THE ROLE OF THE ACUTE CARE NURSE PRACTITIONER IN THE DEVELOPMENT OF AN IN-PATIENT PALLIATIVE CARE PROGRAM IN A RURAL SETTING:

AN INTERDISCIPLINARY, COLLABORATIVE APPROACH TO PATIENT AND FAMILY CENTERED CARE FOR THOSE WITH ADVANCED ILLNESS

By

Julie Anne Hilton

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APPROVAL BY GRADUATE PROJECT COMMITTEE CHAIR

Shu-Fen Wung, PhD, MS, RN, ACNP-BC, FAHA, FAAN
Associate Professor of Nursing
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DEDICATION

Advanced illness and the journey of dying is a profound experience which we are honored to witness. I dedicate this project to those who care for the weary soldiers of chronic and acute critical illness; to the dedicated nurses, clergy, social workers and tireless nurse’s aides who bring a sense of peace and comfort in times of suffering. And to my father, whose last days were made more comfortable because of the dedication of these remarkable angels.
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ABSTRACT

The purpose of this project is to explore the feasibility and process in designing a formal palliative care program in the in-patient setting of rural Southern Arizona hospitals and to determine the appropriate model for such program. The aging population of the United States is growing at a rapid pace, increasing the number of patients requiring technologically advanced in-patient care. Traditionally, in-patient care has been based on a curative model that encourages treatment. This curative model may result in physical, psychological and financial burdens that far outweigh potential benefits for the patient or family. The concept of palliative care enhances care for those with advanced illness or at the end of their life by providing holistic, comprehensive care. The in-patient palliative care concept is an emerging model which offers physical, emotional and spiritual support to those who are experiencing difficulties with symptoms or complex treatment of their illnesses. While in-patient palliative care programs are emerging in metropolitan hospitals, rural hospitals, particularly designated Critical Access Hospitals (CAHs), face unique challenges in providing comparable care for rural residents. The Acute Care Nurse Practitioner can offer guidance to the CAHs in the successful development and maintenance of in-patient palliative care programs.
CHAPTER ONE
Exploring Palliative Care in the Rural In-patient Setting

In the United States (US), over 90% of the population desire to die at home, however only 20% of those can hope to get their wish (Advanced Practice Position Statement, July 2002). While the hospitals in the US are technologically advanced to care for the critically and terminally ill, in-patient settings are not traditionally prepared for the myriad of needs presented by such patients and their families. Palliative care offers physical, emotional, spiritual support while attending to the practical burdens of illness for patients and families who are facing advanced chronic and life-threatening illness (Center to Advance Palliative Care, 2004). It has been demonstrated that academic centers and larger hospitals are more likely to implement a palliative care program (ISNA Bulletin, 2005). The need for palliative care programs however, is not an exclusive need of large hospitals serving metropolitan areas. Those residing in the rural areas of the US such as Southeastern Arizona are also in need of comprehensive palliative care programs. However, due to limited resources in the rural setting, these residents have the added challenge of traveling long distances to find palliative health care to meet their needs.

There is a need for in-patient palliative care programs in rural Arizona. These programs must be developed to provide the desired services to this rural population, while not placing a financial burden on small rural hospitals. This project will examine the process for determining the feasibility of implementing an in-patient palliative care program to meet the need of the rural in-patient population in a cost-effective and perhaps
even revenue generating manner. There is paucity in the literature regarding the utilization of in-patient palliative programs in rural settings. Therefore, developing an in-patient palliative care program in rural Southern Arizona hospitals will require the exploration of existing models used most often in the metropolitan in-patient setting and modification of these models to fit the rural setting.

**Definition of Palliative Care**

Palliative care is a philosophy and holistic approach to care that focuses on relieving the suffering caused by many serious, progressive and life-threatening illnesses. Palliative care is optimally delivered by an interdisciplinary team. This interdisciplinary team uses its collective expertise to decrease pain and suffering through providing treatment of the disease and alleviating symptoms of the disease (Stevens, L.M., Cassio, L, Richard, M., 2006).

The World Health Organization defines palliative care as “an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual” (World Health Organization, 2002, p. 83).

**Origin and History of Palliative Care**

The origins of palliative care can be traced back to the hospice care movement from the United Kingdom in the 1960’s. However, this author proposes that palliative care finds its true origins in the care rendered by nursing pioneers such as Florence Nightingale as early as in the 1800s. These nurses cared for the emotional, spiritual,
physical and psychological needs of their patients. There was, however, no formal title given to this type of care, except for that of “nursing care”. It became evident in the 1960’s through observations by pioneers such as Dame Cicely Saunders, that when a cure was not possible, the available technology used in the traditional cure-driven approach to care needed to be used to alleviate pain. The definition of pain was then clarified to include the mental distress and social or spiritual problems associated with death and dying, or “total pain” (Saunders, 2001).

In the early era of palliative care, cancer was the main disease from which hospice and palliative care were modeled (Meghani, S.H., 2004). The first hospice was started in the United Kingdom in 1961 and was exported to the US in Connecticut in 1974. A second hospice was established in 1975 in New York (Meghani, S.H., 2004). These early hospice programs were linked heavily with cancer-oriented care to meet the needs of patients immediately before death. In the mid 1980s and the 1990s, the traditional hospice or end-of-life model of palliative care for the terminally ill was broadened to include palliative care of the acutely ill who were still seeking medical cure. While the traditional hospice model still exists and provides a needed service at the end-of-life, the application of the broad concept of palliative care to those seeking curative treatment has emerged. This broadened palliative care concept was due in part to advanced technology which allowed patients to live longer even with serious or terminal illnesses (CAPC, 2004).

The Center to Advance Palliative Care (CAPC) was developed in 2000. This program exists to provide support to all health care settings, including hospitals that are
establishing and maintaining palliative care programs (Meghani, S.H., 2004). Along with this support, the Joint Commission of Accreditation of Hospitals Organization (JCAHO) now reviews palliative care and pain management in the accreditation of hospitals (Gordon, Berry & Dahl, 2000).

**Palliative Care versus Hospice Care**

It is important to recognize the difference in traditional hospice care versus palliative care. Palliative care can be described as an umbrella of services, under which one element is hospice. While hospice can be viewed as an intensification of palliative care at the end of life, the context of palliative care is not exclusive to hospice programs. There has been, and continues to be, confusion as these terms are often used interchangeably. Hospice care is aimed at the palliative care of patients and families at the end-of-life, and in the US this is defined as the last six months of life (Kinsbrunner, 2001). Entrance into hospice care usually occurs when the patient is no longer seeking curative treatment. In contrast, palliative care is not time-limited and may be implemented closer to the end-of-life or at any point in the course of illness, including when a potentially life-threatening or progressive illnesses diagnosis is made (Meghani, S.H., 2004).

**Definition of Rural**

It is important to understand the rural setting and its characteristics in order to better understand the challenges and unique needs of the rural population as it relates to palliative care. Definitions of rural America are largely directed for statistical use, but are important when distinguishing the unique needs of the rural versus metropolitan
patient and the impact of the rural setting on the ability of the health care system to meet those needs. There are many definitions of rural, however two prevailing definitions are used most often. The Office of Management and Budget (OMB) and the U.S. Bureau of the Census describe “urban” as “all territories, populations and residential spaces in urbanized areas or in locations of 2,500 or more people outside of urbanized locations.” Therefore, by default, "rural" areas are all areas not defined as urban. The OMB's definition uses the urban/ rural definitions formulated by the Census Bureau to classify counties as either "metropolitan" or "non-metropolitan" (U.S. Department of Health and Human Services, 2004). The OMB’s definition of Metropolitan Statistical Areas (MSAs) is particularly important for rural hospitals seeking designation as Critical Access Hospitals (CAHs). Hospitals serving MSAs are not candidates for CAH designation. CAH designation will be discussed in subsequent sections of this paper. MSAs are defined by the OMB as: “a core area containing a large population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. Current standards to qualify an area as an metropolitan area are that the area include: (1) one city with 50,000 or more inhabitants; and (2) a Census Bureau-defined urbanized area (of at least 50,000 inhabitants) and a total metropolitan population of at least 100,000 … (New Hampshire Economic and Labor Bureau, 2001 Glossary M ).”

Cochise County is the largest county in Southern Arizona with a total population of 135,150. There are five hospitals and four are considered CAHs (Arizona Department of Commerce, 2006). Of the four CAHs, each serves a population ranging from 3,910-17,660 (AzDC, 2006).
Definition of Critical Access Hospitals

CAHs are hospitals that provide critical health care access to very small rural communities that would likely have no access to health care at all without these facilities. The US Federal government provides additional re-imbursement incentives for Medicare patients who are cared for in these designated facilities.

It is important to understand the unique criteria required for CAH designation when determining the feasibility of palliative care services in a rural in-patient setting. Per the Critical Access Conditions of Participation (2004) set forth by Medicare, among the many CAH standards, the facility requesting CAH designation must demonstrate the following:

1. Must be located outside of any area that is a MSA as defined by the OMB.
2. Must be located more than a 35-mile drive from a hospital or another CAH or, if the hospital is in a mountainous road area, the drive can be 15 miles to another CAH or hospital, OR
   The CAH is certified by the State as being a necessary provider of health care services to residents in the area.
3. Have no more than 25 in-patient beds
4. The average length of stay (LOS) in the CAH for acute needs must be no more than 96 hours. (p. 2-3)

It is apparent from these rather strict guidelines for CAHs that these facilities are isolated and extremely small which makes extension of many services a challenge.

Therefore, rural facilities such as the CAHs often offer limited services. These facilities
struggle to recruit and retain healthcare providers from many disciplines, adding to the difficulty in providing interdisciplinary and specialized needed services. In a report from the Center on an Aging Society (2003), it was recommended that there be a provider-to-patient ratio of 1:2,000. In most rural areas however, the provider-to-patient ratio is closer to 1:3,500. This is attributed to the high-tech specialties available for providers in the urban areas, along with family issues such as spouse’s careers, schools for their children and social life (Center on an Aging Society, 2003). The inadequate number of physicians in the rural community is a rich opportunity for the advanced practice nurse to fill an urgent healthcare need.

Many very small rural hospitals in Southern Arizona are designated as CAHs and are presented with challenges in providing adequate palliative care to the area residents. The purpose of this project is to discuss processes and challenges when developing palliative care programs in the unique CAHs.

Summary

Healthcare in the US has evolved to an astonishing technologically advanced level. Though we may offer our patients unparalleled evidenced-based medicine, we fall short in offering the desperately needed spiritual, emotional, social and physical care provided by palliative care in the critically ill. Palliative care has evolved from the early stages which focused on pain management in the imminently dying to the present day model of caring for each patient’s emotional, spiritual and social needs as well as treating the disease. It can be said that care and cure are not mutually exclusive concepts. In recent years, the need for in-patient palliative care has been recognized. Due to the
recent technological advances in medicine, patients are living longer and are often enduring great emotional strain related to their burden of illness. This fact makes the need for palliative care more urgent. Many large academic centers are implementing in-patient palliative care programs, however small rural hospitals face great challenges in order to offer palliative care to those in need.
CHAPTER TWO
The Need for Palliative Care in the Hospital Setting

Historical View: Caring for the Critically Ill and Dying in the In-patient Setting

Throughout history, patients seeking care in the hospital setting have been the sickest of the sick. Because of the intensity of medical services needed by hospitalized patients, care has become progressively specialized and fragmented. Patients with life-threatening illnesses may not receive appropriate care because their needs such as emotional and spiritual support may not fit with the traditional curative culture of the in-patient setting in large hospitals (Toscani, Giulio, Brunelli, Miccinesi, Laquintana, 2001). Many in-patient settings are not geared to care for those who are not actively seeking curative or life prolonging therapies. Patients may reach a point in which prolonging life is no longer the goal, or for which the burden of treatment outweighs any potential or perceived benefit.

Over-treatment of patients occurs when one has reached the point where the benefit of life-prolonging efforts no longer outweighs the physical and emotional burden these efforts pose to the patients’ quality of life (Fischber, Manfredi, Meier, 2005). Middlewood, Gardner and Gardner (2001) studied 100 patients who died of oncological or hematological malignancies and found that 60 patients received active treatment, such as artificial nutrition, intravenous antibiotics and intubation, at the time of death (Middlewood, Gardner and Gardner 2001). This over-treatment of hospitalized patients has been a common practice due to the traditional emphasis to prolong life at all costs in the in-patient setting.
Middlewood and colleagues (2001) suggests that late implementation of end-of-life management plans along with fragmented, specialized care was the cause for patients being subjected to medical intervention and investigation up to the time of death. While the timing for transitioning to palliative care may be dictated by the patient’s perception of health and quality of life, traditionally health care providers often attempt to continue life-prolonging treatments up to the last minute, while not offering alternatives. In the hospital setting, coordination of end-of-life care decisions is lacking. When critical end-of-life decisions must be made, the valuable palliative care is also underused (Middlewood, et.al. 2001).

**Institute of Medicine Position Statement**

According to the Institute of Medicine (IOM), palliative care in the in-patient setting, offers an answer to the traditional curative model of death and dying in the twentieth century (Field & Cassel, 1997). It further stated that all people should be able to expect a decent death. The IOM Committee on Care at the End of Life proposes the following principles to guide the care of critically ill patients (Field and Cassel, 1997):

1) Care for those approaching death is an integral and important part of health care.

2) Care for those approaching death should respect both patients and those close to them.

3) Good care at the end of life depends on strong interpersonal skills, clinical knowledge and technical proficiency, and it is informed by scientific evidence, values, and personal and professional experience.
4) Changing individual behavior is difficult, but changing an organization or a culture is potentially a greater challenge—and often is a precondition for individual change.

5) The health care community has special responsibility for educating itself and others in the identification, management and discussion of the last phase of fatal medical problems.

6) More and better research is needed to increase our understanding of the clinical, cultural, organizational, and other practices or perspectives that can improve care for those approaching death. (p. 22)

Historically, those who are critically ill or dying in American hospitals have received care rendered with the traditional philosophy of medicine. Most physicians and other healthcare providers are trained to provide life-saving care. However, there are times when the patient needs care aimed at alleviation of symptoms caused by their illness or the treatment for their illness.

The SUPPORT Study

The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT) was a landmark trial with the objective of improving care for the seriously ill hospitalized patient and to improve end-of-life decision making (SUPPORT Principal Investigators, 1995). There were two phases in the study.

Phase I was a 2-year prospective observation involving 1,403 patients. A nurse was specifically trained for the study to have frequent contact with physicians, families, patients and hospital staff to elicit preferences regarding end-of-life choices,
understanding of outcomes, to determine adequacy of pain control and to determine the
efficacy of the communication between the patient and the physician regarding early
advanced care planning. Results from this Phase I observation documented severe
shortcomings in the communication between physician and patient/families. Only 47%
of physicians knew if their patients preferred cardio pulmonary resuscitation (CPR). In
addition, for 46% of patients, Do Not Resuscitate (DNR) orders were written within 2
hours of death. Finally, as reported by family members, 50% of conscious in-patients
were in moderate to severe pain at least half of the time (SUPPORT Principal
Investigators, 1995).

Phase II of the SUPPORT study was a two-year randomized clinical trial with
4,804 patients randomized to an intervention group or a control group. Intervention was
provided by a trained nurse to initiate multiple contacts with patient and families as well
as with physicians and staff to determine care preferences, improve understanding of
outcomes, encourage attention to pain control and to facilitate advance care planning and
patient-physician communication. Results from the Phase II study were disappointing
and showed that the participants in the intervention group experienced no improvement in
communication with their physicians. Only 40% of patients in the intervention group
discussed their preference regarding CPR. Therefore, despite the above interventions,
there were no improvements in any of the five targeted areas (SUPPORT Principal
Investigators, 1995).

The SUPPORT study concluded that there are marked shortcomings regarding the
end-of life decision-making in seriously ill adults and interventions such as improving
opportunity for physician and patient communication did not improve outcomes. It was
determined that the most effective method to significantly improve the care of the
seriously ill or dying is to garner more societal influence and commitment. This may be
accomplished through additional research regarding the impact of positive provider-
patient communication. This study prompted a national dialogue regarding the need for
creative palliative care approaches and an increasing need for palliative care in the in-
patient setting (Meghani, S.H., 2004). Through the application of palliative care in the
in-patient setting, the frequency of painful, prolonged dying process could be reduced.

Challenges and Advantages to Hospital-Based Palliative Care in the Small Rural
Hospital Setting

Rural hospitals face unique challenges surviving in today’s atmosphere of
healthcare reimbursement. The average daily acute care census for most CAHs is 3.9 as
compared with 7.3 in small hospitals that are not designated as CAHs and 24.0 for rural
hospitals as a group (Casey, Moscovice & Klingner 2004). This lower patient volume is
one factor in the relatively low profit margin for most CAHs. This low operating margin
makes capital, maintenance, and operations expenses difficult to overcome. However,
those program initiative endeavors that do not require a large capital expense and can use
existing staff may be advantageous. The Medicare Rural Hospital Flexibility Program
states that flexible staffing allowed by the CAH license promotes staffing more
intensively when the demand is up, but shifting staff to other departments when demand
is low (Poley, Dalton, Fruhbeis, Howard & Ricketts, 2007). This sharing of staff is
beneficial in areas such as home health, inpatient and outpatient rehabilitation services,
skilled nursing, swing beds, hospice beds and palliative care beds. While this is similar to
the concept of “floating” in large urban hospitals, the ability to use existing staff for
palliative care patients rather than having to flex down on staff during low census periods
may be an opportunity for more efficient use of staff in the rural setting.

Summary

In-patient care has become increasingly specialized and fragmented due to the
increased intensity of medical care and the traditional curative approach to medicine.
Without consideration of patient’s wishes, those with life-threatening illnesses may
receive treatment that results in a high burden that far exceeds the benefits of life
prolonging attempts and thus affect the quality of life for that individual (Fischber,
Manfredi, Meier, 2005). The IOM states that palliative care in the in-patient setting offers
an opportunity to respond to the changing demographics of death and dying in the
twentieth century. The classic SUPPORT study (1995) provided important insight into
the need for an effective palliative care in the hospital. The conclusions drawn from the
SUPPORT study demonstrated the marked shortcomings regarding the in-patient
palliative care for seriously ill adults. There is a remarkable opportunity to improve
physician and patient communication. Rural hospitals, however, face unique challenges
in today’s healthcare reimbursement due to a relatively low Acute Daily Census resulting
in a low operating margin. While there is a need for palliative care programs in the rural
areas, initiating such services may require creative resource utilization approaches, such
as training and using existing staff rather than recruiting additional staff.
CHAPTER THREE

Acute Care Nurse Practitioner’s Role in Palliative In-patient Care in the Rural Setting

Roles and Core Competencies of the Acute Care Nurse Practitioner

Acute Care Nurse Practitioners (ACNPs) are advanced practice nurses who are prepared at the master’s or doctoral level to care for patients with complex acute health problems, as well as those with critical and chronic health problems. The ACNPs practice in higher acuity settings where patients require complex monitoring, therapies or interventions (Acute Care Nurse Practitioner Competencies, 2004).

Hamric (2000) introduced a set of six central core competencies relevant to all advanced practice nurses. Many specialties refine these competencies to fit their focus of care. The six core competencies introduced by Hamric are:

1. Expert guidance and coaching of patients, families, and other care providers
2. Consultation
3. Research skills, including utilization, evaluation, and conduct
4. Clinical and professional leadership, which includes competence as a change agent
5. Collaboration
6. Ethical decision-making skills (p. 62).

Core competencies for the ACNP (National Organization of Nurse Practitioner Faculties, 2004) are based on Hamric’s core competencies. A complete set of these core competencies include:
competencies with definitions is listed in Appendix A. These ACNP competencies include:

1. Health promotion, health protection, disease prevention and treatment
2. Diagnosis of health status
3. Plan of care and implementation of treatment
4. Nurse practitioner-patient relationship
5. Teaching-coaching function
6. Professional role
7. Managing and negotiating health care delivery systems
8. Monitoring and ensuring the quality of health care practice

Through the demonstration of these competencies, the ACNP can guide the development and implementation of an in-patient palliative care program. The relevant core competencies essential in garnering administrative and health care team support when developing and sustaining an in-patient palliative care program in a rural setting are: teaching-coaching function, professional role, managing and negotiating health care delivery, monitoring and ensuring the quality of health care practice and cultural competence.

The ACNP must be proficient at integrating research to promote evidence-based practice when developing palliative care protocols and plans. Unfortunately, the evidence for symptom management approaches in palliative care is extremely limited. The ACNP can design palliative care services and educate health care team regarding
pain and symptom management. To be successful in implementation and maintenance of
an in-patient palliative care program, the ACNP should be proficient in utilizing internal
resources such as the ethics committee to advocate for the patient. The ACNP also need
to be competent to care for the diverse cultures in the rural environment.

Core Competencies in Palliative Care

The ACNP core competencies are in concert with the core competencies for
palliative care. Palliative care requires many skills or competencies that are unique to the
specialty. A complete list of the core competencies for palliative care along with their
definitions is in Appendix B. As stated earlier, palliative care has been described as the
“comprehensive care and management of the physical, psychosocial, emotional and
spiritual needs of patients (of all ages) and their families with chronic, debilitating, or
life-threatening illness” (CAPC, 2004, pp. 8.21). Through several Core Competencies
identified by the CAPC, the goals of palliative care can be reached.

The following core competencies are essential to provide and subsequently
evaluate the quality of palliative care (CAPC, 2004);

1. Pain and symptom management
2. Emotional support
3. Psychosocial support
4. Spiritual/cultural support
5. Relationship building and support
6. Honoring patient care wishes
7. Dying and death support
8. After death communication and support, bereavement

9. Communication skills, teaching

10. Team collaboration (p. 8.15)

ACNP and palliative care core competencies build upon one another to create an excellent combination for the ACNP to apply in the in-patient palliative care setting. Mastery of these core competencies allows the ACNP to serve as an expert and change agent. The ACNP can apply these competencies to enhance the patient-provider relationship. Expert communication and team building competencies will aid the ACNP in collaborating with health care team members and hospital administrative leaders to determine the feasibility and facilitate the successful development and implementation of the in-patient palliative care program. A summary of the ACNP Core Competencies and the Palliative Care Core Competencies is available for contrast and comparison in Appendix C.

Summary

Advanced practice nurses should possess core competencies essential to holistic patient care. The ACNP core competencies are in concert with the core competencies for palliative care. Through achieving the ACNP and palliative care core competencies, the ACNP is well positioned to lead the palliative team toward a successful quality palliative program to care for patients and families in need.
CHAPTER FOUR

A Model for Development of Palliative Care Services in a Rural In-Patient Setting

*Delivery of In-Patient Clinical Palliative Care Services*

There are many models for the delivery of palliative care. When determining the best model for hospitalized patients in a rural setting, the philosophy of the organization must be evaluated. Two main palliative care functional models proposed by the CAPC are suitable in a small in-patient setting. The first and an ideal model, is the Geographic Model, and second is the Full Team Model (CAPC, 2004).

*Geographic Model*

The Geographic Model is a program that has a designated in-patients palliative care unit. This model offers the benefit of an in-patient staff team trained in palliative care which includes a physician, advanced practice nurse, social worker, chaplain and physical and occupational therapists. In this model, the staff in the unit is fully trained in palliative care and the focus is to create a supportive inpatient environment (CAPC, 2004). After a referral from the primary care provider or the attending physician and when the patient meets admission requirements, the palliative care team assumes responsibility for managing the in-patient course as well as coordinating the discharge planning and follow-up. In this model, reimbursement is acute care oriented and allows the unit to flex capacity as needed for staffing levels and census (CAPC, 2004).

The benefits to the Geographical Model include that the staff is specifically trained in palliative care and can therefore create a patient and family friendly unit. Also, the proximity of patients gives the providers and staff more control over the patient care.
As with any high-profile unit, philanthropic opportunities may be more easily developed and marketed to aid in funding the program. Disadvantages to the Geographical Model mirror the benefits in many ways. The specific unit, while aiding in control of patient care and specialized training of the staff, may become financial losses for the hospital if the beds cannot be filled causing under-use of the medical staff, nursing staff and ancillary support. Also, a contained fully functioning unit would require increased staffing resources to provide primary service caring for the patient and families (CPAC, 2004).

Full Team Model

The Full Team Model is based on a consultative approach with a full team of palliative care specialists including a physician, an Advanced Practice Nurse and a social worker (CPAC, 2004). This team assesses and follows the patient when referred by the attending physician. In this model, the palliative care team may act as a consultant or may assume and coordinate patient care as deemed appropriate through collaboration with the attending physician. In this model, there is no specific geographic location or unit for the delivery of palliative care. Instead, palliative care is incorporated into the care of patients in all units and thus must also be incorporated into the mission of all hospital units. In the Full Team Model, the physician bills for fee-for-service as a consultant (CAPC, 2004).

The benefits to the Full Team Model include the fact that the facility can utilize existing beds without the financial burden of constructing and staffing a unit specific to palliative care. This model also offers consultative services to large number providers.
The disadvantages to the Full Team Model include the fact that all nursing staff in all units will have to be educated in palliative care placing increased demands on nursing administration time along with the added conundrum to keep nursing staff competent if palliative care skills are not used on a consistent basis. Also, this model begets the added cost of services with limited or no additional revenue save that of the potential to increase bed occupancy. Because of this opportunity to fill unoccupied beds and increase the Average Daily Census, this would be of particular benefit to the CAH. Lastly, this model is a consultative model, meaning that the advice of the team may or may not be followed by the primary physician resulting in less effective care for the patient (CAPC, 2004).

Nursing Grand Theory Model

It is incumbent upon the palliative care team to determine a suitable grand theory for application. For the purposes of this paper, The Human Becoming Theory conceptualized by Rosemarie Parse is proposed for integration of a palliative care program into an in-patient setting. While this is a Nursing Grand Theory, it is one that has the potential to be used universally by all members of the palliative care team in the development of the program and the subsequent care of patients.

Parse’s Theory of Human Becoming is an Unitarian Theory that is in accordance with the philosophy of palliative care to treat the patient and family as a whole with spiritual, emotional, psychological and physical needs (Wills, 2002). Unitary theories are based on the belief that humans are unitary beings who are embedded in the universe and who are self-determined and self-aware. Parse describes humans as intentional beings who are involved with their worlds and have a fundamental nature of knowing, being
present, and being open to their worlds (Wills, 2002). For Parse, “nursing is guiding humans toward ways of being, finding meaning in situations, choosing ways of cocreating their own health, and living true presence in the day-to-dayness of the person’s life” (Wills, 2002). It is central to the philosophy of Human Becoming that the nurse must be truly present, and “being present” is a key concept in palliative care. “According to Parse, true presence is lived in the nurse-person processes of illuminating meaning, synchronizing rhythms, and mobilizing transcendence” (Pilkington, 2005). The nurse is not expected to work through the steps of the nursing process rather he/she is to act as a loving, non-judgmental stranger who seeks opportunities to “be truly present with persons/group” (Pilkington, 2005). Through being present, the nurse acts as a witness to the becoming of the individual. Nurses act as guides through the process of finding meaning in situations and in choosing ways of cocreating health. In the Human Becoming theory, the act of guiding or “powering” (Wills, 2002) is the key to the relations of the human/nurse. Powering is pushing or guiding the human toward becoming. The nurse is to dwell in the “day to day” of the human. The experience of dwelling in the “day to day” allows the nurse to understand how the patient and family perceive and react to their situation. This then allows the nurse to empower the patient and family to make choices to change their perception of health care experience. The Theory of Human Becoming is applicable in all areas of healthcare to include palliative care. Specifically, Parse relates Human Becoming Theory to family practice, adult and child settings and acute care settings. Regardless of the setting, the nurse-person relationship starts with the nurse “being with” the person and bearing witness to their
becoming. The nurse is to follow the lead of the person/group with respect to their wishes and plans for quality of life. The context for use is embedded in the prospect of shifting nursing, or in palliative care practice, from the problem based, bio-psycho-social theory to Parse’s nursing theory of Human Becoming (Pilkington, 2005).

The palliative care team is comprised of physicians, advanced practice nurses, nurses, social workers and clergy. However, the core values of palliative care can be realized through the application of an appropriate nursing theory such as Parse’s Theory of Human Becoming. The advanced practice nurse must have a deep understanding of nursing theory and its application in order to guide the team to infuse nursing theoretical concepts into everyday practice.

Summary

There are several functional models for the design of a palliative care program. Both the Geographic Model and the Full Team Model demonstrate benefits and disadvantages. However, given the unique challenges of small rural CAHs, including recruitment of specialty medical and nursing staff, increasing financial challenges and limited beds, the Full Team Model is appropriate. Through the use of available staff and flexibility to capitalize on the often empty beds of the CAH, the Full Team Model provides an opportunity to expand services with little cost, while receiving reimbursement for palliative care in occupied beds.

Additionally, it is imperative that the Advanced Practice Nurse guides the selection and application of a grand nursing theory to direct the palliative care team in the care of patients and lay a foundation for a sustainable mission and vision. Parse’s Theory
of Human Becoming is one example that can shift nursing practice from the problem-based, bio-psycho-social theory to that of being truly present with the patient and the family. This encourages each member of the palliative care team to follow the lead of the person or family with respect to their wishes and plans for quality of life.
CHAPTER FIVE

Designing and Implementing an In-Patient Palliative Care Program in the Small Rural Hospital

Palliative care offers patients residing in rural areas the service they need when faced with a life-threatening or debilitating disease. Though in-patient palliative care programs are increasing in the metropolitan areas, hospitals in rural areas are still challenged to implement a program. An exhaustive literature review revealed that there is paucity in research regarding rural in-patient palliative care. Pantilat and Billings (2003) found that of 112 California hospitals, none of the 26 hospitals with less than 100 beds had in-patient palliative care programs. Of the four urban hospitals that had consultative in-patient palliative care programs, only two provided details regarding staffing. The CAPC developed a system to address the challenging task of developing and implementing an in-patient based palliative care program. In this paper, the system developed by the CAPC will be used as a guide for developing an inpatient palliative care program, while keeping in mind the unique challenges faced by the small rural hospital. Rural communities and landscapes present providers with unique barriers and challenge which must be taken into account when developing new programs (National Rural Health Association, 2005). This systematic approach by CAPC may assist small hospitals to determine feasibility in implementing a program.

According to CPAC (2004), in order to design and implement an in-patient palliative care program relevant to the rural hospital in-patient setting, the organizers must work through the following steps:
1) Build the case for an in-patient palliative care
   i. Develop a core planning team
   ii. Conduct a systems and needs assessment
   iii. Develop the financial case
   iv. Develop the clinical case

2) Design an in-patient palliative care program
   i. Characteristics to consider
   ii. Estimating program costs and revenues

3) Present the business plan
   i. Securing approval for the program

4) Implementing an in-patient palliative care service
   i. Ensuring the delivery of palliative care services
   ii. Administration issues for palliative care programs

5) Measuring program quality and impact
   i. Overview of measurement
   ii. Selecting clinical assessment and evaluation tools
   iii. Systems for storing and analyzing data and reporting outcomes (p i-iv)

Building the Case: Core Planning Team

A vital first step will be to assist the hospital administrators and board of directors to see the business case for the in-patient palliative care program. It is imperative that the program be in alignment with the hospital’s overall mission, vision and values as well as
the goals for financial viability. As this program is presented, the designers must understand the focus of the hospital leadership and how the palliative care program will help to address this focus. While hospital administrators have many considerations with any decision made for their hospital, they must also support a collaborative environment and provide resources to meet the scope of services offered (The Joint Commission on Accreditation of Hospitals, 2008).

After the organization has decided to investigate the feasibility of the program, it is vital that a team be assigned to participate in core planning and take on the responsibility for program development and presentation (CPAC, 2004). This team must be given the time and resources to assess needs and implement the program. The team should be made up of those strong in leadership and teamwork skills and in positions to influence change within the organization and facilitate effective communication throughout the program (The Joint Commission of Accreditation, 2008). Members of this team should include someone from the medical Staff. This can be a physician champion or leader who has the credentials in palliative care and the respect his or her peers. The physician champion must be committed to the facility and patient care and ideally be an expert in symptom management (CPAC, 2004).

While a physician champion would be beneficial to the team, the addition of a nursing leader is imperative to the success of the team. This nursing leader should ideally possess advanced clinical skills with experience in palliative care. The ACNP possesses unique skills and core competencies which make him or her an excellent candidate as the nursing leader on the team. Achievement of ACNP and palliative care core competencies
is important in making changes in the organization and in implementing policies and guidelines for practice.

Another key team member is the administrative champion. The administrative champion is vital to the team’s ability to present credible ideas to hospital administration and the board of directors. This person should be in a high-level administrative position and be one who understands the importance of a palliative care program, while understanding the needs of the hospital and its stakeholders. This team leader must possess collaboration skills which work well with the administrative body of the hospital as well as community members.

Another key player on the core planning team for the palliative care program is someone influential in the hospice or community-based palliative care programs in the area. In the rural setting, this key player may be difficult to find; however, home health organizations often take on the role of community-based palliative care in rural areas (J. Morrow, personal communication. February, 2008). There should be open communications between the core planning team and personnel of the existing palliative care programs in the community. The palliative care member from the community can provide a wealth of knowledge and experience that would be valuable to the core planning group. This will also create an opportunity to bridge palliative care service between the hospital and the community.

The ideal team, made up of the physician and administrative champions, the nursing leader, and the hospice or palliative care champion from the community, will be the driving force for the development of the program. Their involvement in the design,
implementation and maintenance of the program may change over time, but their contributions will continue to be important. While it may be difficult to have such human resources in the rural setting, most CAH will likely to have a nursing leader, physician and administrative leader (CAH, 2004). The challenge may be to find a hospice or palliative care expert in a small rural community thus expertise may need to be sought outside of the community. This adds to the challenges of the CAH in the implementation of a palliative care program.

Building the Case: Systems and Needs Assessment

The systems and needs assessment process is both informal and formal. This process involves getting participation from vested community members who will assist the core planning team in defining the scope of the program based on the needs assessment results (National Rural Health Association, 2005). One component of this process involves an assessment of the hospital’s existing strengths and weaknesses and any apparent challenges or barriers to the implementation of the program. This assessment provides the knowledge of these existing strengths and weaknesses. The team can then work together to leverage the existing resources in the hospital and community to best address the needs of the patients and the hospitals (CPAC, 2004). Once the assessment is completed, the team must determine whether the organization can offer specific services and if an existing external service is available to maintain continuity of care. The following system assessment tool can be used to assist organizations to understand how effectively they are addressing important palliative care
issues of the patients, families and providers (Appendix D). This tool includes the following areas for assessment (Supportive Care Coalition, 2001):

1) Vision and management standards

2) Individual performance/competency standards established and monitored at least annually

3) Community network and partnerships (p. 1)

After assessing the existing health care system for strengths and weaknesses, the team must conduct a needs assessment. This needs assessment is conducted to determine areas in the hospital in which palliative care would provide the greatest contribution to the experience of the patient, staff and ultimate mission of the hospital (CAPC, 2004). This assessment is aimed to identify gaps in care that a palliative care program can fill. CAPC suggests the following questions to be answered in any needs analysis:

1) Does the hospital have a patient population that would benefit from a palliative care program?

2) Does the hospital currently provide services that could benefit from collaboration with a palliative care program?

3) Do pain and symptom distress scores for patients with life-threatening conditions show room for improvement?

4) Do staff satisfaction surveys show staff stress related to perceived understaffing for the treatment of patients with life-threatening illness?

5) How will the palliative care program save the hospital money?
6) How will the palliative care program help the hospital increase bed capacity and revenues?

7) How will the palliative care program help the hospital improve quality and meet JCAHO or Medicare requirements?

Due to the unique challenges of the small rural hospital, the following additions to the CAPC questions are suggested for a needs assessment:

1) Does the hospital currently have the capability to house a designated palliative care unit?

2) Does the hospital currently have the staff required for the additional census of the palliative care population?

In order to find and use credible data, the team must have access to the hospital’s financial and quality data. These data include financial statements such as average LOS, overall occupancy of the hospital, payer mix, number of hospice referrals a year and total number of staffed acute in-patient beds. Quality reporting clinical outcomes, such as assessment of pain, advanced directive planning and documented goals of care, are important in determining a need or area for improvement that palliative care may fill.

Lastly, patient and family satisfaction surveys will provide information about the perception of the stakeholders regarding the current efficacy of matters such as pain and symptom control, treatment quality, attitudes of the providers, timeliness of care, communication between the patient/family and the provider and customer service. All of these data will be used during the needs assessment as well as during the implementation and evaluation of the program (CPAC, 2004).
Building the Case: The Financial Case

Anytime a new program is introduced to an organization the program’s estimated costs and revenues must be explored and projected in order to determine feasibility. In the hospital setting, these considerations must be included along with the clinical implications of a program. Among these financial considerations are the staffing requirements, projected overhead costs as well as projected revenues through patient billing and physician billing. When presenting the case for an in-patient palliative care program, it is important that the team be as specific as possible in order to give the administrative decision-makers a clear idea of potential financial risks and benefits for the organization and its stakeholders.

Estimation of required Full Time Equivalents (FTE’s) is a component of the estimated program costs. This estimation is based on the projected daily census for the program determined by the core planning team early during needs assessment. The human resources department can assist the team in determining average salaries for each FTE as well as benefit percentages. Table 1, the Palliative Care Services Salary Worksheet, is an example of a staffing worksheet designed by the CPAC (Appendix E) (CPAC, 2004). This table gives an example on how to determine staffing for an in-patient palliative care consultative service with a four-year projection.

When using the Full Team Model the projected FTEs for additional registered nurses, certified nursing assistants and unit clerks must be incorporated. The core planning team can determine if additional staff is needed based on initial projection of palliative care patients and the staff to patient ratios.
Many small rural hospitals are designated as CAHs. The payment structure and regulations of these CAHs change the reimbursement mechanism from prospective to cost-based payments for Medicare patients (NRHA, 2005). This is a very important concept to understand when determining financial impact of a new palliative care program at a CAH versus a hospital that is reimbursed via Diagnosis Related Groups (DRGs). Much of the literature regarding financial analysis for the implementation of an in-patient palliative care program is based on the assumption that the hospital is reimbursed under DRGs. Because the reimbursement for Medicare patients in CAHs is cost-based, the revenue generated by a Medicare patient does not increase if the LOS is shorter than the time allotted under a specific DRG. In fact, more revenue is generated by longer in-hospital stays; keeping in mind that one requirement to qualify for a CAH designation is that the average LOS should be no longer than 96 hours (CAH, 2004). Palliative care is very likely to require more than the average LOS of 96 acute care hours allocated; therefore, changing care to a skilled nursing level may need to be considered in appropriate patients.

The financial case must be developed with these above challenges in mind. Traditionally, in-patient palliative care programs make their major contribution to the financial bottom-line by reduced LOS and cost per day, whereas in the small CAH, the financial case must be made through an increased hospital bed occupancy (CAPC, 2004). In the case of the CAH, prediction of an increase in patient volume will be the priority to demonstrate how a palliative care program can benefit the hospital. This can be done by the core team through review of the hospital statistics on total admissions for certain
diseases, such as chronic obstructive pulmonary disease, pain control, congestive heart failure and cancer. Of true benefit in this case is the review of in-patient hospice referrals. When no in-patient palliative care or hospice program exists in a rural area, the local CAH is often used to provide care for those experiencing uncontrolled pain as well as those at the end-of-life (J. Morrow, personal communication, February, 2008). The analysis of these types of admissions to the CAH could give the team an insight into the potential need in the area.

Another statistic to review to determine the local need for palliative care is the number of deaths occurring annually at the facility. If this number is not currently tracked by the facility, it can be estimated using the national statistics that estimate a death rate of 2.5% of all hospital admissions (AHRQ, 2000). This statistic gives a projection of the potential client base of an in-patient palliative care program.

**Building the Case: The Clinical Case**

After completing a systems and needs analyses, the core team will need to determine unmet clinical needs and how a palliative care program can meet these needs (CPAC, 2004). It is very important that the team conveys a clear picture of gaps in care and how this program can address them through leveraging existing strengths and resources available within the organization and community. Examples of palliative care case studies are an effective means to convey this picture. Also, the team must make the hospital decision makers aware of the history of palliative care and what the overall goals of palliative care are. The team should provide them with current research regarding current in-hospital palliative care practices in patients with critical illness as discussed in
Chapter One. The administrative leaders must have a clear understanding of the need for ethical and compassionate care for all patients, and how the development and implementation of an in-patient palliative care program can fulfill that need. The program can provide tools for the staff to incorporate the philosophy of palliative care as well as the formal adoption of a nursing grand theory into all patient care areas through the Full Team Model and Parse’s Human Becoming Theory, thereby increasing staff satisfaction throughout the organization (Grade, et.al., 2008).

Characteristics to Consider When Designing an In-Patient Palliative Program

When designing an in-patient palliative care program, it is important to incorporate the information obtained from the systems and needs analyses and customize the program design to include ideal components such as space for the patients, adequate staffing, and a full interdisciplinary team while acknowledging available resources of the CAH’s.

When designing the program, the mission, vision and values of the hospital must be reflected in the program. When developing the interdisciplinary team it is preferable to employ team-members with a background in palliative care (CAPC, 2004). The team must consist of members who are experienced in medicine, nursing, pharmacology, rehabilitative services, social work and spiritual care (The Joint Commission on Accreditation of Hospitals, 2008). Clergy, rehabilitation providers, pharmacists and psychologists/psychiatrists can assist the team in providing holistic quality palliative care. In the small rural in-patient setting, the ACNP may need to act as the surrogate for the physician due to insufficient number of physicians in the rural area. The ACNP can
provide excellent services in this underserved population through the application of advanced skills in assessment, diagnosis and management of the acutely ill.

To avoid over-taxing the financial impact to the hospital, the team may have to be developed over time, or started in a part-time fashion when the program is initially implemented. Another option is to draw upon existing resources such as physician, ACNP and social services staff who are already working in the hospital. These team members would begin to focus part of their time and resources toward in-patient palliative care patients. The expertise of the team will need to be evaluated based on formal training and professional experience in palliative care. Dependent on the existing expertise of the team, some or all may have to receive additional training in symptom management, pain management and utilization of social resources. If the expertise of existing health care providers cannot be validated, experienced providers may need to be recruited from outside the hospital (CAPC, 2004).

It is also important for the successful program to be visible and accessible. Community education as well as staff education must be established through open relations with existing organizations through media outreach, outreach education, fund raising events and word of mouth (NRHA, 2005). Access to the palliative care program can also be improved through patient care coordination between different settings. For example, most seriously ill patients receive care, when available, in a variety of settings such as the emergency department, home health care, community hospice organizations and primary care physician offices. It is imperative that a collaborative relationship be
built with these organizations and departments in order to facilitate easy and smooth referrals to the palliative care program. To do this, patients, families and healthcare providers must have 24-hour/7-day a week access to the program. The patients and their families must be informed about how to access care, treatment and services during and after business hours (The Joint Commission, 2008). The on-call contact for the palliative care team should be familiar with the case or have access to the patient’s information in order to offer support (CAPC, 2004).

*Clinical Guidelines for Measuring Palliative Care Program Quality and Impact*

When designing and implementing an in-patient palliative care program, it is important to first understand the clinical practice guidelines for quality palliative care. The National Consensus Project for Quality Palliative Care (2004) proposed the practice guidelines for palliative care to promote quality in palliative care across settings. Eight domains are proposed and each domain incorporates guidelines that embrace the core concepts of assessment, information sharing, decision-making, care planning and care delivery. Specific guidelines for each domain can be found at [www.nationalconsensusproject.org](http://www.nationalconsensusproject.org). The eight domains identified for quality palliative care (NCP, 2004) are:

1. Structure and processes of care
2. Physical aspects of care
3. Psychological aspects of care
4. Social Support
5. Spiritual, religious, and existential aspects of care
6) Cultural considerations

7) Care of the imminently dying patient

8) Ethics and law (p. 15)

The JCAHO has recently published draft standards for palliative care certification and these standards are likely to be adapted by the commission when evaluating palliative care programs (The Joint Commission on Accreditation of Hospitals, 2008). The proposed Palliative Care Certification Standards and Elements of Performance can be found at

http://www.jointcommission.org/Standards/FieldReviews/fr_022508_palliative_care_certification.htm. These proposed standards stipulate that palliative care is delivered through compassionate, interdisciplinary care aimed at supporting patients and families with chronic debilitating or life-threatening illness, regardless of its duration.

In addition, national palliative care organizations such as the CPAC, the American Academy of Hospice and Palliative Medicine, Hospice and Palliative Nurses Association, Last Acts Partnership and the National Hospice and Palliative Care Organization worked together with the National Consensus Project’s (NPC) to develop the Clinical Practice Guidelines for Quality Palliative Care. Currently, these guidelines are recognized as the gold standard for quality and quality measurement in palliative care (CPAC, 2004).
Quality of delivered health care services is a national focus. A high quality inpatient palliative care program requires systematic regular evaluation of the processes for providing care as well as established outcome measurement (National Consensus Project, 2004). These outcomes must be beneficial clinically and financially. The core planning team should have a clear plan on how the outcomes of the program will be evaluated prior to its initiation. According to CPAC, the four main categories needed to ensure efficient, appropriate and effective palliative care programs are (CPAC, 2004):

1) Pain and symptom control
2) Patient, family and health care provider satisfaction surveys
3) Program operational measures such as volume and type of referrals and team workload
4) Financial impact such as professional billing revenues, hospital and ICU LOS and cost per day (p. 5.1).

These categories can be measured by monitoring facility financial and patient data banks, patient, family and staff surveys, as well as patients’ symptom burden over time measured by tools such as the Condensed Memorial Symptom Assessment Scale and the Modified Edmonton Symptom Assessment Scale. Data stored in a well-presented systematic fashion will assist the team in demonstrating how the program improves clinical care such as pain management. These data will also help demonstrate patient and family satisfaction as well as the program’s fiscal status. The program leaders must set performance improvement priorities and identify how the program will respond to the data collected (The Joint Commission on Accreditation of Hospitals, 2008).
Summary

Building the case for an in-patient palliative care program must be done systematically and with appropriate members of the care team. A systematic approach to determine the feasibility of implementing a program can assist small hospitals in their decision to develop an in-patient palliative care program (CAPC, 2004). The CAPC has developed a system to address the challenging task of developing and implementing an in-patient palliative care program. In brief, this system includes the following steps. First, a core group of organizers must be established. This team is made up of a physician champion, an Advanced Practice Nurse such as an ACNP, an administrative champion, a nurse leader and a palliative care champion. These organizers should then build the case for an in-patient palliative care by conducting a thorough systems and needs assessment of the organization. From that assessment, the customized financial case and clinical case must be made to the administrative decision makers of the organization. When designing the scope of the in-patient palliative care program, it is important to reflect the mission, vision and values of the hospital in the program’s design.

CONCLUSION

The purpose of this project is to explore elements required to evaluate the feasibility and process involved when designing an in-patient palliative care program in rural CAHs. Palliative care is an interdisciplinary approach to care for the emotional, spiritual, physical and psychological needs of critically ill or dying patients and their families. While US hospitals have advanced in the medical technology needed to care for the critically ill, in-patient settings are not traditionally prepared for the myriad of
emotional, social and spiritual needs that accompany patients and families enduring devastating or terminal illnesses. In the US, the aging population is growing rapidly and our technical advancements in medicine have resulted in more intensive, protracted care. Because of these developments, the need to focus on developing in-patient palliative care programs has become a national interest.

The SUPPORT study published in 1995 demonstrated the marked shortcomings regarding the in-hospital care for seriously ill adults and the need for effective palliative care. This landmark study spurred national dialogue regarding the need for coordinated care in those with advanced or terminal illness. According to the IOM, in-patient palliative care offers a response to the growing needs of critically ill and dying patients.

Many large academic centers are implementing in-patient palliative care programs. However, small rural hospitals, in particular CAHs, face unique professional staff resource and financial challenges when establishing the much needed in-patient palliative care programs. These challenges include a lower average daily census resulting in a lower operating margin as well as difficulty in recruiting specialty-trained healthcare providers. To ease the financial burden of the CAH, using the Full Team Model approach to establish the in-patient palliative care program may be a solution. This model is a consultative model that shares existing medical, nursing and ancillary staff in the hospital thereby alleviating the need for additional staff. In this model, attention must be given to ensure adequate palliative care training in all team members.

The Advanced Practice Nurses, and specifically the ACNP, possess core competencies essential to holistic patient care in an in-patient setting. The ACNP training
in acute and chronic management of illness as well as pain management is valuable when providing palliative care. Through application of the ACNP and palliative care core competencies, the ACNP is well positioned to lead the palliative care team toward a highly successful in-patient palliative care program.

The Advanced Practice Nurse can guide the palliative care core planning team in the selection of a theory for the palliative care practice. The Parse’s Human Becoming Theory is a grand theory that can shift nursing practice from the bio-psycho-social problem-based to that of being truly present with the patient, thereby guiding the patient and the family in making choices regarding their care. This theory encourages palliative care team member to follow the lead of the patient and/or family with respect to their wishes and plans for quality of life.

The organizers of the program must first build the case for in-patient palliative care, design the program, present a business plan, implement the program and finally measure the quality of the program. These steps must be coordinated and performed by a core team made up of a physician champion, an Advanced Practice Nurse such as an ACNP, an administrative champion and a nurse leader. After a thorough systems and needs assessment, the financial case, as well as the clinical case, must be made to the administrative decision makers of the organization.

Many factors come into play when determining the feasibility of developing an in-patient palliative care program in a rural CAH. Rural CAH facilities present unique challenges that must be reflected in the design of the program. When customizing the design of the program, it is important to reflect the mission, vision and values of the
hospital as well limited financial base in these rural facilities. The core team members
must propose an in-patient palliative care program that serves the needs of the
community while protecting the financial viability of the organization.
APPENDIX A

ACUTE CARE NURSE PRACTITIONER COMPETENCIES

Adapted from the National Organization of Nurse Practitioner Faculties (2004)

Assessment of Health Status

1. Assesses the complex acute, critical, and chronically-ill patient for urgent and emergent conditions, using both physiologically and technologically derived data, to evaluate for physiologic instability and potential life-threatening conditions.
2. Obtains and documents a health history for complex acute, critical, and chronically-ill patients.
3. Performs and documents complete, system-focused, or symptom-specific physical examinations on complex acute, critical, and chronically-ill patients.
4. Assesses the need for and performs additional screening, based on initial assessment findings.
5. Performs evaluations for substance use, violence, neglect and abuse, barriers to learning, and pain.
6. Distinguishes between normal and abnormal developmental and age-related physiologic and behavioral changes in complex acute, critical, and chronic illness.
7. Assesses for multiple interactive and synergistic effects of pharmacological agents, including over-the-counter (OTC) preparations and alternative and complementary therapies, in patients with complex acute, critical, and chronic illness.
8. Assesses the impact of an acute, critical and/or chronic illness or injury on the individual’s:
a. Health status (physical and mental)

b. Functional status, including activity and mobility

c. Growth and development

d. Nutritional status

e. Sleep and rest patterns

f. Quality of life

g. Family, social, and educational relationships

9. Provides for the promotion of health and protection from disease by assessing for risks associated with care of complex acute, critical, and chronically-ill patients, such as:

a. Physiologic risk, including, but not limited to, immobility, impaired nutrition and immunocompetence, fluid and electrolyte imbalance, invasive interventions, therapeutic modalities, and diagnostic tests.

b. Psychological risk, including, but not limited to, impaired sleep and communication, and crisis related to threat to life, self-image, finances, medication side-effects, home and educational environment, and altered family dynamics.

c. Health care system risks associated with care of complex patients, including, but not limited to, multiple caregivers, continuity of care, coordination of the plan of care, polypharmacy, communication with family or between multiple care providers.
10. Prioritizes data collection, according to the patient’s immediate condition or needs, as a continuous process in acknowledgement of the dynamic nature of complex acute, critical, and chronic illness.

11. Assesses the needs of families and caregivers of complex acute, critical, and chronically-ill patients.

**Diagnosis of Health Status**

1. Diagnoses acute and chronic conditions that may result in rapid physiologic deterioration or life-threatening instability.


3. Utilizes specialty-based technical skills in the performance of diagnostic procedures to confirm or rule-out health problems.

4. Synthesizes data from a variety of sources to make clinical judgments and decisions about appropriate recommendations and treatments.

5. Prioritizes health problems during complex acute, critical, and chronic illness.

6. Formulates differential diagnoses by priority considering multiple potential mechanisms causing complex acute, critical, and chronic illness states.


8. Diagnoses common mental health and substance use or addictive disorder/disease, such as anxiety, depression, and alcohol and drug use, in the presence of complex acute, critical, and chronic illness.
9. Reformulates diagnoses by priority based on new or additional assessment data and the
dynamic nature of complex acute, critical, and chronic illness.

**Plan of Care and Implementation of Treatment**

1. Formulates a plan of care to address complex acute, critical, and chronic health care
   needs.
   
   a. Integrates knowledge of rapidly changing pathophysiology of acute and critical
   illness in the planning of care and implementation of treatment.
   
   b. Prescribes appropriate pharmacologic and non-pharmacologic treatment
   modalities
   
   c. Utilizes evidence-based practice in planning and implementing care.

2. Implements interventions to support the patient with a rapidly deteriorating physiologic
   condition, including the application of basic and advanced life support and other invasive
   interventions or procedures to regain physiologic stability.

3. Manages, through ordering, performance, interpretation, or supervision:
   
   a. Interventions that utilize technological devices to monitor and sustain
   physiological function;
   
   b. Diagnostic strategies and therapies to monitor and sustain physiological
   function and ensure patient safety, including, but not limited to, EKG
   interpretation, x-ray interpretation, respiratory support, hemodynamic monitoring,
   and nutritional support.

4. Performs therapeutic interventions to stabilize acute and critical health problems, such
   as suturing, wound debridement, line and tube insertion, and lumbar puncture.
5. Analyzes the indications, contraindications, risk of complications, and cost-benefits of therapeutic interventions.

6. Manages the plan of care through evaluation, modification, and documentation according to the patient's response to therapy, changes in condition, and to therapeutic interventions to optimize patient outcomes.

7. Manages the patient’s response to life support strategies.

8. Manages pain and sedation for patients with complex acute, critical, and chronic illness.
   a. Prescribes pharmacologic and non-pharmacologic interventions.
   b. Monitors patient’s response to sedation.
   c. Evaluates patient’s response to therapy and changes the plan of care accordingly.

9. Implements palliative and end of life care in collaboration with the family, patient (when possible), and other members of the multidisciplinary health care team.

10. Initiates appropriate referrals and performs consultations.

11. Assures that the plan of care is individualized, recognizing the dynamic nature of the patient's condition, reflecting the patient’s and family’s needs, and considering cost and quality benefits.

12. Coordinates inter- and intra-disciplinary teams to develop or revise plans of care focused on patient and/or family concerns.

13. Incorporates health promotion, health protection and injury prevention measures into the plan of care within the context of the complex acute, critical, and chronic illness.
14. Facilitates the patient's transition between and within health care settings, such as admitting, transferring, and discharging patients.

NURSE PRACTITIONER-PATIENT RELATIONSHIP

1. Applies ethical principles in caring for complex acute, critical, and chronic patients.

2. Communicates effectively with the patient and the family experiencing complex acute, critical, and chronic illness.

3. Facilitates patient and family decision making regarding complex acute, critical, and chronic illness treatment decisions, end of life care, and organ donation.

4. Applies principles of crisis management in assisting the patient and family experiencing complex acute, critical, and chronic illness.

5. Functions as patient advocate for those unable to do so for themselves due to acute, critical, and chronic illness or injury or developmental level.

TEACHING-COACHING FUNCTION

1. Develops with the patient, family, and caregiver(s) educational interventions appropriate to the complex acute, critical, and chronically-ill patient’s needs, values, and cognitive level.

2. Demonstrates effective communication skills in addressing sensitive topics with patients and families such as life-threatening illness, organ transplantation, death, anxiety, substance use, palliative care and other related problems.

3. Provides anticipatory guidance that is age and developmentally appropriate within the context of complex acute, critical, chronic illness.
4. Incorporates the integration of self-care activities for complex acute, critical, and chronically ill patients.

5. Reinforces positive health behaviors among complex acute, critical, and chronically ill patients.

6. Teaches patients and families to advocate for themselves in complex acute health care environments.

7. Demonstrates leadership of the health care team through teaching, coaching, and supporting to advance the plan of care for complex acute, critical, and chronically ill patients.

**PROFESSIONAL ROLE**

1. Participates in formal and informal education provided to other health care professionals to promote positive outcomes during complex acute, critical, and chronic illness.

2. Integrates research to promote evidence-based practice for patients with complex acute, critical, and chronic illness.

3. Contributes to research that promotes positive outcomes during complex acute, critical, and chronic illness.

4. Participates in professional organizations that influence the health of acute, critical, and chronically-ill patients and support the role of the ACNP.

5. Interprets the ACNP role to other health care providers and to the public.

6. Integrates the ACNP role into systems, processes, and decision making to function fully within the health care team.
7. Serves as a knowledge resource in the design and development of complex acute, critical, and chronic health services.

8. Integrates knowledge of stress management principles when faced with complex acute or traumatic situations.

MANAGING AND NEGOTIATING HEALTH CARE DELIVERY SYSTEMS

1. Works collaboratively with a variety of health professionals to promote stabilization and restoration of health in complex acute, critical, and chronic illness.

2. Promotes collaboration among members of the multidisciplinary health care team to facilitate optimal care for complex acute, critical, and chronic patients.

3. Utilizes principles of case management when overseeing and directing health care services for complex acute, critical, and chronic illness.

4. Maintains current knowledge regarding state and federal regulations impacting ACNP practice.

5. Promotes efficient use of resources and provision of quality care to achieve optimal cost-effective outcomes.

MONITORING AND ENSURING THE QUALITY OF HEALTH CARE PRACTICE

1. Utilizes internal resources (e.g. ethics committee, risk management, legal department) and external resources (e.g. professional organizations, government officials, community agencies) to facilitate the resolution of patient advocacy, moral, and ethical issues.

2. Promotes an environment for ethical decision-making and patient advocacy.
3. Promotes valuing of lifelong learning and evidence-based practice while continually acquiring knowledge and skills needed to address questions arising in practice to improve patient care.

4. Contributes to the knowledge base of the healthcare community through research, presentations, publications, and involvement in professional organizations.

**CULTURAL COMPETENCE**

Utilizes research and knowledge of cultural diversity in caring for patients from various cultures.
APPENDIX B: PALLIATIVE CARE COMPETENCIES
### APPENDIX B

**Palliative Care Core Competencies**

Center to Advance Palliative Care (2004)

<table>
<thead>
<tr>
<th>Competency Focus</th>
<th>Description of Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain and Symptom</td>
<td>Appropriately manages patient pain and other distressing physical symptoms of disease, illness or treatment in a timely manner and achieves outcomes acceptable to the patient / family. Management may include referral to appropriate specialist and / or acceptance and support of the patient’s decision to include complementary therapies in treatment.</td>
</tr>
<tr>
<td>Management</td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td>Supports patient and family expression of emotional needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and / or professionals with expertise in this area. May use open-ended questions such as “How are you doing? How are things going in your life? What, if anything, are you feeling anxious about?”</td>
</tr>
<tr>
<td>Psychosocial</td>
<td>Provides an environment to support patient and family expression of psychosocial needs. Listens actively, supports as appropriate, and refers to support groups, other patients and families with similar conditions, and / or professionals with expertise in this area. Integrates this area with each interaction. May use open-ended questions such as “How are you doing? How are things going in your life? How have things changed for you in your life? How are your spirits?”</td>
</tr>
<tr>
<td>Spiritual / Cultural</td>
<td>Manages interactions to support patient and family expression of spiritual needs and strengths and cultural practices. Creates environment that allows integration of dialogue about spiritual issues within care experience. Refers to spiritual care staff and community resources as congruent with patient / family values. Communicates cultural care preferences to others. May use questions such as “What is the meaning of this illness to you and for your life? What lessons would you want to share? How has your sense of time changed? What strength have you called upon as you go through this illness? What are the culturally specific care parameters you wish us to observe?”</td>
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<tr>
<td>Competency Focus</td>
<td>Description of Competency</td>
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</tr>
<tr>
<td>Relationship – Family and Community</td>
<td>Addresses desires and needs for support from family and friends. Determines if there has been a change in family communication. Facilitates family communication of specific issues by structure of interactions. Provides anticipatory guidance for family as they focus on their relationships. This may include reconciliation of relationships. Provides helpful tools and / or refers for assistance with family communication. May use questions such as “How have things been within your family? What messages do you want to give to each other before death occurs? How much change has occurred with your social relationships outside the family?”</td>
</tr>
<tr>
<td>Honoring Patient Care Wishes</td>
<td>Understands and communicates patient and family end of life care wishes prior to crises or impending death. Honors wishes as care goals change from cure to comfort care. Only carries out interventions that make a difference for patient comfort and / or recovery. Supports patient and family when treatments are refused. Provides welcoming environment for family to stay with patient.</td>
</tr>
<tr>
<td>Dying and Death</td>
<td>Identifies those who are approaching last days of living. Communicates honestly to patient / family about approaching death and gifts of last days. Speaks of death as natural process not failure of treatment. Determines patient / family wishes regarding place of death and seeks to have death occur where desired. Assists family to give patient permission to die, to say “good bye”, and to bring reconciliation to family relationships.</td>
</tr>
<tr>
<td>After Death</td>
<td>Prepares family for events that occur immediately following death, i.e. select funeral home, make funeral arrangements, notify agencies such as SRS, Medicare, Attorney who handles Estate, financial issues, canceling appointments etc. Hints: This could be presented to the family in a packet of information.</td>
</tr>
<tr>
<td>Bereavement</td>
<td>Manages interactions with the bereaved that support communication of clinical concerns and questions as appropriate. Actively initiates referrals for support during bereavement.</td>
</tr>
<tr>
<td>Relationship</td>
<td>Establishes rapport with patient and family. Is viewed as “present, really listening, caring, and trustworthy”. Initiates contact with bereaved family as appropriate to relationship.</td>
</tr>
<tr>
<td>Communication</td>
<td>Is available physically and mentally for patient and family communication. Delivers difficult information in honest clear manner. Maintains hope by focusing on palliative care when cure no longer possible. Focuses on helping patient / family live in way meaningful to them.</td>
</tr>
<tr>
<td>Competency Focus</td>
<td>Description of Competency</td>
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</tr>
<tr>
<td>Teaching</td>
<td>Assesses for knowledge and questions. Refers to appropriate resources for additional information and support. Provides anticipatory guidance about illness, treatments, possible outcomes, and health system issues.</td>
</tr>
<tr>
<td>Team Collaboration</td>
<td>Provides care with a team approach that includes patient and family as integral and essential members of the care team.</td>
</tr>
</tbody>
</table>
APPENDIX C: ACNP/PALLIATIVE CARE CORE COMPETENCIES
### APPENDIX C

<table>
<thead>
<tr>
<th>ACNP Core Competencies</th>
<th>Palliative Care Core Competencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health promotion, protection and disease prevention and treatment</td>
<td>• Pain and symptom management</td>
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<tr>
<td>• Diagnosis of health status</td>
<td></td>
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<tr>
<td>• Plan of care</td>
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</tr>
<tr>
<td>• Cultural competence</td>
<td>• Emotional support</td>
</tr>
<tr>
<td>• Plan of care</td>
<td>• Psychosocial support</td>
</tr>
<tr>
<td>• Fostering Nurse Practitioner/patient relationship</td>
<td>• Spiritual/cultural support</td>
</tr>
<tr>
<td>• Cultural competence</td>
<td>• Relationship building and support</td>
</tr>
<tr>
<td>• Fostering Nurse Practitioner/patient relationship</td>
<td></td>
</tr>
<tr>
<td>• Teaching/coaching</td>
<td>• Honoring patient care wishes</td>
</tr>
<tr>
<td>• Professional Nursing Role</td>
<td>• Dying and death support</td>
</tr>
<tr>
<td>• Professional Nursing Role</td>
<td>• After death communication, support and bereavement</td>
</tr>
<tr>
<td></td>
<td>• Communication skills/teaching</td>
</tr>
<tr>
<td></td>
<td>• Team collaboration</td>
</tr>
</tbody>
</table>

Managing and negotiating the healthcare delivery systems
Monitoring and ensuring quality of health care practice
APPENDIX D: SYSTEM ASSESSMENT TOOL
APPENDIX D

System Assessment Tool
Assessing Organizational Infrastructure for Provision of Excellent Palliative Care

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Rev 9/2001

Scope of assessment includes:

<table>
<thead>
<tr>
<th>Standards</th>
<th>Organization Priorities</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policies</td>
<td>Vision</td>
<td>Spiritual care</td>
</tr>
<tr>
<td>Procedures</td>
<td>Annual goals &amp; objectives</td>
<td>Pain &amp; symptom management</td>
</tr>
<tr>
<td>Standards of care</td>
<td>Quality initiatives</td>
<td>Transition services</td>
</tr>
<tr>
<td>Practice guidelines</td>
<td>Management priorities &amp; objectives</td>
<td>Family services</td>
</tr>
<tr>
<td>Strategy to identify population</td>
<td>Personnel education &amp; competency standards</td>
<td>Emotional / supportive services</td>
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<tr>
<td></td>
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<td>Education services for ill persons and their caregivers</td>
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<tr>
<td></td>
<td></td>
<td>Hospice</td>
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<tr>
<td></td>
<td></td>
<td>Hospice approach available</td>
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<td></td>
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<td>pre-hospice</td>
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</tbody>
</table>

ITEM

P=Present, NF=Not Present

<table>
<thead>
<tr>
<th>Rate effectiveness of implementation from 0 to 10</th>
<th>Rate priority for action plan from 0 to 10</th>
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</thead>
<tbody>
<tr>
<td>0=not at all 10=fully implemented and effective</td>
<td>0=not at all 10=undertake within one year</td>
</tr>
</tbody>
</table>

Vision and Management Standards

Vision for excellence in end of life care is created

Organization annual objectives include focus on end of life care

Administrative executive staff support implementation of initiatives to improve care at end of life

Medical staff support implementation of initiatives to improve care at end of life

Manager’s objectives include focus on end of life care

Education resources are designated to support development of competencies and practices in end of life care

Excellent caregivers and caregiving examples are honored and their stories made visible

Practice Standards (procedures, policies, care protocol)

Population served is defined and communicated

Confidentiality standards clearly communicated
<table>
<thead>
<tr>
<th>ITEM</th>
<th>P=Present, NP=Not Present</th>
<th>Rate effectiveness of implementation from 0 to 10</th>
<th>Rate priority for action plan from 0 to 10</th>
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<tbody>
<tr>
<td>Advance care planning supports available and plan communicated</td>
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<tr>
<td>Cultural / religious guidelines integrated</td>
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<tr>
<td>Organ / tissue donation guidelines implemented</td>
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<tr>
<td>Comfort care or palliative care standard implemented</td>
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</tr>
<tr>
<td>Includes guidelines for pain and symptom management, and hydration / nutrition</td>
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<tr>
<td>Interdisciplinary palliative care consult services available</td>
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<tr>
<td>Hospice care available wherever the patient resides</td>
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<tr>
<td>Hospice care includes assistance with transportation, household chores, personal care, and respite care</td>
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<tr>
<td>Hospice volunteers screened and trained</td>
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<tr>
<td>Hospice volunteer supervised</td>
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<tr>
<td>Volunteer support routinely included in program, e.g. ongoing training, support groups, inclusion with team discussion, 1:1 support, and recognition activities / celebrations</td>
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<tr>
<td>Hospice trained volunteers available to visit</td>
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<tr>
<td>Hospice trained volunteers available to provide respite</td>
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<tr>
<td>Hospice trained volunteers available to provide assistance with transportation and household chores</td>
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<tr>
<td>Complementary or integrative therapies supported</td>
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<tr>
<td><strong>Space Standards</strong></td>
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<tr>
<td>Patient room is comfortable, homelike, supports family visiting and confidentiality</td>
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<tr>
<td>Homelike or living room type space is available for family</td>
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<tr>
<td><strong>Visiting Standards</strong></td>
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<tr>
<td>Welcoming for families</td>
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<tr>
<td>Support for family ADL’s available</td>
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<tr>
<td>24 hour visiting for family and close friends with ill person/family allowed to determine numbers, hours, and age (with respect for other patient care needs)</td>
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<tr>
<td>Family participates in care as desired</td>
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<tr>
<td>Children welcomed with supervision</td>
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<tr>
<td>Pet visiting with supervision and respect for other patient care needs</td>
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<tr>
<td>ITEM</td>
<td>P=Present, NP=Not Present</td>
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<tr>
<td>Communication Standards</td>
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<tr>
<td>Care preference, values, spiritual, emotional, and relationship needs as well as treatment decisions consistently and accurately communicated between care settings and professional providers.</td>
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<tr>
<td>Care preference, values, spiritual, emotional, and relationship needs as well as treatment decisions consistently honored.</td>
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<tr>
<td>Physician communication frequent during the dying process</td>
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<tr>
<td>Transfer of care occurs with communication of preferences, values, spiritual / emotional, and relationship needs and patient / family care decisions</td>
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<tr>
<td>Standards and expectations about excellent end-of-life care routinely communicated to community</td>
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<tr>
<td>Communication with community spiritual care providers routine as well as specific</td>
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<tr>
<td>Professional Experiential Education during Orientation and as Continuing Education</td>
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<tr>
<td>CONTENT: &quot;Living and healing during life-threatening illness&quot;, dying process, and death. <em>(Provided for all leadership team, employed staff and physicians)</em></td>
<td></td>
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<tr>
<td>Organization values and strategic objectives</td>
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<tr>
<td>Ethics – End-of-life care</td>
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<tr>
<td>Practice standards</td>
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<tr>
<td>Quality standards</td>
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<tr>
<td>Communication</td>
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<tr>
<td>Grief and bereavement</td>
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<tr>
<td>Patient / family supports</td>
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<tr>
<td>Professional caregiver / staff support</td>
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<tr>
<td>Spiritual / religious / cultural standards</td>
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<tr>
<td>Individual performance expectations</td>
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<tr>
<td>Volunteer Program Standards – if applicable</td>
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<tr>
<td><em>(Prepared volunteers have been very helpful in meeting care needs in some organizations)</em></td>
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<tr>
<td>Volunteers screened using a set criteria</td>
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<tr>
<td>Training program for volunteers required <em>(e.g. hospice volunteer training program)</em></td>
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<tr>
<td>Volunteers supervised</td>
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<tr>
<td>Volunteer support routinely included in program, e.g. ongoing training, support groups, inclusion with team discussion, 1:1 support, and recognition activities / celebrations</td>
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<tr>
<td>Volunteer support includes assistance with transportation and household chores</td>
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<tr>
<td>ITEM</td>
<td>P=Present, NP=Not Present</td>
<td>Rate effectiveness of implementation from 0 to 10</td>
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<td>---------------------------------------------------------------------</td>
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<tr>
<td>Volunteers present to provide support to family during acute or terminal phase of illness</td>
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<tr>
<td>Volunteers available to visit and maintain vigil with dying person if appropriate</td>
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</table>

**Quality Improvement Standards**

- Routine feedback from patients, family caregivers, bereaved family, and community partners is obtained.
- Quality priorities include response to above.
- Significant events are assessed for learning and quality improvement.
- "Stories" are shared and used to teach about care and to set standards.
- Research to continue developing new ways to improve care is developed or findings are applied to practice change initiatives.
- Annual objectives and priorities include focus on end of life care.

**Employee Support Standards**

(This area includes items to support employees as professional caregivers and as ill person, caregiver, or bereaved family)

- Human Resources policies support bereavement leave for those the person defines as close or family.
- Human Resources policies allow flexibility in work time during illness and caregiving.
- Human Resource policies allow at least 7 days bereavement leave per event per employee.
- Human Resources policies allow others to "give" vacation time or time off to support other employees.
- Employees are supported in reaching out to fellow employees with practical help.
- Acuity and patient assignments provide time to "be with" the patient and family during the process of dying.
- Professional caregiver is supported to attend memorial / funeral service of patients.

**Community Network and Partnerships**

- Formal relationship established with Hospice care providers in community.
- Formal relationship established between healthcare and community faith based ministries to meet care needs at end of life.
<table>
<thead>
<tr>
<th>ITEM</th>
<th>P=Present, NF=Not Present</th>
<th>Rate effectiveness of implementation from 0 to 10</th>
<th>Rate priority for action plan from 0 to 10</th>
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</thead>
<tbody>
<tr>
<td>Care offered by faith based ministries and healthcare coordinated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthcare partnerships with formal and informal community organizations to meet support needs for patient and family caregiver</td>
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<tr>
<td>Parish nurse or similar program, if available, and linked with healthcare</td>
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<td></td>
</tr>
<tr>
<td>Hospice / home care services available and linked to other healthcare organization services</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Services are provided that achieve continuity of care within and between community and healthcare organizations</td>
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<tr>
<td>Community volunteers screened using a set criteria</td>
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<tr>
<td>Training program for volunteers required (e.g., hospice volunteer training program)</td>
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</tr>
<tr>
<td>Community volunteers present to provide support to family during acute or terminal phase of illness</td>
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<tr>
<td>Volunteer support includes assistance with transportation and household chores</td>
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</tr>
<tr>
<td>Community volunteers available to visit and maintain vigil with dying person if appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End-of-life palliative care and hospice services available to the homeless</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>End-of-life education, including advance care planning, integrated within schools, workplaces, faith based organizations, and other community formal and informal gatherings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education about helping those facing end-of-life integrated within schools, workplaces, faith based organizations, and other community formal and informal gatherings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Palliative Care Services Salary Worksheet

<table>
<thead>
<tr>
<th>Position</th>
<th>Hourly Rate</th>
<th>Hours</th>
<th>Annual Salary</th>
<th>Add-on for Benefits $</th>
<th>Salary + Benefits $ A + C</th>
<th>FTE % for Pall.Care Services</th>
<th>Total Cost, prorated @FTE % (E) x (F)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Year 1 (first full year of operation)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Medical Director (clinical &amp; educational roles)</td>
<td>180,000</td>
<td>20%</td>
<td>36,000</td>
<td>0.3</td>
<td>64,800</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Practice Nurse (Nurse Practitioner)</td>
<td>20%</td>
<td>14,560</td>
<td>0.3</td>
<td>64,800</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Program Coordinator (RN)</td>
<td>52,000</td>
<td>10%</td>
<td>4,080</td>
<td>0.0</td>
<td>62,400</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker (partnering with Discharge Planning)</td>
<td>45,000</td>
<td>20%</td>
<td>9,000</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ad hoc team members including chaplainy and possibly a clinical pharmacist</td>
<td>40,000</td>
<td>20%</td>
<td>8,000</td>
<td>0.0</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Social Worker (MSW)</td>
<td>40,000</td>
<td>20%</td>
<td>8,000</td>
<td>0.3</td>
<td>48,000</td>
<td></td>
<td>14,400</td>
</tr>
<tr>
<td>Chaplain</td>
<td>0</td>
<td>20%</td>
<td>-</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Pharmacist, Other team members</td>
<td>0</td>
<td>20%</td>
<td>-</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Staff Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>515,760</td>
</tr>
<tr>
<td><strong>Year 2 (Includes 3% Merit Increase)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Medical Director (clinical &amp; educational roles)</td>
<td>185,400</td>
<td>20%</td>
<td>37,080</td>
<td>0.5</td>
<td>111,240</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced Practice Nurse (Nurse Practitioner)</td>
<td>35 2080</td>
<td>20%</td>
<td>14,597</td>
<td>0.0</td>
<td>89,981</td>
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</tr>
<tr>
<td>Program Coordinator (RN)</td>
<td>53,560</td>
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<td>6,427</td>
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<td>64,272</td>
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<tr>
<td>Social Worker (partnering with Discharge Planning)</td>
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<td>20%</td>
<td>9,000</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ad hoc team members including chaplainy and possibly a clinical pharmacist</td>
<td>40,000</td>
<td>20%</td>
<td>8,000</td>
<td>0.0</td>
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</tr>
<tr>
<td>Social Worker (MSW)</td>
<td>41,200</td>
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<td>8,240</td>
<td>0.3</td>
<td>49,440</td>
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<td>14,832</td>
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<tr>
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<td>20%</td>
<td>-</td>
<td>0.0</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Pharmacist, Other team members</td>
<td>0</td>
<td>20%</td>
<td>-</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Staff Costs</strong></td>
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<td></td>
<td></td>
<td></td>
<td>528,173</td>
</tr>
<tr>
<td><strong>Year 3 (Includes 3% Merit Increase)</strong></td>
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<tr>
<td>Physician Medical Director (clinical &amp; educational roles)</td>
<td>190,962</td>
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<td>114,577</td>
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</tr>
<tr>
<td>Advanced Practice Nurse (Nurse Practitioner)</td>
<td>35 2080</td>
<td>20%</td>
<td>15,447</td>
<td>0.0</td>
<td>82,680</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Coordinator (RN)</td>
<td>55,167</td>
<td>10%</td>
<td>6,620</td>
<td>0.0</td>
<td>66,200</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>45,000</td>
<td>20%</td>
<td>9,000</td>
<td>0.0</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker (MSW)</td>
<td>42,436</td>
<td>20%</td>
<td>8,487</td>
<td>0.3</td>
<td>50,923</td>
<td></td>
<td>25,462</td>
</tr>
<tr>
<td>Chaplain</td>
<td>0</td>
<td>20%</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Pharmacist, Other team members</td>
<td>0</td>
<td>20%</td>
<td>-</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Staff Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>595,870</td>
</tr>
<tr>
<td><strong>Year 4 (Includes 3% Merit Increase)</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Physician Medical Director (clinical &amp; educational roles)</td>
<td>196,691</td>
<td>20%</td>
<td>39,338</td>
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<td>118,015</td>
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</tr>
<tr>
<td>Advanced Practice Nurse (Nurse Practitioner)</td>
<td>35 2080</td>
<td>20%</td>
<td>15,447</td>
<td>0.0</td>
<td>82,680</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program Coordinator (RN)</td>
<td>55,167</td>
<td>10%</td>
<td>6,620</td>
<td>0.0</td>
<td>66,200</td>
<td></td>
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</tr>
<tr>
<td>Registered Nurse</td>
<td>44,000</td>
<td>20%</td>
<td>8,800</td>
<td>0.0</td>
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<tr>
<td>Social Worker (MSW)</td>
<td>43,709</td>
<td>20%</td>
<td>8,742</td>
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<tr>
<td>Chaplain</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Pharmacist, Other team members</td>
<td>0</td>
<td>20%</td>
<td>-</td>
<td>0.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Staff Costs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>595,870</td>
</tr>
</tbody>
</table>

### Appendix E

**Palliative Care Services Salary Worksheet**

<table>
<thead>
<tr>
<th>Hourly Rate</th>
<th>Hours</th>
<th>Annual Salary</th>
<th>Add-on for Benefits $</th>
<th>Salary + Benefits $ A + C</th>
<th>FTE % for Pall.Care Services</th>
<th>Total Cost, prorated @FTE % (E) x (F)</th>
</tr>
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<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
REFERENCES


Arizona Department of Commerce: Cochise County Profile July 2006.


National Rural Health Association (2005). *Providing Hospice and Palliative Care in Rural and Frontier Areas in Hospice and Palliative Care Manual*.


