JOURNAL OF PALLIATIVE MEDICINE
Volume 19, Number 7, 2016

DOI: 10.1089/jpm.2015.0491

The Advanced Practice Registered Nurses Palliative Care Externship: A Model for Primary Palliative Care Education

Constance Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN,[1–3]
Patrick J. Coyne, MSN, ACNS-BC, ACHPN, FPCN, FAAN,[4] and J. Brian Cassel, PhD[5]

Abstract

Background: Nationally, the contribution of palliative care to high-quality health care continues to be recognized resulting in demand for palliative care services. This has resulted in an expected shortage of clinicians with palliative care knowledge and experience. The education and scope of practice of advanced practice registered nurses (APRNs) provides an ideal foundation for further palliative care education and training to fill this gap.
Objective: The authors sought a method to provide midcareer APRNs with education and training in primary palliative care.
Setting: The program took place at a well-established palliative care program at an academic medical center. This article describes an Institutional Review Board-approved week-long intensive APRN externship designed to provide education and training in primary palliative care for APRNs across disease populations. To best educate these APRNs, who did not have formal palliative care in their graduate education, the externship includes didactic, experiential, and clinical components to meet the needs of APRNs with minimal palliative care education and/or experiences.
Measurement: Precourse and postcourse data collection was performed. Results demonstrated increased knowledge, skills, and confidence in palliative care.
Conclusion: This is a sustainable model for primary palliative care and midcareer APRNs who wish to enter palliative care. It is replicable for other disciplines as well.

Introduction

Palliative care occurs in urban, suburban, and rural territories across settings: the hospital (acute or chronic), the clinic, the home, the long-term care facility, the nursing home, the shelter, and beyond for adults and children. Despite its benefits, including better symptom control, less depression, and better quality of life, many patients lack access to palliative care and experience higher rates of hospital deaths, fewer home deaths, and more aggressive and expensive medical interventions than they prefer. Over the next decade, an approximate gap of 10,000 specialty trained palliative care clinicians will limit access to specialty palliative care.[1,2] By virtue of their education, scope of practice, and proven record of effective, safe quality care and patient satisfaction, advanced practice registered nurses (APRNs) are well suited to address the shortage.[3–10]

Palliative care crosses all health settings from acute care hospitals, rehabilitation hospitals, primary care and specialty clinics, long-term care, and the home. APRNs provide care in community and rural health centers, telehealth settings, schools, clinics, home health, hospices, and commercial clinics.[11] Primary and specialty palliative care are delivered in these settings. APRNs have a prominent role in care across facilities and diseases. Because of the shortage of palliative providers, it is essential to ensure APRNs have primary palliative care skills so that palliative care specialists will be utilized for more difficult cases. Moreover, if APRNs integrate primary palliative care into their routine practice, it will enhance patient care throughout the illness trajectory.

[1]Hospice and Palliative Nurses Association, Pittsburgh, Pennsylvania.
[2]Center to Advance Palliative Care, New York, New York.
[3]North Shore Medical Center, Salem, Massachusetts.
[4]Medical University of South Carolina, Charleston, South Carolina.
[5]Hematology/Oncology and Palliative Care, School of Medicine, Virginia Commonwealth University, Richmond, Virgina.
Accepted March 7, 2016.

This will ultimately promote the triple aim of better care, better health, and lower health care costs.[12]

Palliative Nursing Graduate Education

The American Nurses Association (ANA) states that ''the aims of nursing actions are to protect, promote and optimize health; prevent illness and injury; alleviate suffering.''[13] The APRN's role builds on the education and practice of a registered nurse to allow a ''greater depth and breadth of knowledge and an ability to synthesize complex data to develop, implement, and coordinate comprehensive holistic patient-centered plans of care with goals of maximizing health, quality of life, and functional capacity.''[14] Thus, the role of the APRN is synchronous with the goals of palliative care, making APRNs uniquely qualified and positioned to address the myriad needs of individuals facing life-threatening, progressive illness.[3,4,15]

However, APRN education and training often leaves the APRN feeling ill-prepared to meet this demand.[16–19] A review of national programs revealed a handful of graduate curricula that include palliative care content, few palliative nursing fellowships, and limited palliative care certificate programs for nurses. These vary greatly, often lacking expert palliative nursing faculty and leadership, few opportunities for clinical practice, or exposure to high-quality interdisciplinary teams. Overall, there has been little attention to the funding of APRN education in palliative care.

The result is limited options for APRNs to receive graduate training or specialty palliative nursing fellowships. While there are some palliative care certificate programs currently available, many do not include clinical practice or exposure to high-quality interdisciplinary teams.[20–22] Currently, there are approximately 6 established APRN palliative nursing fellowships as opposed to some 140 palliative medicine fellowships for physicians. Most APRN fellowships cater to nurse practitioners (NPs) and occur at academic medical centers where the focus has been on staff recruitment rather than APRN leadership development for the field.

By numbers alone, these programs cannot reach enough APRNs to provide essential palliative training and education. In addition, their small capacity cannot have a great effect on large numbers of APRNs. Moreover, fellowships are mostly suited for new graduates, who can accept a low salary and have the ability to relocate to accommodate fellowship site. For mid-career APRNs, fellowships are not financially feasible because they require a severe reduction in salary, loss of seniority, as well as loss of health care and retirement benefits. APRN fellowships require untangling the complexities of the varied scope of practice and licensing specific to each state in order to meet the increasingly specific requirements of the APRN Consensus Model: Licensing, Accreditation, Certification, and Education (LACE).[23] It is imperative to provide more palliative care education for APRNs. Given the disparity in education and lack of educational opportunities, an intensive course for APRNs seemed the most practical way to quickly respond to the shortage and provide primary palliative education.

Development of the APRN Palliative Care Externship

We designed a new APRN externship program in primary palliative nursing. The choice of an externship was deliberate. An externship is defined as a limited experiential learning opportunity that gives practice experiences; such experiences allow training, observation, and focus on a specialty practice.[24] Because the audience was practicing clinicians, they already had experience in the field but needed information on a specialty focus. Specifically, the externship included both didactic education and experiential opportunities. To meet the National Council of State Board of Nursing requirements, educational content was aimed at the advanced nursing practice (APN) level and included the requirements of: advanced physical assessment, advanced pathophysiology, and advanced pharmacology. Prescriptive privileges, as well as full scope of practice issues, were addressed.[23]

Specialty palliative nursing is defined as the assessment, diagnosis, and treatment of human responses to actual or potentially life-limiting illness within the dynamic caring relationship with the patient and family, in order to relieve or reduce suffering and optimize health (wholeness, integrity of the person, quality of life, and function).[25] Primary palliative nursing focuses on those aspects of palliative nursing that are inherent in all nursing care. The APRN Palliative Care Externship included these aspects of primary palliative nursing,[14,26] as well as primary palliative care principles[27] with an emphasis on essential knowledge for palliative clinical practice and business aspects of palliative care. Topics emphasized clinical and programmatic areas including fundamental aspects of clinical care; an overview of the role; pain management; symptom management; communication; business planning; and finances, quality, and metrics. These topics were covered in both didactic and experiential components (see Table 1). Moreover, intensive involvement of the faculty allowed APRNs to consider immediate integration of palliative care principles into practice resulting in increased access to palliative care.[28] Because the understanding of palliative quality, metrics, and business planning is essential to current health reform and the creation of new payment models, these topics were included. Additionally, we hypothesized that many of these clinicians would be involved in the initiation or have a role is the support of a palliative program

Externship Application and Selection

The APRN Palliative Care Externship was advertised though advanced practice nursing organizations and palliative care internets sites over the course of 3 months. The application process included essays, statement of the need, and how the education would be used. This publicity resulted in more than 200 applications for 36 slots and inquiries from around the world from many health care disciplines. Selection of externs was based on completeness of application, geography of practice, access to other palliative care programs, and plan for use of the externship. Priority was given to rural and community providers without access to the potential education of academic palliative care teams.

APRN Program description

While there was the potential to cover myriad palliative care topics, the curriculum focused on five areas important to primary palliative care: pain management, symptom management, communication, palliative care program development, and developing community partnerships. End-of-Life Nursing Education Consortium (ELNEC) APRN modules on pain and symptom management were utilized with the

Table 1. Comparison of Self-Confidence Ratings Before and After the Advanced Practice Registered Nurse Palliative Care Externship

	Baseline (n = *48*)		*1-month follow-up* (n = *48*)		*Paired* t *test*		
Description	*Mean*	*SD*	*Mean*	*SD*	t	df	*Significance (two-tailed)*
Quality initiatives	1.10	0.97	2.41	1.13	−8.56	45	$p < 0.001$
Developing a program	1.15	1.07	2.28	1.15	−7.02	45	$p < 0.001$
Processes, policies, procedures	1.23	1.15	2.40	1.16	−7.23	47	$p < 0.001$
Sustainability strategies	1.44	0.94	2.73	1.01	−7.34	47	$p < 0.001$
Resolving conflict	1.58	1.05	2.60	0.88	−6.71	46	$p < 0.001$
Outpatient PC	1.60	1.25	2.55	1.08	−5.67	45	$p < 0.001$
Inpatient PC	1.75	1.25	2.64	1.09	−5.84	46	$p < 0.001$
Leadership skills	1.77	1.02	3.17	0.78	−9.83	47	$p < 0.001$
Running family meetings	2.02	1.25	2.83	1.04	−5.86	47	$p < 0.001$
Delivering bad news	2.15	1.24	2.98	0.82	−5.47	46	$p < 0.001$
Symptom management	2.31	0.72	3.13	0.67	−7.99	47	$p < 0.001$
Pain management	2.35	0.79	3.08	0.87	−7.15	47	$p < 0.001$
Role of IDT	2.54	1.11	3.65	0.48	−7.24	47	$p < 0.001$
Participating in IDT	2.62	1.29	3.55	0.69	−4.99	45	$p < 0.001$
Patient communication	2.63	0.91	3.38	0.64	−6.20	47	$p < 0.001$
Caring for patients	2.71	0.82	3.28	0.69	−4.56	45	$p < 0.001$
Symptom assessment	2.72	0.85	3.38	0.61	−5.55	46	$p < 0.001$
Provider communication	2.83	0.95	3.46	0.68	−4.41	47	$p < 0.001$
Pain assessment	2.85	0.74	3.44	0.68	−5.09	47	$p < 0.001$

Rating scale: 0 (not at all confident) to 4 (very confident).
SD, standard deviation; PC, palliative care; IDT, interdisciplinary team.

permission from ELNEC, and multimedia instruction utilized for other topics was available on the Internet.[16,29] Communication included didactic and interactive experiences to learn essential skills. Program development included the fundamentals principle of quality improvement, measurement, and metrics. Community partnerships included identifying resources in the community.

The clinical experience was developed to offer fundamental building blocks to palliative care practice. Two of the clinical experiences occurred in the inpatient setting: one on the palliative care unit and the other with the consult palliative care team to ensure essential knowledge in pain and symptom management. Another elective allowed further education about care that affected their practice. These experiences ranged from attending the wound care clinic, participating in a house call visit, attending the outpatient palliative care clinic, rounding with the pain team, observing the rehabilitation therapists (physical therapy, occupational therapy, and speech and language pathology), working with chaplaincy, and focusing on program management. In order to promote continuity of care, individualized learning, and respond to issues related to APRN practice, the course directors were present for all sessions. Moreover, externs benefitted from discussions that were specific to APRN role development, scope of practice, and varied regulations and statues. As part of the formal evaluation, follow up e-mail and phone calls were conducted with each participant at 6 months and 1-year postcourse as part of the formal evaluation process. The participants also utilized a listserv of other participants for questions and encouragement. All participants had access to both course directors for discussion and problem-solving of clinical or professional issues.

In order to promote continued support and learning on the topics areas, externs received several resources. They received a disc of the National Consensus Project for Quality Palliative Care *Clinical Practice Guidelines*, which was chosen because it offer the standards for palliative care delivery at the specialist level. The goal was that each extern could share all or essential information from the guidelines with colleagues or their employer. In addition, they received an advanced practice nursing reference specific to APN practice and content, the second edition of the Hospice and Palliative Nurses Association *Core Curriculum for the Advanced Practice Hospice and Palliative Nurse*. Finally, as an essential review of palliative care topics essential for primary and palliative nursing, each extern received the third edition of the Hospice and Palliative Nurses Association *Conversations in Palliative Care: Questions and Answers with the Experts*. Each internal also received a thumb drive of seminal palliative care literature related to the module topics specifically program development in rural and community areas, business aspects of care, metrics and quality, palliative nursing, pain/symptom management, and pertinent policies and procedures. These thumb drives were updated throughout the externship to reflect current literature and publications that could affect their practice. Additionally, externs requested specifics resources throughout the week and these were uploaded to the thumb drives at the end of the week and for future cohorts.

Key characteristics of the program included:

1. A competitive externship application and acceptance process. The program occurred in the setting of a nationally regarded interdisciplinary palliative care program. It had access to a variety of settings including an inpatient consultation service, an inpatient palliative care unit, an ambulatory palliative care clinic for oncology patients, and a well-established house call

program. This well-established program delivered excellent palliative care, practiced interdisciplinary team collaboration, and received optimal institutional support and collaboration with many departments. Most important, it had demonstrated APRN leadership, and demonstrated successful history in palliative care education.
2. A 5-day curriculum created to provide the necessary time for knowledge and skill-building, and establishing trust between externs and educators to discuss the challenges of care. The 5-day program ensured the program's accessibility to busy clinicians, many of whom used personal or vacation time to attend. However, to enable basic knowledge and understanding of palliative care and its potential impact and make the most of the limited time, externs were assigned pertinent readings prior to the course. These were subsequently discussed at the course introduction.
3. Two nationally recognized APRN leaders with a range of hospice and palliative care experience as course directors, as well as a nationally recognized interdisciplinary palliative care faculty
4. Limited cohort size of six externs, to best maximize participants' exposure to experiential learning opportunities in the clinical setting, and access to the course directors.
5. Experiential learning interspersed with didactic information. Externs appreciated the change in educational methods as well as application of palliative care principles.
6. At the conclusion of the week, each extern created two goals for changing patient care practice in his or her setting. The focus was on measurable goals which would improve patient care and patient care delivery within their local setting (i.e. unit, clinic, or department). Examples of goals included: initiation of a nonverbal pain scale across their institution; patient education regarding advance directive within their clinic; developing a guideline for methadone administration; and developing an inpatient consult service for palliative care. This had both educational purposes and measurement purposes: the former to prompt learners to connect the program with their career and personal goals and the latter to assess over time whether learners are achieving the goals set in the context of this course. Participants received follow-up communication from the course directors at set intervals to follow-up their progress, address their concerns, and support their practice.

Methods

Evaluation of this externship was approved by the Institutional Review Board at Virginia Commonwealth University. We collected precourse data, immediate course evaluation, postcourse data, and follow-up on participants. To assess results of the first eight cohorts of this program, we gathered baseline information from participants ($n=48$) and conducted follow-up surveys at 1 month postprogram ($n=48$) and at 6 months postprogram ($n=35$). Baseline measurement focused on the preparation for palliative care that the participants had received in graduate school on 5 domains, and their self-confidence in 19 specific aspects of PC clinical care and program management. Follow-up measurement reevaluated the self-confidence of participants.

Five Domains

The five domains included: providing advanced palliative nursing and end of life care to their patients; recommending pain management medications; recommending symptom management medications; communicating about end of life; and developing programs in hospice and palliative care.

Setting

To best conduct the externship, we sought a palliative care program that was well-established, delivered excellent palliative care, practiced interdisciplinary team collaboration, had optimal institutional support, demonstrated APRN leadership, and demonstrated successful history in palliative care education. The program provides palliative care across the spectrum of settings: an inpatient consult service, an acute inpatient unit, outpatient clinic, house calls, and collaboration with many departments.

Results

Participant characteristics

From 2013–2014, 8 cohorts of an average of 6 externs attended the program. Of the 48, almost all (47) were female. Ten were clinical nurse specialists (CNSs) and 38 were nurse practitioners (NPs). The median number of years in nursing was 21.0 (range, 0.5–42 years), years in advanced practice nursing was 6 (range, 1–34). Half (50%) of the externs had no experience in palliative care, and 75% had no experience in hospice care. They worked in a range of settings, from hospitals, clinics, nursing home, and case management.

Assessment of graduate training in palliative care

Participants rated their graduate nursing education on five aspects of palliative care. On a scale from 0 (none) to 4 (excellent), mean ratings were low, with the highest being 1.3 (see Table 2).

Participants' ratings of self-confidence

Participants rated their self-confidence in 19 specific areas of palliative care provision and program management on a

Table 2. Ratings of Graduate Nursing Education on Five Palliative Care Domains

Domain	*Mean*	*SD*
Preparing them to provide advanced palliative nursing and end-of-life care to their patients	1.21	1.09
Preparing them to write/make recommendations about pain management medications	1.23	0.90
Preparing them to write/make recommendations about symptom management medications	1.31	0.97
Preparing them for communication about end of life, including both goals of care and advance care planning	1.02	1.06
Preparing them about program development in hospice and palliative care	0.27	0.57

Rating scale: 0 (none) to 4 (excellent).
SD, standard deviation.

scale from 0 (not at all confident) to 4 (very confident). The same questions were asked 1 and 6 months postprogram. The results are shown in Table 1, sorted by the mean rating at baseline. Several of the lowest rated items (rated less than 1.5 on the 0–4 scale at baseline) had to do with program management issues such as developing a program and establishing processes, policies, and procedures. Several of the highest-rated items, rated 2.6 or higher, were related to core clinical aspects such as communication with providers and patients, caring for patients, and symptom assessment.

At the 1-month follow-up assessment, there was a significant increase in participants' self-confidence on all 19 items (paired *t*-tests; all *p* values less than 0.001). The lowest-rated items increased from about 1.1 to 2.3 or greater. The highest-rated items increased from 2.3 to 3.1 or higher.

Data are available for 35 participants at the 6-month follow-up assessment. Only 1 item had a statistically significant change from the 1-month follow-up: Resolving Conflict showed a further increase from 2.42 to 2.85 (df 32; $t - 3.078$; $p = 0.004$). No item had a statistically significant decrease at 1-month or 6-month follow-up assessments.

Course Evaluation

As part of the continuing education process, participants completed evaluation for continuing education. However, in addition, we included an hour-long discussion of each course: what went well, what could have been better, suggestions for change. In the first pilot cohort, the externs stated that the flow, the length, and the topics were appropriate in content and amount of time. They confirmed the schedule of pain and symptom management before the day of clinical. They asked for more clinical, which was increased from 8 to 12 hours. They also critiqued the teaching methods and resources and confirmed they were the ones they could use practically after the course. They suggested more role plays and time with the palliative care team. These recommendations were incorporated into future cohorts. There was also confirmation of the maintenance of small cohort size to faster group process, and individualized adult learning. The other cohorts believed that once these adjustments were made, there was not much to change in the course. They appreciated the content, the flow, the process, and the mix of clinical and didactic education.

Personal and professional goals

At the 6-month follow-up, 77.1% said that their professional goals were met, with the remaining 22.9% saying ''partially'' and none reporting they were unmet. Personal goals were met for 88.6% with the remaining 11.4% saying partially met. Several of the externs who partially met their goals changed employment. One extern retired unexpectedly, another extern moved into the academic setting from the nursing home, and two externs made lateral transitions within their organization. Additionally, externs consistently stated they had integrated the knowledge, education, and skills into their practice. They used the thumb drive and the publications as resources to reinforce learning.

Discussion

APRNs with adequate education and training in primary palliative care are necessary to ease the generalist and specialist palliative care workforce shortage.[26,28,30] The results of the baseline assessment of this project indicate that participants perceived they had not received education on palliative and end-of-life care topics during their graduate nursing training. A 1-week externship program was designed to improve knowledge and self-confidence among participants on clinical and program management domains, and did so. Improvements in self-confidence were stable over time (from 1 month to 6 months postprogram). This program was supported with in-kind support from an institution in the mid-Atlantic region.

To determine the potential utility of such an educational program beyond this pilot, the potential cost and revenue of such a program was explored. Cost for the week without grant support was estimated at $2,400 per extern. This amount includes course development, faculty time, educational resources, and both clerical and administration costs. However, these cost will vary on location of externship (large or small urban area, community, or rural), availability of interdisciplinary educators within a team, and type of setting with overhead (academic medical center versus community hospital or organization). National inquiry of similar immersion courses elsewhere revealed a range of potential expenditures $1,400.00 to $2,800.00 per person. Externs were required to pay their own travel expenses, lodging, and evening meals.

Because of the demand for the APRN Palliative Care Externship, we envision moving the model from a pilot at its current site to a self-sustaining model at other sites across the country. We envision utilizing well-established palliative care programs across the continuum from academic medical centers, community-based programs, collaborations between hospices and other agencies with strong APRN leadership. These programs would demonstrate the ability to deliver the same content with adequate fidelity to the curriculum. Given the size of the externship cohort, adaptability and flexibility was easy to manage to meet the individual needs of the learners. It cannot be overemphasized that the small group size was an essential element of the program success as perceived by the investigators and the participants. We would continue our survey data and evaluation process to compare it from the original site and other sites. However, we envision adding evaluation to determine longer term effects, competence, and movement toward specialty palliative care.

Limitations

This pilot-testing phase of the project had a limited sample size, but the sample was still adequate to demonstrate significant effects on self-confidence. The outcome we chose, self-confidence reflects that the externship curriculum was focused both on knowledge-based domains (e.g., symptom assessment and management) and on practical skills (e.g., running an interdisciplinary team meeting; resolving conflict), and self-confidence is germane to all of those. Self-assessment of knowledge and competence (reflect by the self-confidence outcome we chose) has been used in other published trainings of palliative and end-of-life care.[31–34] The study did not objectively assess participants' knowledge or clinical skills. While not unique to this educational program, this could potentially be addressed in future studies. This model was specific to APRNs, however, it could be adapted to other disciplines.

Implications for practice

Because there will be a shortage of palliative care clinicians, a multidimensional approach will be necessary to assure primary palliative care. The APRN Palliative Care Externship is an important model to promote palliative care education for practicing midcareer APRNs. It will be important to compare programs like this one with certificate programs and immersion courses in terms of feasibility and promoting primary palliative with sustainable results. It could also be an important model for midcareer education for other disciplines with codirector representing each model.

Conclusion

Ensuring adequate palliative care education and training of APRNs and other clinical disciplines is not a simple task; multiple educational and training approaches will be necessary. A 1-week immersion course that includes both didactic educational and clinical experiences and ongoing mentoring appears to increase the confidence of APRN participants and is an economically feasible solution to this workforce shortage crisis. Data demonstrated positive and sustained results. Further research is needed to test this education model in other settings and regions and within other disciplines. APRN Palliative Care Externship appears to be a promising model.

Author Disclosure Statement

No competing financial interests exist.

References

1. Kirch D, Henderson M, Dill MJ: Physician workforce projections in an era of health care reform. Ann Rev Med 2012;63:435–445.
2. Lupu D: Estimates of current hospice and palliative medicine workforce shortage. J Pain Symptom Manage 2010;40: 899–911.
3. Promoting Excellence in End-of-Life Care: Advanced Practice Nurses Role in Palliative Care. A Position Statement from American Nurse Leaders. Promoting Excellence in End-of-Life Care. Missoula, MT: A National Program of the Robert Wood Johnson Foundation, 2002.
4. Hospice and Palliative Nurses Association: HPNA Position Statement—The Value of the Advanced Practice Nurse in Palliative Care. 2015. www.hpna.org/DisplayPage.aspx?Title=Position Statements (Last accessed May 2, 2016).
5. Newhouse R, Stanik-Hutt J, White K, et al.: Advanced practice nurse outcomes 1990–2008: A systematic review. Nurs Econ 2011;29:230–250.
6. National Governors Association: *The Role of Nurse Practitioners in Meeting Increasing the Demand for Primary Care*. Washington, D.C.: March 9, 2012.
7. National Association of Clinical Nurse Specialists: Impact of the Clinical Nurse Specialist Role on the Costs and Quality of Health Care. 2013; http://www.nacns.org/docs/CNSOutcomes131204.pdf (Last accessed May 1, 2016).
8. Soltis LM: Role of the clinical nurse specialist in improving patient outcomes after cardiac surgery. AACN Adv Crit Care 2015;26:35–42.
9. Reuben D, Ganz D, Roth C, et al.: Effect of nurse practitioner comanagement on the care of geriatric conditions. J Am Geriatric Soc 2013;61:857–867.
10. Babine RL, Honess C, Wierman HR, Hallen S: The role of clinical nurse specialists in the implementation and sustainability of a practice change. J Nurs Manage 2016;24: 39–49.
11. Selway J: Nurse practitioners: A vital force in healthcare delivery. Am Nurs Today 2012;7:8–11.
12. Berwick D, Nolan TW, Whittington J: The triple aim: care, health, and cost. Health Aff (Millwood) 2008;27:759–769.
13. American Nurses Association: *Nursing: Scope and Standards of Practice, 3rd ed.* Silver Spring, MD: Nursebooks .org, 2015.
14. American Nurses Association, Hospice and Palliative Nurses Association: *Palliative Nursing: Scope and Standards of Practice—An Essential Resource for Hospice and Palliative Nurses, 5th ed.* Silver Spring, MD: American Nurses Association and Hospice and Palliative Nurses Association, 2014.
15. Hansen-Turton T, Ware J, Bond L, et al.: Are managed care organizations in the U.S. impeding the delivery of primary care by nurse practitioners? A 2012 update on managed care organization credentialing and reimbursement practices. Pop Health Manage 2013;16:306–309.
16. Shea J, Grossman S, Wallace M, Lange J: Assessment of advanced practice palliative care nursing competencies in nurse practitioner students: Implications for the integration of ELNEC curricular modules. J Nurs Educ 2010;49:183–189.
17. Chrash M, Mulich B, Patton C: The APN role in holistic assessment and integration of spiritual assessment for advance care planning. J Am Acad Nurs Pract 2011;23:530–536.
18. Shawler C: Palliative and end-of-life care: Using a standardized patient family for gerontological nurse practitioner students. Nurs Ed Perspect 2011;32:168–172.
19. White K, Coyne P, Lee J: Nurses' perceptions of educational gaps in delivering end-of-life care. Oncol Nurs Forum 2011;38:711–717.
20. Hospice and Palliative Nurses Association. Graduate Program Listing. 2014. www.hpna.advanceexpertcare.org/education/graduate-program-listing (Last accessed May 2, 2016).
21. Hospice and Palliative Nurses Association. Nursing Fellowships. 2014. http://hpna.advanceexpertcare.org/education/palliative-care-aprn-fellowships (Last accessed May 2, 2016).
22. White K, Coyne P, White S: Are hospice and palliative care nurses adequately prepared for end of life care? J Hosp Palliat Nurs 2012;14:133–140.
23. APRN Consensus Work Group, National Council of State Boards of Nursing APRN Advisory Committee. Consensus Model for APRN Regulation: Licensure, Accreditation, Certification, and Education. 2008. www.nursingworld.org/ConsensusModelforAPRN (Last accessed May 2, 2016).
24. Externships.com: Internships vs. Externships. 2014. www.externships.com/p/difference-between-internship-externship.html#.VWx05LNG7tQ (Last accessed May 2, 2016).
25. Lynch M, Dahlin C, Hultman T, Coakley E: Palliative care nursing—Defining the discipline? J Hosp Palliat Nurs 2011;13:106–111.
26. Dahlin C: Palliative care–Delivering comprehensive oncology nursing care. Semin Oncol Nurs 2015;31:327–337.

27. Quill T, Abernathy AP: Generalist plus specialist palliative care—Creating a more sustainable model. N Engl J Med 2013;368:1173–1175.
28. Deitrick LM, Rockwell EH, Gratz N, et al.: Delivering specialized palliative care in the community: A new role for nurse practitioners. Adv Nurs Sci 2011;34:E23–E36.
29. American Association of Colleges of Nursing: ELNEC-APRN. 2015. www.aacn.nche.edu/elnec/elnec-curricula/aprn (Last accessed May 2, 2016).
30. Institute of Medicine: *The Future of Nursing: Leading Change, Advancing Health*. Washington, DC: The National Academies Press, 2011.
31. Alvarez MP, Agra Y: Systematic review of educational interventions in palliative care for primary care physicians. Palliat Med 2006;20:673–683.
32. Runkle C, Wu E, Wang EC, et al.: Clinician confidence about conversations at the end of life is strengthened using the four habits approach. J Psychosoc Oncol 2006;26:81–95.
33. Dryden H, Addicott R: Evaluation of a pilot study day for healthcare assistants and social care officers. Int J Palliat Nurs 2009;15:6–11.
34. Fischer SM, Gozansky WS, Kutner JS, et al.: Palliative care education: An intervention to improve medical residents' knowledge and attitudes. J Palliat Med 2003;6:391–399.

Address correspondence to:
Constance Dahlin, MSN, ANP-BC, ACHPN, FPCN, FAAN
Palliative Care Service
North Shore Medical Center
81 Highland Avenue
Salem, MA 01970

E-mail: Cdahlin3@gmail.com