type="radio"/>	• Record, communicate and coordinate the care plan. <input type="radio"/>	

Please register on the SPICT website (www.spict.org.uk) for information and updates
SPICT™, April 2017 (Patient record version - April 2018)

Appendix B

Outline of Educational Session

- I. Introduction to practice improvement project
 - A. Brief summary of purpose of project
 - B. Definition of palliative care
 - C. Gaps in diagnosis and treatment for palliative care
 - D. Benefits of early recognition and treatment
- II. Supportive and Palliative Care Indicators Tool (SPICT)
 - A. Introduction to the SPICT tool
 1. Why use SPICT
 2. When to use SPICT
 3. Conversation starter tips
 - B. Sections of the SPICT tool
 1. Ask-will the patient die within six to twelve months?
 2. Look-for two indicators of deteriorating health
 3. Look-for clinical indicators of one or more advanced conditions
 4. Assess-review current care planning and discuss current and future goals
- III. Process for initiation of project
 - A. Discussion surrounding patient population in Transitional Care Services clinic
 - B. IRB approval granted
 - C. Demographic sheet and Informed Consent
 - D. Start date of November 5, 2018-January 5, 2019
 - E. Retrospective Chart Review for August 5, 2018-October 5, 2018

Appendix C

IRB Letter

Office of Regulatory
ComplianceInstitutional Review Board
Human Research Subjects Protection Program805 S Beaver St
Building 22, Room 216
PO Box: 4062
Flagstaff AZ 86011
928-523-9551
[http://nau.edu/Research/Compliance/Human-Subjects/
Welcome](http://nau.edu/Research/Compliance/Human-Subjects/Welcome)

To: Norma Clark, MS
From: NAU IRB Office
Date: September 26, 2018

Project: Palliative Care: Identification and Early Intervention
Project Number: 1301498-1
Submission: New Project
Review Level: Administrative Review
Action: NOT RESEARCH
Project Status: Not Research

The project listed above does not require oversight by the Northern Arizona University Institutional Review Board because the project does not meet the definition of 'research' and/or 'human subject'.

- **Not Research as defined by 45 CFR 46.102(d):** As presented, the activities described above do not meet the definition of research as cited in the regulations issued by the U.S. Department of Health and Human Services which state that "research means a systematic investigation, including research development, testing and evaluation, designed to contribute to generalizable knowledge".
- **Not Human Subjects Research as defined by 45 CFR 46.102(f):** As presented, the activities described above do not meet the definition of research involving human subjects as cited in the regulations issued by the U.S. Department of Health and Human Services which state that "human subject means a living individual about whom an investigator (whether professional or student) conducting research obtains data through intervention or interaction with the individual, or identifiable private information".

Note: Modifications to projects not requiring human subjects review that change the nature of the project should be submitted to the Human Research Protection Program (HRPP) for a new determination (e.g. addition of research with children, specimen collection, participant observation, prospective collection of data when the study was previously retrospective in nature, and broadening the scope or nature of the research question). Please contact the HRPP to consult on whether the proposed changes need further review.

Northern Arizona University maintains a Federalwide Assurance with the Office for Human Research Protections (FWA #0000357).

Appendix D

Demographics Form-English

ID #: _____

Demographics Questionnaire

Please circle the answer that applies to you

1. Are you a new patient?

- A. Yes
- B. No

2. Which category below includes your age?

- A. 18-34 years old
- B. 35-44 years old
- C. 45-54 years old
- D. 55-64 years old
- E. 65-74 years old
- F. 75 years or older

3. What is your ethnicity of origin?

- A. White
- B. Hispanic or Latino
- C. Black or African American
- D. Native American or American Indian
- E. Asian / Pacific Islander
- F. Other

4. Do you identify as:

- A. Male
- B. Female
- C. Transgender
- D. Other
- E. Decline to answer

5. What city do you live in?

- A. Yuma
- B. Foothills
- C. Somerton
- D. Gadsden
- E. San Luis
- F. Other

6. What is your marital status?

- A. Single, never married
- B. Married or domestic partnership
- C. Widowed
- D. Divorced

E. Separated

7. Living arrangements

- A. With family
- B. With spouse
- C. With friends
- D. Alone

8. What is your annual income?

- Less than \$10,000/year
- \$10,000-25,000/year
- \$26,000-35,000/year
- \$36,000-45,000/year
- \$46,000-55,000/year
- \$56,000-75,000/year
- \$76,000-100,000/year
- Greater than \$100,000

9. What is the highest degree or level of school you have completed? *If currently enrolled, highest degree received.*

- A. Less than high school degree
- B. High school degree or equivalent (e.g., GED)
- C. Some college but no degree
- D. Associate degree
- E. Bachelor degree
- F. Graduate degree

10. What health conditions do you have? (Please circle all that apply)

- A. Coronary artery disease
- B. Diabetes mellitus
- C. Liver Disease
- D. COPD
- E. Chronic kidney disease
- F. Congestive Heart Failure
- G. Cancer
- H. Other

Appendix E
Demographics Form-Spanish

CARNÉ DE IDENTIDAD #: _____

Cuestionario de Demografía
Por favor circule la respuesta que se aplique a usted

1. ¿Eres un nuevo paciente?
 - A. si
 - B. no

2. ¿Qué categoría de abajo incluye tu edad?
 - A. 18-34 años
 - B. 35-44 años
 - C. 45-54 años
 - D. 55-64 años
 - E. 65-74 años
 - F. 75 años o más

3. ¿Cuál es su origen étnico?
 - A. Un blanco
 - B. hispano o latino
 - C. negro o afroamericano
 - D. nativo americano o indio americano
 - E. Asia / isleño del Pacífico
 - F. Otro

4. ¿Te identificas como:
 - A. Un hombre
 - B. hembra
 - C. Transgénero
 - D. Otro
 - E. Declinar responder

5. ¿En qué ciudad vives?
 - A. Yuma
 - B. estribaciones
 - C. Somerton
 - D. Gadsden
 - E. San Luis
 - F. Otro

6. ¿Cuál es su estado civil?
 - A. Soltero, nunca casado
 - B. Casado o sociedad doméstica
 - C. viuda
 - D. Divorciado
 - E. Separado

7. Arreglos de vivienda.
 - A. con la familia
 - B. con el cónyuge
 - C. con amigos
 - D. solo

8. ¿Cuál es su ingreso anual?
 - Menos de \$ 10,000 / año

- \$ 10,000-25,000 / año
- \$ 26,000-35,000 / año
- \$ 36,000-45,000 / año
- \$ 46,000-55,000 / año
- \$ 56,000-75,000 / año
- \$ 76,000-100,000 / año
- Más de \$ 100,000

9. ¿Cuál es el grado o nivel más alto de la escuela que ha completado? Si actualmente está matriculado, el grado más alto recibido.

- A. Menos que el título de secundaria
- B. Título de escuela secundaria o equivalente (por ejemplo, GED)
- C. Algo de universidad pero sin título
- D. grado asociado
- E. licenciatura
- F. Licenciatura

10. ¿Qué condiciones de salud tienes? (Por favor circule todo lo que corresponda)

- A. Enfermedad de la arteria coronaria
- B. diabetes mellitus
- C. Enfermedad hepática
- D. EPOC
- E. enfermedad renal crónica
- F. Insuficiencia cardíaca congestiva
- G. cáncer
- H. Otro

Appendix F
Individual Tracking Sheet

1. Identification Number:

2. Patient Eligible for palliative care referral: Yes _____ No _____

3. If Yes to #2: Referred? Yes _____ No _____

4. If no to #3 select reasons from below:

- A. Patient wants to discuss further with primary care provider**
- B. Family not in agreement**
- C. Financial reasons**
- D. Hospice candidate**
- E. Other-Prefers to discuss with spouse first**

Appendix H

Final Questionnaire-NP #1

1. How beneficial was the educational packet and orientation to the project and the SPICT tool?

The educational packet and orientation to the SPICT tool helped increase my understanding of the proposed project and the tool selected for use. I found the educational packet and orientation very beneficial. The orientation also provided the opportunity to ask questions and receive clarification.

2. Please share some thoughts regarding the actual use of the tool.

I found the SPICT tool very user friendly and straightforward. The tool itself did not take a lot of time to complete. The most labor-intensive aspect of this project was the time spent educating patients and their families on the project, discussing project participation and providing education about Palliative Care.

I found the tool to be helpful in determining eligibility for Palliative Care based on more standardized characteristics. My patient visits did take more time than usual due to extra time spent on educating, discussing, and clarifying questions about the project and Palliative Care. I would continue to use this tool in practice, but have not done so as currently, the Palliative Care program is not accepting new patients. As the Palliative Care program continues to grow, I think consistent utilization of the SPICT tool would be ideal not only in Transitional Care, but also in PCP and specialists' clinical practices.

3. Please share other insights regarding this practice improvement project and use of the SPICT tool.

Currently, there are limited Palliative Care resources in our community; therefore, it was difficult to discuss Palliative Care services with the patient and family. If they were agreeable to the referral, it was questionable if the referral/ patient would be accepted.

We have discussed utilization of the SPICT tool with the Palliative Care Director and she is interested in learning more. She agreed that standardized eligibility criteria would be helpful in identifying eligible patients to receive Palliative Care services once the service grows. There is planned growth in the Palliative Care program in the near future that will help us more adequately reach patients that would benefit from such services.

Appendix I

Final Questionnaire-NP #2

1. How beneficial was the educational packet and orientation to the project and the SPICT tool?

Having the SPICT tool available during the patient visit (and just reviewing it before each visit) was extremely helpful in honing in on specific patient needs in terms of end of life/quality of life needs.

2. Please share some thoughts regarding the actual use of the tool.

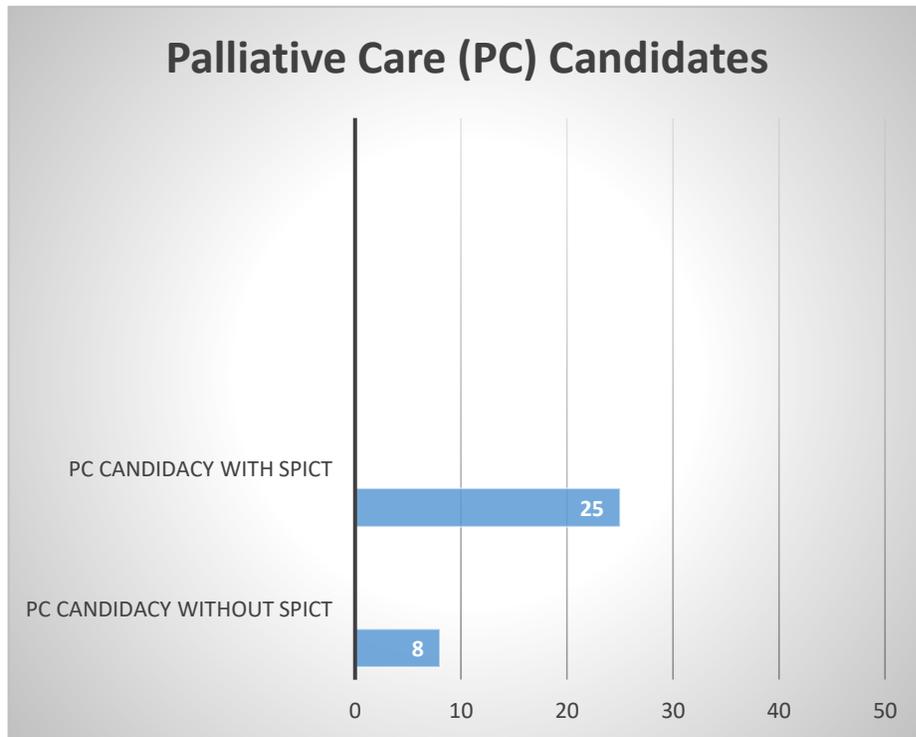
We tend to focus on the status quo because it is easier than having those difficult conversations with patients and their family members. The SPICT tool was a reminder that an aggressive approach to patient care is not always the best choice, and maybe less aggressive care really is more as quality of life is immeasurable. Overall, the tool helped guide the plan of care (even though most patients/families declined) and was great reminder that we need to be more mindful of what the patient wants and not what everyone else wants.

3. Please share other insights regarding this practice improvement project and use of the SPICT tool.

This practice improvement project reminded me that our town and our organization lack the resource to accommodate this patient population. Having the tool as a reminder was definitely beneficial.

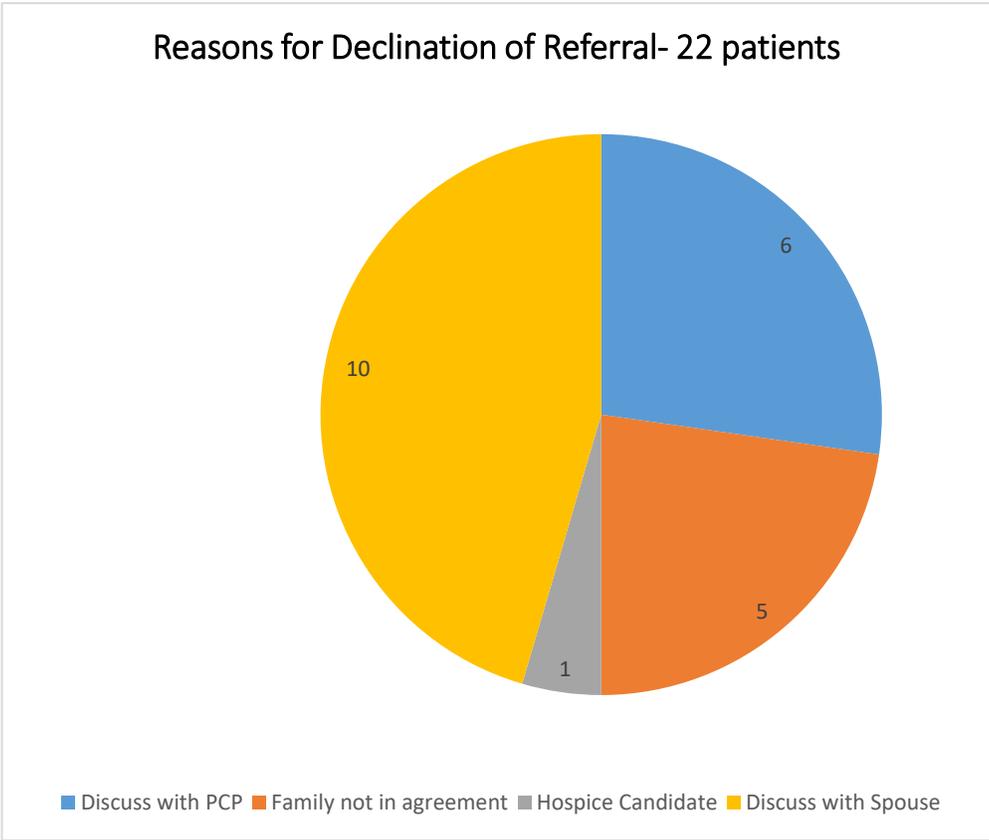
Appendix J

Number of PC Candidates-With and Without SPICT Tool



Appendix K

Reasons for Declination of PC Referral



Appendix L
Letter of approval



May 9, 2019

In Re: Norma Heather Clark
Project title: Palliative Care: Identification and Early Intervention
Date of research: November 5, 2018 through January 5, 2019

To Whom It May Concern

The purpose of this letter is to inform you that Norma Heather Clark was given permission to conduct the research title "Palliative Care: Identification and Early Intervention" at Yuma Regional Medical Center. This also serves as assurance that this organization complies with requirements of HIPAA and patient safety and all requirements were followed in the conduct of this research.

Sincerely

Deborah Aders, RN, MS, CIC
VP Patient Care Services and CNO