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Early Discussion of Palliative Care Benchmark Project

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Early Discussion of Palliative Care

For patients with an advanced stage cancer diagnosis (III-IV) (P), does early discussion of palliative care services (I) compared with no palliative care discussion (C) improve the patient and caregiver's quality of life (O) in the last 6 months of life (T)?

Executive Summary

Nurses play a fundamental role in helping patients and families addressing their needs throughout the dying process (Hold, Ward, & Blake, 2014). In addition, nurses are the ones that typically spend the most time with patient, providing additional teaching, emotional support, following up with phone calls and messages sent in patient portals. Therefore, it is paramount that nurses are equipped to initiate and engage in conversations surrounding palliative care.

Within an academic cancer center, oncology nurses are expected to obtain oncology certification as well as maintain competencies within their sub-specialties. Palliative care also needs to be included in the standards an oncology nurse is expected to maintain. This is in order to ensure they are able to provide specialized end of life care as in our patient population, we care for numerous advanced stage cancer patients within each of our practices. Patients will travel to academic centers for high quality care and the hope for new treatment options when they have been informed that treatment options are likely limited. Our nurses need to be equipped to have conversations surrounding palliative care and provide accurate information about what this care truly entails.

Oncology nurses have high levels of assessment and critical thinking skills. However, it is when the advanced skills and training coupled with compassion and caring for each patients' cancer experience come together in an extraordinary way so that the oncology nurse actually

enters the patients' journey towards end of life. The relationship between oncology nurse and patient with cancer, provides a powerful mechanism for both parties to experience the art of nursing (Barnard, Hollingum, & Hartfiel, 2006). The need has been identified for all parties involved (physician, nurse, patient, and their family) to be more prepared to address issues surrounding palliative care. The focus in each of the professions that provide care for the patient needs to be how the implementation of palliative care however, needs to focus on providing guidance for the patient and how they may benefit from an improved quality of life, throughout their entire cancer journey with the assistance of palliative care.

By having the tough and frank conversations surrounding palliative care early on in the treatment process, patients are better able to make informed decisions about treatment, depending on the trajectory their disease takes. Such conversations provide patients with a clearer picture of what is likely expected as they continue on their cancer journey. Unfortunately, currently, patients report a lack of understanding and meaning to what palliative care truly is and what it entails. Zimmerman et al. (2016) discovered that the stigma associated with palliative care has created a disconnect for patients during their cancer journey. Based upon the participant's perceptions of palliative care, Zimmerman et al., (2016) concluded that palliative care services need "rebranding" in order to reduce the negative stigma about what palliative care actually is and to provide patients' with a better experience throughout their treatment and beyond. By creating a better understanding of what the service of palliative care can offer, with patients understanding that it can be an adjuvant to treatment, and through squashing the notion that palliative care is the "final resort" when all other lines of treatment have failed, the patient is the one that benefits (in more ways than one).

Therefore, the overall aim of the benchmark project, based upon the best available evidence, clinical experience of oncology nurses, and patient preferences for information about palliative care, is to propose the creation and initiation of a protocol which empowers oncology/palliative care nurses to be able to initiate early discussions about palliative care for patients with advanced stage cancer (III-IV) diagnoses.

Rationale

Currently within UT Southwestern Simmons Cancer Center, there are no established protocols regarding the initiation of palliative care discussions. Furthermore, it is unclear as to who may initiate the palliative care discussion. Currently, the palliative care discussion is initiated by the provider based upon their perception of the patients' readiness to discuss palliative care. However, while this approach may be well intentioned, it is not based upon best practice guidelines.

According to the American Society of Clinical Oncology (ASCO), any patients with advanced cancer should receive dedicated palliative care services, early in the disease course, as an adjuvant to concurrent active treatment of their cancer (Ferrell et al., 2017). Yet, due to the negative perception by many patients as an abandonment of care as opposed to an adjuvant of treatment, providers are reluctant to introduce this topic too early on in patient's treatment. This is not unique to our intuition however, Hui et al. (2016) found that there are significant inconsistencies in the criteria and timing of referrals to palliative care.

Our oncologists are equipped to manage secondary nausea/vomiting, and neoplasm-related pain, to a certain degree. If first and second-line interventions fail for these adverse reactions, the patient should be appropriately referred to our palliative care team for guidance. However, if we take this one step further, by addressing palliative care upon diagnosis, this helps

to reduce the negative stigma surrounding this service and the patients learn that this is standard of care treatment. This is ideal in each department within our cancer center. Due to the current practice within our institution, this would need to be established as a multi-phase process.

Project Goals

The goal of this project is to bring heightened awareness to the benefits of early initiation of palliative care and thereby improve the quality of life for our patients throughout their cancer journey. In an oncology setting, it can be difficult to identify each patient that will need (or at what point they may wish to use) palliative services. It is, therefore, important that at each new patient visit, the patient and their family is made aware that these services are always available to them, at any point in time during their treatment. If the patient progresses through treatment, it is critical for us as nurses to recognize when palliative services may be more prudent to the patient's care, advocate to the healthcare provider (HCP) to have these difficult conversations, and serve as a resource to patients as to what these services can offer to enhance their care.

A recent study showed that patients that were assigned by an "early specialized palliative care team" felt as though they were well supported and better able to navigate the healthcare system throughout their care (Hannon, Swami, Rodin, Pope, & Zimmermann, 2017). While at our patient's follow up visits, we as nurses are ensuring that their medications are up to date, we've done proper teaching about side effects of therapy, and that their chemotherapy and radiation schedules are aligned correctly. However, are we doing a disservice to them by not addressing the more difficult conversations that might be approaching quickly in the coming months as this is now their sixth line of therapy, with mounting side effects with each new regimen? Patients need to be aware of the resources available to them and understand that palliative treatment is to improve quality of life, at any stage in their treatment journey.

Literature Synthesis

A review of the literature was conducted to determine the research that has been done thus far on the early initiation of palliative care. Initially, research was not limited to palliative care but also initiation of hospice services. As the project focus narrowed, hospice was no longer used for the purposes of this study. Key words included: early palliative care, delays in palliative care, perceptions of palliative care. Years included in the search were from 2000 – present. Only one article from 2004 was eventually used, with a majority of articles selected being from 2014 – present. The two main databases used for this project were CINAHL and PubMed.

Zimmerman et al. (2014) conducted a randomized controlled trial to determine the effect of the early initiation of palliative care in patients with advanced cancer. There were 461 patients enrolled in the study with approximately 50% in each group – one group received early initiation of palliative care while the control received standard of care. The study was inconclusive at the end of the end mark of the study (3 month) but at the four-month mark, all of the change scores used showed improved scores for the early initiation of palliative care and the patient's quality of life. In addition, the patients were more satisfied with the care they received in the early initiation of palliative care group throughout the study.

Maltoni et al. (2016) conducted a similar randomized control study that evaluated the outcomes of early referral to palliative care versus requests for a palliative care consultation. Newly diagnosed inoperable, locally advanced, pancreatic patients were randomized to receive early palliative care with treatment or the control study where a referral would be placed if requested by patient or the provider throughout their course of treatment. With 207 patients enrolled (97 intervention group and 89 in control arm), the study found that there was significant improvement in quality of life in all areas of data analysis favoring the intervention group.

Project Stakeholders

Nurses, oncologists, social workers, and the cancer center as a whole are all stakeholders with this project. Each plays a vital role in the execution and success of this project. In order for this to be successful, each team member needs to have the commitment to learning the new standards established from the evidence as well as providing top notch care to the patients we serve. As a Magnet institution, nurses are challenged to evaluate their practice and question the cost analysis of the practices in place to determine if there are more effective ways to do the processes in place (Wise, 2009). However, as nurses transcend through many different facets of care for the patient, the interdisciplinary collaboration is essential for the project's success.

Most importantly, the patient is the primary stakeholder as they will be the ones that will be benefiting from the advantages of the early initiation of palliative care.

Proposed Outcomes

The first phase of this project is education on palliative care for all of our cancer center nurses. The nurse educator for the cancer center will attend the American Association of Colleges of Nursing (AACN)'s End-of-Life Nursing Education Consortium (ELNEC) train the trainer course. The ELNEC course helps guide oncology nurses on pharmacologic and nonpharmacologic interventions, helps yield fruitful discussions on palliative care, and differentiate palliative care, end of life, and hospice care to nurses. The foundation research circles back to educating all parties (provider, nurse, patient, family) on what palliative care truly entails. The curriculum in this course was developed by nationally recognized palliative care experts and is revised on an annual basis to include new advances in the field (American Association of Colleges of Nursing, 2019).

Multiple sessions of this course would then be hosted by our nurse educator on different days and times to accommodate varying schedules. Each of our oncology nurses in the cancer center would then be required sign up and attend one of the multiple sessions by a predetermined deadline. As a parallel with this phase of implementation, this course would be required as a part of the onboarding process with each new hire nurse to the cancer center. Any new updates provided to our educator by AACN regarding end-of-life care would then be presented to nurses either through an email bulletin or at the quarterly all-staff nursing meeting. From the nursing educator attending the train-to-teach conference to having each staff member attend the course, approximately 6-9 months would be required.

Phase two of this initiative would be written information and handouts for patients on palliative care. While noted as the secondary phase, this can be done concurrently with phase one of this project. This would be a collaborate process involving social work, our nursing educator, and our palliative care team. As a part of newly diagnosed patient's education folder, a handout would be included that defines palliative care and includes information on the cancer center's palliative care department. This handout would also be displayed on the pamphlet boards in each clinic within the cancer center. While this is not a direct referral, patients are introduced the topic of palliative care and helps provide a better understanding on why a referral to this team may benefit the patient. As we work to provide the most comprehensive care to patients while also navigating the somewhat novel, palliative care consult, ensuring thorough understanding of what this essential component to oncology care is, education and appropriate reinforcement of this process is key.

First and foremost, a preliminary handout would be developed in collaboration with my educator. This would then be sent to our palliative care social worker and one of our palliative

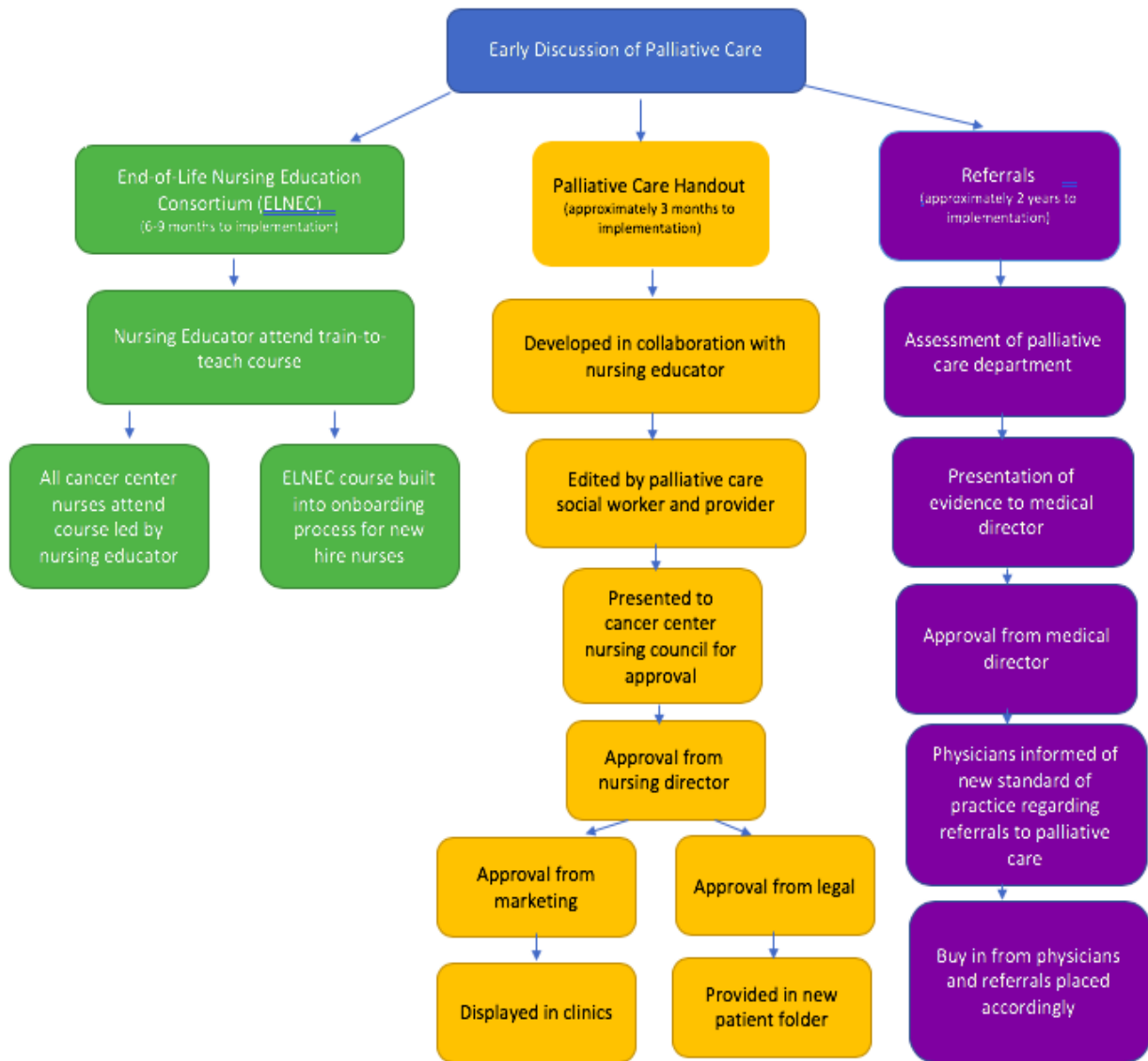
care physicians for any necessary revisions. Once finalized from this standpoint, the final draft would then be sent to our cancer center nursing council for review and seal of approval. As soon as this is completed, our nursing director would need to endorse the document before it moves forward to the marketing and legal teams for seal of approval as an institutional handout. Once approved from all levels, our educator would announce the new handout to all nurses and providers and explain that it would be included in each new patient folder and displayed in each clinic. From the initial draft to the final handout, approximately 3 months would be needed in order to receive each level of approval.

There is a strong stigma related to palliative care that many providers mention as their reason for delayed referrals to palliative care services (Zimmermann et al., 2016). By educating nurses on how to address this topic with patients, combined with a that is handout provided to all patients and is also displayed in the clinic the patient attends for each treatment appointment, the topic of palliative care becomes less taboo. The intent is to normalize the topic of palliative care and help prompt discussion with their oncologist early on in the treatment process.

The final phase of this project involves discussion of palliative care and a referral to the palliative care department for any advanced stage III-IV oncology patient by their oncologist at the time of diagnosis. First and foremost, discussion of feasibility of our palliative care department to be able to accommodate a larger volume of patients would be assessed with our palliative care team. Secondly, a presentation discussing the evidence for this initiative would be discussed with the cancer center medical director. Approval at this level must also be obtained. In collaboration with the director and his team, this initiative would then be presented to all of our oncology physicians as a new standard of practice within our cancer center. Phase three

would be approximately two years from ensuring capability of our palliative care department has the necessary personnel to physicians executing the referrals by this new standard.

Timetable/Flowchart



Cost Benefits Analysis

Preisler, Heuse, Riemer, Kendel, and Letsch (2018) proved that in order for early palliative care to be effective, structural conditions, procedures, and information provided and resources for patients need to be in place. The costs identified within this project would be the travel and training costs associated for the oncology nurse educator to receive necessary training

for the ELNEC course, likely approximately \$800. Following the educator's training, various training session times will need to be held in order to educate all the nurses within the cancer center. While this may not have a monetary cost, managers will have to coordinate staggering staff accordingly. In addition, coordination with the Epic team would need to take place in order to implement the questionnaires to auto-populate for the patient upon check in. Depending on the coding needed, additional costs may incur with rollout of this process.

The largest cost could come into play with a new palliative care provider. Given the number of additional referrals through the last phase of this project, a standard referral for any patient with a stage III or IV diagnosis, it would almost certainly need a new provider to adjust for the influx of patients. This would need to be thoroughly assessed through justifying the need for the new provider as well as approval from upper management on the new position. This would likely run the institution \$200,000.

The benefits however, is far greater than the costs associated with implementation of this project. Nurses will be better educated and prepared to handle palliative care discussions. Most importantly, the patient will benefit from more comprehensive care provided and a better quality of life overall through the interventions provided by the palliative care department. In the long run, palliative care has been proven to reduce healthcare cost while simultaneously improving the care provided to patients (Jones, 2015).

Proposed Evaluation

In order to evaluate the effectiveness of the protocols being put into place, each process will need to be examined on an individual level. Each nurse will be required to complete a survey following completion of their ELNEC training. This survey will evaluate how their perception of palliative care has changed, what changes they plan to make in their practice based

on what they've learned, and their comfortability of talking about palliative care with patients. Based on the results of this survey, determination will be able to be made if additional support or trainings are needed on the subject of palliative care.

It has been shown that new graduate nurses do not feel adequately prepared to deal with the difficulty and dilemma surrounding palliative care discussions (dos Santos Germano & Meneguín, 2013). Requiring the ELNEC course as a part of the onboarding process, nurses (newly graduated or not) will have had training prior to tackling these difficult conversations within our cancer center.

Following the distribution and display of the palliative care handouts as well as the referrals that will be made for patients with advanced disease to the palliative care service, patients will then complete surveys at three different intervals during their care. The patients will be given the same survey to complete at three, six, and twelve months once they are under the palliative care service. The Epic EMR will auto populate the survey as a part of their online check-in once they have been under the palliative care service after each timeframe has passed. If patients do not check in online, the survey will print as a part of their check-in paperwork when they arrive for their appointment.

This survey will investigate how their perceptions of palliative care have changed from initial diagnosis and discussion of the palliative care referral to present. It will also ask what benefit palliative care has provided throughout their treatment with multiple response options for them to check off as well as a free text area for them to type in their own response as well. These surveys will then be evaluated to ensure adequate patient support and also provide feedback for the palliative care and social work departments on where they are excel and also where improvements can be made as well.

Recommendations

Palliative care is an essential component in providing quality care for patients with advanced stage cancers. As research shows, there is a lack of standardization within what criteria need to be met and when a patient should be referred to palliative care (Hui et al., 2016). By providing more thorough education to our nurses and patients and through collaboration by all professions involved to implement a protocol on referring patients with advanced cancer early on in treatment, our patients will benefit significantly. It is a disservice to our patients to not provide adequate education regarding additional measures that may be taken to help improve their quality of life throughout their cancer journey. The small steps we take early on in treatment can have lasting effects and provide better outcomes for our patients.

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Appendix

	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
1	Brickner, L., Scannel, K., Marquet, S., & Ackerson, L. (2004). Barriers to hospice care and referrals: survey of physicians' knowledge, attitudes, and perceptions in a health maintenance organization	<ul style="list-style-type: none"> • Discover perceptions of physicians for using hospice • Determine their knowledge of hospice • Find out barriers for hospice utilization 	Not seen in this study	<ul style="list-style-type: none"> • Quantitative; • Survey with anonymous responses • Descriptive design 	<ul style="list-style-type: none"> • 125 physicians within 2 internal medicine departments within a not-for-profit organization in Northern California • 89% response rate (unstated reason as to the rationale of this number) 	No IV or DV but the categories studied: <ul style="list-style-type: none"> • Physician demographics and their personal experience with hospice services • Professional experience with hospice • Valuation of hospice service benefits • Perceived barriers to making hospital referrals 	<ul style="list-style-type: none"> • Means, median, and standard deviations used to further explain the data • χ^2 test used as well in conjunction with Fischer's to test p with low sample sizes 	<ul style="list-style-type: none"> • Surveys – organized into sections to evaluate data accordingly • Summarized using frequencies 	<ul style="list-style-type: none"> • Hospice added quality to patients' end of life care • Physicians have difficulty predicting life expectancy • Lack of knowledge of patient eligibility guidelines • 28% of physicians believe that patients may view a hospice referral as a cost-saving initiative 	<ul style="list-style-type: none"> • Level VI • Strengths: <ul style="list-style-type: none"> - Gives us insight into why there are barriers to hospice - Informs us what barriers there are to hospice care and referrals and therefore we can move forward to make adjustments accordingly • Weaknesses: <ul style="list-style-type: none"> - Only a survey of a select number of physicians in a broad-spectrum field of internal medicine - Omission of data collection about physician awareness of the qualifications for hospice referral • Further research: use in oncology-centered facility, a larger sample size
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])

2	<p>Hui, David, Meng, Yee-Choon, Bruera, Sebastian, Geng, Yimin, Hutchins, Ron, Mori, Masanori, . . . Bruera, Eduardo . (2016). Referral Criteria for Outpatient Palliative Cancer Care: A Systematic Review.</p>	<ul style="list-style-type: none"> •Determine the criteria that is used to determine a palliative care referral is necessary 	<ul style="list-style-type: none"> •Lack of standardization exists for determining which patients are appropriate to refer to palliative care 	<ul style="list-style-type: none"> •Systemic review of Ovid Medline and Ovid Embase for articles 	<ul style="list-style-type: none"> •186 articles initially found with •21 in the final group used for the study 	<p>No variables as this was a systematic review.</p> <ul style="list-style-type: none"> •Databases were searched for articles including the following words: <ul style="list-style-type: none"> - neoplasms - palliative care - supportive care - outpatient - ambulatory clinic •The search was then narrowed to only include outpatient cancer palliative care referrals 	<ul style="list-style-type: none"> •If a certain criteria was mentioned by at least 5 or more of the 21 articles, this was considered to be a "major" theme/criteria 	<ul style="list-style-type: none"> •Frequencies and percentages were used to condense the data 	<p>Six major categories for referral criteria found:</p> <ul style="list-style-type: none"> -physical symptoms -cancer diagnosis -prognosis - performance status - psychosocial distress -end-of-life care planning 	<p>Level I Strengths:</p> <ul style="list-style-type: none"> •Showed the lack of consistency of referrals and demonstrated the need for more standardized criteria on which patients need outpatient palliative care referrals <p>Weakness (limitations):</p> <ul style="list-style-type: none"> •Of the literature available, there were only 21 articles that were suitable for use in this study. •Further research is needed in a number of categories identified in order to bridge the discrepancy gaps
	<p>Citation: author(s), date of publication & title</p>	<p>Purpose of Study</p>	<p>Conceptual Framework</p>	<p>Design/Method</p>	<p>Sample/Setting</p>	<p>Major Variables Studied and Their Definitions</p>	<p>Measurement of Major Variables</p>	<p>Data Analysis</p>	<p>Study Findings</p>	<p>Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])</p>
3	<p>Sekse, R., Hunskaar, I., & Ellingsen, S. (2018). The nurse's role in palliative care: A qualitative</p>	<ul style="list-style-type: none"> •Acquire themes through a synthesis of articles to determine how nurse view 	<ul style="list-style-type: none"> •Little is known about the role nurses play in providing palliative care services 	<ul style="list-style-type: none"> •Qualitative systematic review of studies 	<ul style="list-style-type: none"> •Databases: MEDLINE, EMBASE, CINAHL, OVID Nursing, British Nursing Index, PsycINFO, 	<ul style="list-style-type: none"> •Following terms were used: <ul style="list-style-type: none"> - palliative care - terminal care -end-of-life care 	<ul style="list-style-type: none"> •Thematic synthesis of articles •CORE Q was used to determine quality of themes 	<ul style="list-style-type: none"> •Each study was read individually, numerous times to evaluate the data 	<ul style="list-style-type: none"> •Themes established: <ul style="list-style-type: none"> -being available -being a coordinator of care for patients and relatives -doing what's needed 	<p>Level V</p> <ul style="list-style-type: none"> •Strengths: Core themes found as to nurse's perception of their role across multiple intuitions •Weaknesses: <ul style="list-style-type: none"> -Only looks at nurse's perceptions, not other healthcare providers', patient's, or caregiver's perception

	ve meta-syntheses	their role in palliative care			AMED and ISI Web. •Narrowed to 28 articles	combined with: nursing/nurse's role -impact - competence - function - responsibility		•Themes were developed: - descriptive themes -then analytical themes was discussed continually with all authors	-being attentively present & dedicated - standing in demanding situations	-Additional evaluation needed to establish more firm guidelines in the nurse's role.
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
4	El-Jawahri, A., Greer, J., Pirl, W., Park, E., Jackson, V., Back, A., . . . Temel, J. (2017). Effects of Early Integrated Palliative Care on Caregivers of Patients with Lung and Gastrointestinal Cancer: A Randomized Clinical Trial	Evaluate the effect (if any) EPC can have for caregivers of patients with metastatic cancer	EPC can not only positively affect the patient's quality of life, but also their caregiver's well-being	Random Control Trial	•350 caregivers were randomly enrolled •Total of 275 participants •175 in the intervention arm •175 in the standard of care arm.	IV: EPC DV: improvement in caregivers' psychological symptoms	• Hospital Anxiety and Depression Scale (HADS) • Medical Health Outcomes Survey Short-Form	•Data collection through questionnaires at baseline and again at 12 and 24 weeks •Statistical analysis using STATA •3 months prior to death HADS-total distress : EPC 6.84 and control 12.93 •6 month prior to death HADS-total distress : EPC 7.88 and	• Significantly lower psychological distress (depression & anxiety subscales low as well) in caregivers in EPC group than control at 3 and 6 months before death	Level II Strengths: -First study of its kind evaluating EPC and caregivers -EPC is provided by a PC specialty instead of standard of care and discussion of palliative measures with primary oncologist -High participation rates Weaknesses: -Single cancer center -Not blinded study -This was an endpoint of a study

								control 11.60		
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
5	Romano, A., Gade, K., Nielsen, G., Havard, R., Harrison, J., Barclay, J., ... Dillon, P. (2017). Early Palliative Care Reduces End-of-Life Intensive Care Unit (ICU) Use but Not ICU Course in Patients with Advanced Cancer	<ul style="list-style-type: none"> Determine if EPC with advanced cancer patients decreases ICU use at the end of life 	<ul style="list-style-type: none"> EPC reduces ICU use at the end of life with less patients dying in the hospital 	<ul style="list-style-type: none"> Retrospective cohort of patients in an EPC program compared to control group of patients receiving standard of care 	<ul style="list-style-type: none"> University of Virginia program 275 patients enrolled in "CARE" (EPC program) 195 patients standard of care 	<ul style="list-style-type: none"> Independent variable: enrollment of advanced cancer patients in Comprehensive Assessment with Rapid Evaluation and Treatment (CARE) DV: ICU use 	<ul style="list-style-type: none"> Wald chi-square test (categorical variables) t test statistic for difference in means SAS software 	<ul style="list-style-type: none"> ICU in last 6 months was 17.5% (CARE) vs. 31.8% (control) Died in hospital 16% (CARE) and 35.9% (control) Enrolled in hospice 76% (CARE) and 38.5% (control) No statistically significant differences 	<ul style="list-style-type: none"> EPC substantially reduces ICU admissions near EoL (near absolute reduction of 50% during last 6 months) Reduction in number of patients who die in ICU and hospital Enrollment in hospice increased 	<p>Level IV</p> <p>Strengths: -Showed improvement in use if ICU in EPC patients -Showed other positive effects such as death outside of hospital and hospice utilization</p> <p>Limitations: -non-randomized -potential bias in selection and comparison -historic controls</p>
6	Zimmermann, C., Swami, N., Krzyzanowska, M., Leighl, N., Rydall, A., Rodin, G., ... Hannon	<ul style="list-style-type: none"> Determine the perception of palliative care from patients and caregivers 	<ul style="list-style-type: none"> Patients & caregivers will have positive perceptions of EPC and the benefits it can provide 	<ul style="list-style-type: none"> Results were secondary from a RCT that evaluated EPC 	<ul style="list-style-type: none"> Patients from 24 medical oncology clinics - randomized to EPC versus standard of care 48 patients 	<ul style="list-style-type: none"> IV: early initiation of palliative care DV: improvement in perception of palliative care 	<ul style="list-style-type: none"> Interviews conducted with patients and caregivers about: -initial perceptions - probabl 	<ul style="list-style-type: none"> Ground theory method data collection and analysis for qualitative data 	<ul style="list-style-type: none"> Stigma is associated with palliative care Intervention arm developed a broader, positive conception of palliative care 	<p>Level IV</p> <p>Strengths: -Larger sample size -Randomized design -Perceptions of both early intervention and control arms</p> <p>Weaknesses: -Single cancer center -Highly educated population -Women overrepresented</p>

	, B. (2016). Perceptions of palliative care among patients with advanced cancer and their caregivers				& 23 caregivers participated •Toronto, Canada		sources of perceptions - reactions to discussions about palliative care - opinions about renaming palliative care			-Possible unintentional favoring of palliative care
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
7	Zimmermann, C., Swami, N., Krzyzanowska, M., Hannon, B., Leigh, N., Oza, A., . . . Lo, C. (2014). Early palliative care for patients with advanced cancer: A cluster-randomised controlled trial	Evaluate the effect of EPC initiation in advanced cancer versus standard of care	EPC improves: -QoL -symptom control - satisfaction of care -less difficulty with healthcare provider-patient interactions	•Cluster RCT of patients with advanced cancer from 24 medical oncology clinics	•Cancer center in Toronto, Canada •461 patients total •228 in the intervention group •233 in the control group	•Independent variable : immediate outpatient palliative consultation and follow up by palliative care physician and nurse •Dependent (outcome) variable (s): improvement in quality of life	•5 different scales and assessments were used and these scores were compared •FACT-Sp •QAL-E •ESAS •FAMCARE-P16 •CARES-MIS	•Mean change across each of the five scales was compared between intervention and control group	•Outcomes between the two groups were not significant • 4 month mark - differences between groups were significant except CARES-MIS – favor to intervention of EPC	Level II Strengths: -Showed not only QoL measurement but also satisfaction with care (which did improve with intervention group at 3 month mark) -Variety of measures evaluated -Evaluation at two different time intervals Weaknesses: -Was conducted at only one center. Further cross-evaluation across multiple healthcare systems needed -Selection bias
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
8	Maltoni, M., Scarpi, E.,	Evaluate effects of	Systematic EPC improves outcomes,	•RCT •Randomized	•Newly diagnosed inoperable	•IV: Systematic EPC	•Functional Assessment of	•TOI was 78.1 (standard)	•Significant improvement in QoL	Level II Strengths: -Randomization

	Dall'Agata, M., Zagonel, V., Bertè, R., Ferrari, D., ... Early Palliative Care Italian Study Group (EPCISG) (2016). Systematic versus on-demand early palliative care: results from a multicentre, randomised clinical trial	systematic EPC versus on-demand EPC consultations	especially R/T QoL patients with metastatic pancreatic cancer	to receive systematic EPC (intervention) vs. on demand EPC	le, locally advanced pancreatic patients <ul style="list-style-type: none"> •Within 8 weeks of diagnosis. •207 patients enrolled •21 Italian cancer centers used •Standard arm: 89 •Interventional arm: 97 	with standard of care treatment <ul style="list-style-type: none"> •DV: Improvement in quality of life 	Cancer Therapy – Hepatobiliary (FACT-Hep) scale <ul style="list-style-type: none"> •Hospital Anxiety and Depression Scale (HADS) •Family Satisfaction with End-of-Life Care (FAMCARE) •Done at baseline and 12 weeks into treatment •Trial Outcome Index - combines the scores of physical, functional and disease-specific subscales – primary endpoint 	rd arm) vs 84.4 (intervention arm) <ul style="list-style-type: none"> •HCS 48.2 (standard arm) vs. 52 (intervention arm) •FACT-Hep score 113 (standard arm) vs. 119.6 (intervention arm) 	in systematic EPC arm in all aspects studied in intervention arm vs. standard of care	-Multiple centers evaluated -First study evaluating EPC in advanced pancreatic patients Weaknesses: -Majority of the centers used were accredited and had integrated and palliative care designations -Not blinded -Recommendations by palliative care had to be accepted by primary oncology – could have reduced effectiveness
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
9	Temel, J. S., M.D.,	<ul style="list-style-type: none"> • Examine if 	<ul style="list-style-type: none"> • EPC improves: 	<ul style="list-style-type: none"> • RCT • Patients were 	<ul style="list-style-type: none"> • Massachusetts General 	<ul style="list-style-type: none"> • IV: EPC • DV: 	<ul style="list-style-type: none"> • Two-sided Fisher' 	<ul style="list-style-type: none"> • Descriptive 	<ul style="list-style-type: none"> • EPC patients had: 	Level II Strengths:

	Greer, J. A., PhD., Muzikansky, A., M.A., Gallagher, E. R., R.N., Admane, Sonal, MB,B.S .. M.P.H., Jackson, Vicki A,M.D., M.P.H., ... Lynch, T. J., M.D. (2010). Early palliative care for patients with metastatic non-small-cell lung cancer. The New England Journal of Medicine	EPC yields benefit for: -QoL -less aggressive end-of-life care - improvement in depressive moods	-QoL - depressive symptoms -less aggressive end of life care	randomized to: - standard of care oncology treatment -EPC with standard of care	Hospital – Outpatient Thoracic Oncology Clinic •151 patients studied total •EPC arm: 77 •Standard of care arm: 74	-QoL - depressive symptoms -less aggressive end of life care	s exact tests and chi-square tests for categorical variables •t-tests for continuous variables Evaluation through the use of the following screening tools at baseline and at a 12 week interval : •Functional Assessment of Cancer Therapy – Lung (FACT -L) •Trial Outcome Index (TOI) •Lung Cancer Subscale (LCS)	stats were used to estimate frequencies, means, and SD's •Statistical analysis with SPSS software	-prolonged survival by approx. 2 months - Improvements in QoL and mood -greater documentation in resuscitation preferences in the EMR -less aggressive EoL did not adversely affect survival (actually improved) •Increase in all assessments: FACT-L, LCS, and TOI score in EPC •TOI increased from baseline by 2.3 points as opposed to control arm with 2.3 decrease •Half as many patients in EPC arm reported significant depressive symptoms (HADS)	-Numerous findings of positive improvements in QoL with patients that received EPC -Less chemotherapy and more hospice measures given at the EoL -Patients, their families, society can avoid unnecessary burdens and cost with EPC use Weaknesses: -Performed at a single institution -One oncology specialty evaluated -Limited diversification of patient demographics
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
10	do Carmo, T. M., Paiva, B. S. R., de	• Determine impact of early	•Psychosocial intervention combined with EPC	•RCT •Three arms: -EPC with psycho	•63 total patients were enrolled •19 patients	•IV: 1 - EPC with psychosocial	• Hospital Anxiety and Depres	•Depressive symptoms worsened in	•Further studies need to be done with this intervention	Level II Strengths: -First type of study with psychosocial intervention combined with EPC

	<p>Oliveira, C. Z., Nascimento, M. S. de A., & Paiva, C. E. (2017). The feasibility and benefit of a brief psychosocial intervention in addition to early palliative care in patients with advanced cancer to reduce depressive symptoms: a pilot randomized controlled clinical trial</p>	<p>palliative care combined psychosocial interventions on patients with advanced cancer's emotional domain</p>	<p>is thought to reduce depressive symptoms in patients with advanced cancer</p>	<p>social intervention -EPC - standard of care</p>	<p>in EPC and psychosocial intervention •22 patients in EPC •30 patients in standard care •Center for Research Support at Barretos Cancer Hospital</p>	<p>intervention 2- EPC •DV: Improvement in depressive symptoms</p>	<p>tion Scale (HADS), •Patient Health Questionnaire (PHQ-9) •Edmonton Symptom Assessment System (ESAS) •European Organization for Research and Treatment of Cancer Quality of Life Questionnaire Core 15 Palliative (EORTC QLQ-C15-Pal) •Completed at baseline, day 45, 90, 120, 180</p>	<p>patients in arm A compared to B and C •Arm A has better emotional functioning compared to the other two arms however</p>	<p>n and its effects •Indeterminate/mixed results at this time</p>	<p>Weaknesses: -Conducted at a single center (a cancer center as well) -Did not meet goal of enrollment -Patients with pre-existing depression did not meet qualifications for study</p>
	<p>Citation: author(s), date of publication & title</p>	<p>Purpose of Study</p>	<p>Conceptual Framework</p>	<p>Design/Method</p>	<p>Sample/Setting</p>	<p>Major Variables Studied and Their Definitions</p>	<p>Measurement of Major Variables</p>	<p>Data Analysis</p>	<p>Study Findings</p>	<p>Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])</p>
11	<p>Vierhout, M., Daniels, M., Mazzotta, P., Vlahos,</p>	<p>• Evaluate the perceptions of palliative</p>	<p>• Understanding of patients' perspective/baseline of palliative</p>	<p>• Qualitative interviews</p>	<p>• 39 Malignant brain tumor patients • Neurooncology</p>	<p>N/A – qualitative study with interviews</p>	<p>• Audio recording of interviews</p>	<p>• Themes developed based on</p>	<p>• Prefer to receive palliative care at home • More time with</p>	<p>Level IV Strengths: -Better understanding of patient's perceptions of palliative care</p>

	J., Mason, W. P., & Bernstein, M. (2017). The views of patients with brain cancer about palliative care: a qualitative study	ve care from patients with brain cancer	care needed to better serve patients		y clinic at Princess Margaret Cancer Centre (Canada) <ul style="list-style-type: none"> •Not newly diagnosed •Unlikely to die within the following 6 months 		•Grounded theory	open coding	caregivers and family - appeal of home care <ul style="list-style-type: none"> •Dissatisfaction with brief and superficial interactions w/ HCP. •Palliative care can contribute to their emotional well-being •Open to palliative care if they believe that it will not diminish optimism •Established idea that palliative care is associated with active dying - creates fear in some patients •Prefer to be educated about palliative care as an option early on in treatment 	-Insight as to next steps on direction for study – tailoring palliative care based on disease process, etc. Weaknesses: -Insufficient sample size -Varying degrees of where patients are in their treatment/longevity – results could be skewed accordingly -Only from one cancer center
	Citation: author(s), date of publication & title	Purpose of Study	Conceptual Framework	Design/Method	Sample/Setting	Major Variables Studied and Their Definitions	Measurement of Major Variables	Data Analysis	Study Findings	Appraisal of Worth to Practice Strength of the Evidence (i.e., level of evidence + quality [study strengths and weaknesses])
1 2	Hannon, B., Swami, N., Rodin, G., Pope, A., & Zimmermann, C. (2017). Experiences of patients and caregivers with	Discover patient & caregivers experiences of EPC	EPC improves not only QOL but also satisfaction of care	<ul style="list-style-type: none"> •Qualitative •Interviews from intervention group receiving EPC in a RCT 	40 participants from 67 total in the intervention group of the RCT •(Caregivers and Patients)	<ul style="list-style-type: none"> •IV: Patients & caregivers receiving EPC •DV: QOL and improvement of satisfaction with care 	<ul style="list-style-type: none"> •Grounded Theory Method •Interview with qualitative questions 	<ul style="list-style-type: none"> •Taped interviews that were analyzed line by line •Themes identified from the interviews •Patient experts 	<ul style="list-style-type: none"> •Prompt, personalized symptom management •Holistic support of caregivers and patients •Guidance in decision making •Preparation for the future •Overall theme of 	<ul style="list-style-type: none"> •Level IV (noted that this stemmed from a prior RCT) •Strengths: both patient and caregivers included, multiple cancer specialties sampled, larger sample for a qualitative study •Limitations: only from one cancer center, predominantly English, higher educated population, dissatisfied participants may have declined participation •Can be used to reinforce use of EPC in the treatment process

early palliative care: A qualitative study.							provided	feeling guided and supported in the healthcare system	•Future development of referral criteria
Author, Year, Title	Why the study was conducted. Could include the research question, hypothesis, or specific aims of the study	Theoretical basis for study	What research design was used and what was the study protocol	Number, Characteristics, Attrition rate & why?	Independent variables (e.g., IV1 = IV2 =) Dependent variables (e.g., DV =)	What scales were used to measure the outcome variables (e.g., name of scale, author, reliability info [e.g., Cronbach alphas])	What stats were used to answer the clinical question (i.e., all stats do not need to be put into the table)	Statistical findings or qualitative findings (i.e., for every statistical test you have in the data analysis column, you should have a finding)	<ul style="list-style-type: none"> • strengths and limitations of the study • Risk or harm if study intervention or findings implemented • Feasibility of use in your practice • Remember: level of evidence + quality of evidence = strength of evidence & confidence to act • Consider grading criteria such as the USPSTF grading schema http://www.ahrq.gov/clinic/3rduspstf/ratings.htm • Notes regarding gems or caveats about the article • Recommendation for use of evidence in practice &/or Recommendation for further research