The costs, resource use and cost-effectiveness of Clinical Nurse Specialist–led interventions for patients with palliative care needs: A systematic review of international evidence

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Abstract

Background: Patients with palliative care needs do not access specialist palliative care services according to their needs. Clinical Nurse Specialists working across a variety of fields are playing an increasingly important role in the care of such patients, but there is limited knowledge of the extent to which their interventions are cost-effective.

Objectives: To present results from a systematic review of the international evidence on the costs, resource use and cost-effectiveness of Clinical Nurse Specialist–led interventions for patients with palliative care needs, defined as seriously ill patients and those with advanced disease or frailty who are unlikely to be cured, recover or stabilize.

Design: Systematic review following PRISMA methodology.

Data sources: Medline, Embase, CINAHL and Cochrane Library up to 2015. Studies focusing on the outcomes of Clinical Nurse Specialist interventions for patients with palliative care needs, and including at least one economic outcome, were considered. The quality of studies was assessed using tools from the Joanna Briggs Institute.

Results: A total of 79 papers were included: 37 randomized controlled trials, 22 quasi-experimental studies, 7 service evaluations and other studies, and 13 economic analyses. The studies included a wide variety of interventions including clinical, support and education, as well as care coordination activities. The quality of the studies varied greatly.

Conclusion: Clinical Nurse Specialist interventions may be effective in reducing specific resource use such as hospitalizations/re-hospitalizations/admissions, length of stay and health care costs. There is mixed evidence regarding their cost-effectiveness. Future studies should ensure that Clinical Nurse Specialists’ roles and activities are clearly described and evaluated.

Keywords
Economics, cost-effectiveness, cost–benefit analysis, health care costs, health resources, Clinical Nurse Specialist, frail elderly, palliative care, advanced disease

What is already known about this topic?
- Resource use and costs tend to increase for patients with advanced disease and at the end of life.
- Palliative care improves quality of life while reducing health care costs.
- It is difficult to assess the effectiveness of Clinical Nurse Specialists (CNSs) working as individual providers.

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Introduction

There is some evidence that specialist palliative care (SPC) improves quality of care and reduces health system costs and resource utilization, but few who could benefit are likely to access SPC services (such as hospice care). The Worldwide Palliative Care Alliance estimated in 2014 that 20 million people require palliative care (PC) at the end of life, with another 20 million needing PC support earlier in the disease trajectory. Such patients may have their PC needs met to varying degrees by a variety of providers, but there is a lack of evidence about this, especially where multiple professionals are involved and among patients with conditions other than cancer.

Clinical Nurse Specialists (CNSs) play an increasingly prominent role in the support of people with PC needs, even if they do not have the term ‘palliative care’ in their job description or role title. The CNS role as an expert in evidence-based nursing practice in various fields is internationally recognized, although there are a wide variety of professional titles in use. While there is no universally agreed definition of CNS, there is an international consensus that CNSs are nurses who have additional education, preferably at degree level or beyond. An example of a widely accepted definition comes from the International Council of Nurses, which defines the nurse specialist as ‘… a nurse prepared beyond the level of a nurse generalist and authorized to practice with advanced expertise in a nursing field. Specialist practice includes clinical, teaching, administration, research and consultant roles’.

The extent to which CNSs focus on any of the latter areas either singly or in combination varies greatly. CNSs frequently work as part of multidisciplinary groups; this makes it difficult to evaluate their effectiveness as individual providers. There is a risk that interventions that are difficult to evaluate such as those provided by CNSs may have less opportunities in the competition for resources compared to those with higher levels of evidence, meaning that patients with PC needs may be unable to access any potential benefits.

Interventions delivered by CNSs can be described as ranging across several levels, from single patient contacts or advice provided to another staff member, through short-term involvement for multiple problems (such as provision of support and information at the time of diagnosis), and finally long-term involvement with patients with rapidly changing or deteriorating conditions. All interventions delivered by CNSs are complex, comprising several interacting components and with sensitivity to contextual conditions; this makes their evaluation challenging. Despite this, there is some existing research on CNS-led interventions in different settings and with a variety of patient groups showing evidence of clinical and cost-effectiveness. For example, a systematic review of the effectiveness and cost-effectiveness of CNS interventions in outpatient care settings shows reduced costs and resource use compared to usual care, together with consistent evidence of improved patient outcomes and largely similar health care system outcomes. One evaluation of advanced nursing roles in 12 countries shows that CNSs improve access to services, reduce waiting times and, in some contexts, deliver quality of care equivalent to that provided by doctors, with high satisfaction rates among the patients and informal carers. However, there are no systematic reviews of the cost-effectiveness of CNS-led interventions for patients with PC needs despite calls for greater understanding of the contribution that CNSs may be able to make to the quality and delivery of PC at scale. Reasons for the lack of evidence relate in part to the conceptual challenges surrounding the assessment of cost-effectiveness of interventions for PC populations.

This article presents a systematic review of international evidence on the costs, resource use and cost-effectiveness of CNS-led interventions of different types for patients with PC needs.
Objectives

The objectives of the review were to

1. Examine the available international evidence on the cost or resource use of CNS-led interventions in patients with PC needs.
2. Examine the available international evidence on the cost-effectiveness of CNS-led interventions in patients with PC needs.
3. Describe the range of CNS-led interventions in patients with PC needs, within the identified international evidence.

Methods

Protocol and registration

The protocol for this study was registered in the Prospero register of systematic reviews.

Eligibility criteria

Type of study. This review considered quantitative studies addressing cost-effectiveness of CNS interventions including randomized controlled trials (RCTs), quasi-experimental, before and after, prospective and retrospective cohort studies, case control studies, analytical cross-sectional studies, service evaluations and economic analyses.

Type of participants. We included adult patients (>18 years) with a clinical diagnosis of a life-limiting or life-threatening illness, who were unlikely to be cured, recover or stabilize; please see Box 1.

Box 1.

Specific diseases considered in this review included the following:
- Cancer
- Advanced heart, lung, renal or liver disease
- Dementia, epilepsy and neurodegenerative diseases
- HIV/AIDS
- Arthritis
- Diabetes and leg ulcers
- Frail patients (e.g. living in nursing facilities or residential care homes)
- Patients in the intensive care unit (ICU) who were chronically critically ill
- Patients 60 years and older with a concomitant chronic medical condition

Type of interventions. For the purpose of this review, interventions led by CNS (e.g. the CNS had an autonomous and clearly defined role) were included. Studies in which the training or level of education of the nurse was not clear, or in which the nurse was part of a multidisciplinary team (and thus their specific role cannot be established), were excluded.

Type of outcomes. Economic outcomes included the following: (1) costs; (2) objective measures of health system utilization such as length of stay (LOS), hospitalizations/readmissions or health resource use (e.g. medications); and (3) cost-effectiveness measures (e.g. incremental cost/effectiveness ratios). In order for studies to be included, they had to have at least one economic outcome.

Exclusion criteria. Articles were excluded if they were written in languages other than English or Spanish. Other exclusion criteria were as follows: studies published prior to 2000, unpublished or incomplete papers (e.g. conference abstracts or letters to the editor) and systematic reviews or descriptive articles; studies published that included interventions which were not directed exclusively to patients with advanced disease (e.g. if they also included a family member or carer). Interventions directed to children were also excluded.

Information sources

A pilot search in Medline and CINAHL enabled identification of possible terminology. Initially, a pilot search in Medline and CINAHL was undertaken to identify key terms with the guidance from a library expert. We also examined the search strategy employed in related systematic reviews and contacted key authors for their full lists of search terms. In addition, we compared our search terms with the Mesh terms taxonomy in PubMed (and their equivalents in other databases). A second-stage search applied the identified key words and index terms across the following databases:

- Medline via OVID (1946 to October 2015)
- Embase via OVID (1980 to October 2015)
- CINAHL via EBSCO (1986 to October 5 2015)
- The Cochrane Library via Wiley (October 2015).

Search

Three groups of words and their equivalents were combined using OR within each group: (1) advanced disease (including palliative/terminal care/medicine or catastrophic/critical illness or hospice or neoplasm or aged or disease progression or terminally ill), (2) cost-effectiveness (including costs or economics or cost analysis or cost effective or cost benefit analysis or health care costs or patient readmission or LOS); and (3) Clinical Nurse Specialist (including advanced practice nursing or nurse practitioners or critical care nursing or nurse clinicians). Each group was combined again using the operator AND.
All search strategies are presented in Supplementary Material Appendix 1.

**Study selection**

Study selection was conducted in two stages. First, all titles and abstracts were screened for relevance by at least two reviewers (N.S.-B. and J.S. or G.C.). Disagreement was resolved by consensus. Second, studies that met the inclusion criteria were obtained and read. Reasons for exclusion were documented. EndNote was used to manage references.

**Data collection process and data items**

Information was recorded in an Excel chart developed for this review. Data were extracted by a research assistant (N.S.-B.) and included the following: publication details (author, year), country, study design, disease, interventions and nurse activities, nurse training, outcomes, results and conclusions.

**Synthesis of results**

A narrative approach to synthesis was selected because of the great variety of study designs and outcome measures. It was not possible to conduct a meta-analysis of cost and resource utilization findings; instead, we focused on understanding and displaying patterns across the body of research.2

**Quality assessment**

There is no universally validated scale to assess quality in quantitative studies, and there is little evidence that such scales improve the validity of conclusions drawn from systematic reviews. Most tools are scales or checklists.14 We carried out quality assessment using software from the Joanna Briggs Institute for evidence-based health care15 (Supplementary Material Appendix 2). Two reviewers independently answered each question; any disagreement was resolved by consensus. While we did not exclude studies on the basis of our quality assessment, we provide detailed information about study quality within the paper and its appendices.

**Results**

**Study selection**

A total of 7731 papers were obtained from the initial database search (Figure 1). After adjusting for duplicates, 5984 citations remained. Of these, 5749 studies were discarded after reading the title and/or abstract because they clearly did not meet the inclusion criteria. The full text of the remaining 235 articles was read and assessed for eligibility. Of which, 156 studies did not meet the inclusion criteria; the reasons for their exclusion were documented. A total of 79 studies were included in this review.

**Study characteristics**

**General characteristics.** Around 60% of the studies were conducted in the United States and the United Kingdom (27 and 20 studies, respectively) (Figure 2(a)). The majority of studies were conducted in patients with heart failure (HF)16–36 (26.6%) or cancer (25%)37–53 (Figure 2(b)). We found 13 papers reporting formal economic analyses (such as cost-effectiveness ratios),16,30,31,35,39,44,47,54–58 9 of which were based on RCTs16,30,31,35,39,47,54,57,58 and 4 of which were other type of studies.33,44,55,56 We describe this group of studies separately, given the objectives of this review. A further 37 papers reported RCTs where economic outcomes, such as costs or resource use, were included as part of a wider set of outcomes.18,19,23,24,26,27,29,34,37,38,41–43,45,49–52,59–77

In all, 22 papers reported quasi-experimental studies20–22,25,28,32,36,40,46,53,78–89 and 7 reported service evaluations or other types of studies17,48,90–94 (Figure 2(c)). A wide variety of terms were used to describe nurses’ titles (Figure 2(d)), with the most common term being ‘nurse specialist’, employed by one-third of the studies.16–18,27,30,31,33–35,39,42,43,46,47,50,52,54,64–66,72,73,75,76,78,87

**Interventions: type and setting.** A wide variety of interventions were described. In general, interventions were complex and involved multiple interacting components (Figure 3). Interventions in which the clinical component was predominant included activities directed to the diagnosis, treatment and control of the disease and were performed in hospitals, outpatient clinics or patients’ homes.

Some papers described interventions that were supportive. They sought to increase patients’ knowledge about their disease and its management, and at the same time aimed to give psychological/spiritual support. The roles adopted by the CNSs were usually reported to be multiple, and in many cases included care coordination activities.

Table 1 shows the components of the interventions (e.g. nurses’ specific activities) in each of the included papers. It was not always clear what the specific activity involved. For example, use in the papers of general terms such as ‘in-hospital care and self-care’,80 or ‘monitoring patient’s condition’,62 made it difficult to identify nurses’ specific activities. We found a wide range of activities reported, including clinical consultations (in hospitals, at home, specialist clinics or via the telephone), the request of follow-up investigations, prescription or adjustment of medications, referrals to other agencies or staff, provision of support directed at overall well-being, and education to
enhance self-management, as well as administrative work and liaison and communication with other professionals.

**General characteristics by study type**

**Economic studies** \( (n=13) \). A total of 13 economic papers were included. Three reported a modelling of economic data (observational studies).\(^{33,55,56} \) A further nine reported RCTs.\(^{16,30,31,35,47,54,57,58} \) The final paper reported a prospective study.\(^{44} \) In general, studies compared usual care (e.g. care provided by doctor or care provided in hospitals), with nurse specialist care (e.g. specialist clinic, home visit or telephone follow up). Two studies compared interventions with different amount of nurse involvement (e.g. high- vs low-level support).\(^{31,55} \) Table 2 shows the main characteristics of the economic studies, which are described in the following paragraphs.

Six **cost-utility** analyses analysing the cost per QALY gained were found.\(^{30,31,35,44,54,57} \) Three **cost-effectiveness** studies were included comparing the cost per gained health outcome (e.g. year survived,\(^{16} \) HBA1c levels\(^{55} \) and lipid-level reduction\(^{58} \)). Beaver et al.\(^{39} \) and Koinberg et al.\(^{47} \) performed **cost-minimization** studies measuring and comparing input costs, and assuming outcomes to be equivalent. Finally, Stewart et al.\(^{33} \) and Illes et al.\(^{56} \) reported cost **analyses**.

Totally, 11 out of 13 studies reported costs from one-third party/health care system perspective (e.g. only direct
Figure 2. Characteristics of included studies: (a) studies by country (%), (b) studies by disease (%), (c) study designs (%) and (d) nurse title (%).

Cardiac diseases: include coronary artery disease, acute coronary syndromes and atrial fibrillation; chronic diseases: include multiple chronic diseases and severe disability; neurological diseases: include Parkinson’s disease, neurodegenerative diseases and epilepsy; APN: advanced nurse practitioner; AP: advanced practice nurse; other: includes project nurse, qualified cardiac nurse, oncology nurses, contact nurse, cancer nurse and cardiac trained nurse.
costs were considered). Two studies included additional costs. Beaver et al. included indirect costs such as number of missing days at work and patient transportation costs. Ndosi et al. calculated costs from the perspectives of the NHS (clinic and NHS resources), health care (NHS plus out-of-pocket) and ‘societal perspective’ (including lost through time off work). The way costs were calculated varied across studies.

**RCTs (n = 37).** A total of 37 RCTs were included. Most compared a specialist nurse intervention with standard care (e.g. physician-led care or usual care). Four interventions described tele-monitoring or telephone follow up in patients with HF, colorectal cancer, and chronic obstructive pulmonary disease (COPD). Bakitas et al. described a multicomponent educational intervention for patients with advanced cancer, Berkhof et al. evaluated the effects of an outpatient on-demand interventions for patients with COPD, while Cockayne et al. and Heisler et al. described novel interventions for patients with HF. Finally, King et al. evaluated the effects of home-based chemotherapy given by CNSs to cancer patients.

**Quasi-experimental studies (n = 22).** In total, 2 out of 22 papers described telephone/monitoring follow-up interventions for patients with cancer and HF, respectively. One describes the impact of the Evercare managed care intervention led by CNSs on hospital use in a nursing home population. There was a broadly equivalent focus in terms of setting with regard to the studies: eight reported CNS-led interventions targeted at hospital patients and nine reported CNS-led interventions in the community or care home, which included the following: transitional care, care management and self-care/disease management interventions. Two studies focused on CNS-led follow-up clinics as part of a multidisciplinary management programme for patients with rectal cancer.

**Service evaluation and other type of studies (n = 7).** Five studies reported outcomes of ‘before and after’ evaluations of...
Table 1. Components of CNSs interventions.

| Activity                                      | Description                                                                 | Reference                                                                 |
|-----------------------------------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------|
| Clinical consultation (or follow-up) in hospital/nursing home | Patient assessment and care, taking clinical history, physical examination, review signs and symptoms, check vital signs. | 25,29,31,32,34,36,54,63,66,78,83,84,89,91–96                              |
| Clinical consultation (or follow-up) at home |                                                                             | 16,18,21,27,29–36,40,45,49–51,62,64,66,67,73–77,79,84–86,88,90,97          |
| Clinical consultation (or follow-up) in specialist clinic or outpatient setting |                                                                             | 16,17,24,27,28,30,31,33,34,35,41,44,46,48,52–59,65,68,70,98–101            |
| Telephone consultation/follow up/contact      |                                                                             | 16–18,20,22,27–32,34,36–39,41–43,46,49,51,52,58,60,61,64,66,68–71,73–75,79,80,82,84–86,88,90 |
| Request and review lab tests and images        | Mammography, CT scan, colonoscopy, spirometry, electrocardiogram, echocardiogram, etc. | 16,18,24,30,34,35,39,41,44,46–48,53,57,58,63–65,69,73,95                   |
| Prescription/adjustment of medicines          | Titration and prescription of medicines. Discussion of management plan (usually following a protocol). | 16–19,25,28–30,32,34,35,41,45,57–60,63–65,69,70,78,90,94,95              |
| Education and enhancement of self-management  | Patient and/or family education about the disease, causes and symptoms, treatment and life-style changes. Address patient's concerns, and psycho-spiritual and social support. | 16–18,20–22,24,26–28,30–32,34,36–38,40–42,47–49,51,52,55,57–59,61,62,65–74,76–80,82,84–88,90,92,93,95 |
| Communication with treating physician and/or team | Discussing management plan and other concerns with consultant/specialists doctor or GP. Sometimes it also included the nurse giving recommendations regarding medication adjustment or treatment options to primary physician. | 16–19,23,25,28–31,37,38,43,44,47,48,56,58–64,66,67,69,70,72–74–77,80,83–87,90,93,95 |
| Referrals and/or administrative work/discharge planning | Referrals to cardiac/pulmonary rehabilitation, GP, dietician, other specialties, to ER department, supportive services (e.g. Macmillan nurses, hospice). Includes a wide variety of administrative work (coordination of patient care among different providers). Also includes discharge planning and coordination of care. | 17,18,22,24,25,27–29,34,35,47–49,52,54,57,62,66–68,72,77,79,81–85,87,88,90,91,93,95,99 |
| Other                                         | Tele-monitoring (monitoring of weight, blood pressure, heart rate and rhythm). | 19,23,40,72                                                                  |

aEducation and/or supervision exclusively to staff.
bAdvanced life support including early chest reopening and management of post-operative complications.
Table 2. Characteristics of economic studies.

| Reference            | Type of study/no. of participants | Country      | Disease          | Intervention                                                                 | Outcomes                                                                 | Results                                                                 | Nurse training/title                                | Nurse activities                                                                                   |
|----------------------|-----------------------------------|--------------|------------------|-----------------------------------------------------------------------------|---------------------------------------------------------------------------|-------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------------------------------------|
| Adlbrecth et al.14    | Clinical trial – RCT (cost-effectiveness), (n = 190) | Austria      | Heart failure    | UC, home-based nurse care (HNC), HNC depending on NT-proBNP level (BNC)     | C: death and re-hospitalization. E: cost/year survived                    | Costs per year survived after discharge were €19,694 for UC, €14,262 for HNC and €8784 for BNC. | Specialized heart failure nurse                   | Home visits, consultations, telephone follow ups, order and review blood analysis/tests, education to patients and carers Patient care |
| Arts et al.54         | Clinical trial – RCT (cost-utility), (n = 337) | The Netherlands | Diabetes | UC (care provided by physician), I (care by nurse specialist)                 | C: QOL, adverse events – hospital admissions, side effects from drugs, E: costs/QALY | Intervention causes €3.61 reduction in direct costs per QALY gained, compared to UC. The ratio for overall costs shows a €20.34 increase per QALY gained (NS). | Nurse specialist                                   | Patient care                                                                                     |
| Beaver et al.99       | Clinical trial – RCT (cost-minimization), (n = 374) | UK           | Cancer (breast)  | I (telephone follow up by CNS), UC (hospital-based consultations)           | C: psychological morbidity E: resource use, difference in costs          | Telephone follow up was more expensive than UC (mean difference: €55, 95% CI: €29–€77). | Specialist nurse                                  | Apply a structure questionnaire by phone, order test (mammography) Education, self-management advice, monitoring clinical progress, assessing treatment Patient care |
| Haji Ali Afzali et al.55 | Observational (cost-effectiveness), (n = 339) | Australia   | Diabetes | I (high- vs low-level involvement of Practice Nurse consultation)          | C: change in blood pressure, cholesterol and HBA1c levels. E: cost/HBA1c levels | No difference in total cost between the two models. High-level model was associated with better clinical outcomes. | Practice nurse                                   | Education, self-management advice, monitoring clinical progress, assessing treatment Patient care |
| Iles et al.56         | Observational (only cost analysis), (n = 254) | Australia    | Chronic diseases | I (Practice Nurse-led care), UC (GP-led care)                             | E: costs, GP visits                                                     | Net additional cost of PN-led care over GP-led care was US$129 per patient per year. Adjusted cost was £1914/QALY gained for lower risk tumours and £2180/QALY gained for higher-risk tumours. | Practice nurse                                   | Physical exam, PR exam, order tests (e.g. sigmoidoscopy), referrals, counselling Patient education and counselling, order exams (e.g. mammography) |
| Jeyarajah et al.44    | Clinical trial – prospective (cost-utility), (n = 193) | UK           | Cancer (colorectal) | I (cancer follow-up by nurse-led clinic)                                  | C: recurrence of disease, survival, death E: costs/QALY                 | Nurse intervention was 20% less expensive compared to the physician follow up (£495 vs £630). | Colorectal nurse specialist                        | Physical exam, PR exam, order tests (e.g. sigmoidoscopy), referrals, counselling Patient education and counselling, order exams (e.g. mammography) |
| Koinberg et al.47     | Clinical trial – RCT (cost-minimization), (n = 264) | Sweden       | Cancer (breast)  | I (follow up by nurse), UC (follow up by physician)                       | E: resource use, costs                                                 | Nurse intervention was 20% less expensive compared to the physician follow up (£495 vs £630). | Specialist nurse                                  | Patient education and counselling, order exams (e.g. mammography) |

(Continued)
| Reference        | Type of study/no. of participants | Country | Disease             | Intervention                                   | Outcomes                                      | Results                                                                 | Nurse training/title | Nurse activities                                                                 |
|------------------|-----------------------------------|---------|---------------------|-----------------------------------------------|-----------------------------------------------|-------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------|
| Ndosi et al.57   | Clinical trial – RCT (cost-utility), (n = 181) | UK      | RA                  | I (nurse-led care), UC (rheumatologist-led care) | C: disease activity E: costs/QALY             | I was more cost-effective than UC with respect to cost and disease activity score, but not in relation with QALY utility scores. | Clinical Nurse specialist | Consultation, prescribing medications, intra-articular or intramuscular steroid injections, counselling |
| Paez and Allen58 | Clinical trial – RCT (cost-effectiveness), (n = 228) | US      | CAD                 | I (lipid management by nurse), UC (lipid management by primary provider and/or cardiologist) | C: lipid levels E: cost/reduction in lipids (mg/dL) | Annual incremental cost-effectiveness of I was US$26.03 per mg/dL and US$39.05 per percent reduction in LDL-C. | Nurse practitioner | Consultation, prescribing medications, counselling. Telephone follow up |
| Patel et al.39   | Clinical trial – RCT (cost-utility), (n = 31) | Sweden  | Heart failure       | I (home nurse follow-up), UC (conventional care) | C: HRQL, symptom control E: costs/QALY        | Total cost related to HF was lower in the intervention group after 12 months (p=0.05). Costs/QALY was lower in I (NS). | Specialist nurse | Hospital consultation, home visits, telephone availability, education and counselling |
| Postmus et al.31 | Clinical trial – RCT (cost-utility), (n = 1023) | Multicentre | Heart failure | I Basic (basic support by nurse), I Intensive (intensive support by nurse), UC (cardiologist care) | C: readmission, deaths, number of days lost because of death or HF readmission E: costs/QALY | Basic support was found to dominate both care as usual and intensive support because it generated 0.023 and 0.004 excess QALYs while saving €77 and €1178, respectively. | Nurse specialist in HF | Specialist HF nurse Hospital consultations, home visits |
| Stewart et al.31 | Observational (cost-analysis), (n = 122,000) | UK      | Heart failure       | Three models of HF nurse care: clinic-based service, home-based service, hybrid service | C: estimated number of patients exposed to HF services, cost and resource use of services in three models of care E: costs/QALY | Cost of applying a national programme of home-, clinic- or mix-based follow up was calculated to be €69.4, €73.1 and €72.5million per annum, respectively. | Specialist HF nurse | Hospital consultations, home visits |
| Turner et al.35  | Clinical trial – RCT (cost-utility), (n = 1163) | UK      | Heart failure/CAD   | I (nurse management programme), UC (general practice care) | C: QALY E: costs/QALY | I generated additional QALY at an incremental cost of £13,158 per QALY compared to the UC. | Specialist nurse | Consultation, order tests, medication management, home visits |

UC: usual care; I: intervention; C: clinical; E: economic; NS: statistically non-significant; CI: confidence interval; GP: general practitioner; RA: rheumatoid arthritis; CAD: coronary artery disease; LDL-C: low-density lipoprotein cholesterol; HbA1c: glycated haemoglobin; QOL: quality of life; HRQL: health-related quality of life; QALY: quality-adjusted life-year.
specialist nurse-led services, including home-based PC, monitoring and taking care of intensive care unit (ICU) patients, and outpatient clinics for patients with HF or head and neck cancer. Comparison was characteristically made with patients acting as their own controls or with a different cohort of patients prior to the initiation of the intervention. The remaining two studies comprised a natural experiment using a pre–post design to evaluate the effect of a transitional care clinic for individuals discharged from a skilled nursing facility and a retrospective observational cohort study of the effects of a home-based cardiac surgery nurse practitioner intervention on readmissions.

**Synthesis of results**

**Results by study type**

**RCT.** A total of 17 RCTs did not report any significant difference in terms of LOS, emergency department (ED) visits, number of days in the ICU, medication use or readmissions. They examined a model of CNS-led disease management or self-management in HF, COPD, cancer care, COPD, cancer care, or chronic diabetes. Six studies examined a formal PC or supportive care model, and two examined the use of CNS-led tele-care or tele-monitoring. Nevertheless, 13 RCTs reported that CNS-led interventions were effective in reducing specific economic outcomes. Four RCTs reported reduction in doctors' visits (GP or specialist visits), two reported reductions in ED visits, five reported reductions in hospital readmissions, and seven reported reductions in LOS. Two RCTs found that CNS-led interventions were effective at increasing the use or prescription of medications.

CNS-led interventions were found to be less expensive than usual care in 4 out of 20 studies reporting costs. A further 2 of the 20 studies reporting costs found that CNS interventions were more expensive, although in each case, the potential for cost-effectiveness was noted due to other positive outcomes. For example, Strong et al., in a trial of a nurse-led clinic for management of people with depression due to cancer, reported that it was potentially cost-effective due to the increase in quality-adjusted life-years achieved, as well as achieving good feasibility and acceptability. In all, 14 studies found non-significant or inconclusive results regarding costs.

**Quasi-experimental studies.** Readmissions were reduced in the intervention group in 10 out of 17 studies reporting this outcome. 5 evaluated a disease management CNS-led intervention for patients with HF or cardiac disease. 3 evaluated a transitional care model led by CNSs and 1 each evaluated a case management model – Evercare led by a CNS for long-term care residents and a CNS-led psychosocial support intervention for patients with heart disease.

LOS was also reduced in 8 out of 13 studies employing a similar range of care models, that is, disease management, transitional or home-based care. Three of these latter studies also reported that CNS-led interventions reduce costs of care. The CNS-led case management intervention in a long-term care population (Evercare) increased doctors' visits (GP) to the long-term care facilities at the same time as reducing transfers to hospital, while two of the disease-management-directed CNS-led interventions for patients with HF similarly increased prescription and use of medications among recipients.

**Service evaluation and other type of studies.** Of the seven studies included in this category, four showed statistically significant reductions in re-hospitalizations; Lukas et al. and Park et al. also found that the CNS services reduced LOS. Regarding medication use, one study reported an increase in the prescription of medicines on the intervention group after the introduction of a CNS clinic for HF patients, and one of the palliative and supportive care interventions enhanced chemotherapy treatment completion and reduced on treatment dose deviations. Two interventions reported a reduction in hospital and direct readmission costs.

**Results of cost-effectiveness (economic evaluation studies)**

In total, 13 studies were identified that may be classed as formal health economic studies and in which there was a variety of evidence about cost-effectiveness. Most evidence was from studies of HF nurse specialists or CNSs working with high-risk coronary heart disease patients, although there were also some studies of CNS-led cancer care and of other conditions.

In seven studies, there was clear evidence of cost-effectiveness or improvement on health economic outcomes, five of which considered interventions in heart disease or cardiac care patients: Adlbrecht et al. showed in Austria that the supporting home-based nursing care with specialist nurses was both cost-effective and cheaper than standard care for HF patients. The costs per year survived after discharge were significantly lower for the intervention group compared to usual care. In the United States, incorporating nurse case management of cardiovascular disease risk factors into primary care settings was shown to be similarly cost-effective. The annual incremental cost-effectiveness of NP
The remaining two studies classified as economic analyses included a short-term cost-minimization study examining a telephone follow-up CNS-led intervention for patients with breast cancer in the United Kingdom and a cost analysis of effects of practice nurse-led care for chronic diseases. In both cases, the interventions were associated with higher costs compared to usual care although some patients preferred these care models.

**Results of costs and resource use**

The most common economic outcomes reported were costs and readmission rates (Table 3). We found that CNS interventions may be effective in reducing **health care costs** (13 out of 46 studies reported statistical significant reduction). Another 22 out of 46 studies reported that the intervention increases costs, although the results were statistically significant in only six of them.

Regarding resource use (Table 3), there is evidence that CNS interventions may be effective in reducing **hospitalizations and/or readmissions** (20 out of 46 papers showed statically significant reductions in this outcome, while the remaining 26 did not report significant levels or reported non-significant results). **LOS** was significantly reduced in 17 out of 33 studies, and only 1 study showed that the intervention significantly increases LOS. The rest of the papers (15 out of 33) reported no significant levels or it was not clear.

There is insufficient evidence to demonstrate that CNS interventions lower **days in the UCI or ED visits**. Four studies reported UCI days, all of which showed non-significant changes between groups. Regarding ED visits, only 3 out of 16 studies found that intervention group significantly reduced this outcome, while the remaining 13 showed no significant changes.

There is also insufficient information to make conclusions on the effect of doctors (general practitioners or specialist/consultant) and CNS visits in any setting (Table 3). Of 15 studies describing the **utilization of doctors/physicians** as an outcome, only 4 reported a statistically significant decrease in doctors’ visits in the intervention group: Berkhof et al. concluded that intervention group had significantly more visits to the specialist nurse and the other three were inconclusive. There was a lack of evidence regarding **CNS visits**. Of 4 studies examining the latter, one concluded that intervention group had significantly more visits to the specialist nurse and the other three were inconclusive.

There was some evidence with regard to **referrals** (e.g. to other health care professionals, health services or clinics). Of 11 studies, 7 were inconclusive (showing non-significant differences or not reporting significant levels) and 4 others were inconclusive or reported non-significant results. There was a lack of evidence regarding **CNS visits**. Of 4 studies examining the latter, one concluded that intervention group had significantly more visits to the specialist nurse and the other three were inconclusive.

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In four studies, cost-effectiveness was not demonstrated mainly because of methodological challenges. In the first of these, a study of nurse-led care compared to physician-led care of patients with rheumatoid arthritis, CNS care was shown to be equivalent in terms of quality and in some cases cheaper. In the second study, home-based CNS followed up of patients with HF in Sweden was shown to be significantly cheaper at 12 months than standard care, at equivalent clinical outcomes, although small number of patients made conclusions difficult to draw. In addition, costs per QALY were lower in the home care group but the difference did not reach statistical significance. In the third study of CNS-led care for patients with diabetes, CNS-led care generated a modest reduction in costs per quality-adjusted life-year gained compared to usual care, although statistical significance was not reached. Similar conclusions were reached in Australian study of CNS-led care for people with diabetes.

The remaining two studies classified as economic analyses included a short-term cost-minimization study examining a telephone follow-up CNS-led intervention for patients with breast cancer in the United Kingdom and a cost analysis of effects of practice nurse-led care for chronic diseases. In both cases, the interventions were associated with higher costs compared to usual care although some patients preferred these care models.
| Specific component of resource use | Total no. of studies | Reference | Significant effect | Not effective | Descriptive | No clear effect |
|-----------------------------------|----------------------|-----------|------------------|---------------|-------------|---------------|
| **Test/images usage**             | 5                    | –         | 53<sup>a</sup>   | (n = 1)       | –           | 39,40,43,47   |
| **Hospital admission/re-admissions** | 46                   | 16,18,20,22,25,28,29,32,34,48,62,64,79,80,83,84,86,90,91,93 | 19,24,27,36,42,49,52,60,61,63,67–69,71,72,75,81,82,85,87,88 | –             | (n = 5)       |
| **Length of stay (LOS)**          | 33                   | 18,22,23,25,27,28,34,61,64,77,81,83,84,86,88,91,93 | 19,29,32,36–38,63,67,68,72,78,80,82,92 | –             | 17,26         |
| **Doctor visits (GP/specialist)** | 15                   | 49,60,61,63 | 42,69,71,75,85,87 | 83<sup>a</sup> | (n = 7)       | 43,47,56,73   |
| **Nurse specialist visits**       | 4                    | 60<sup>a</sup> | (n = 1)         |               |             | 43,47,56      |
| **Emergency department visits**   | 16                   | 64,77,80 | 37,38,42,49,52,68,71,81,82,85,87,91,93 | (n = 13)      |
| **Intensive care unit visits**    | 4                    |           | 37,38,62,92 | (n = 4)       |             |               |
| **Referrals<sup>b</sup>**         | 11                   | 28,65,83,85 | 42,62,63,84,87 | (n = 4)       |             | 43,47,87      |
| **Medications (prescription/usage/treatment completion)** | 10                   | 17,25,28,34,48,59 | 38,69 | (n = 2)       |             | 18,43         |
| **Costs**                         | 46                   | 16,22,29,30,41,47,57,64,65,81,84,90,91 | 19,31,32,40,50,51,53–55,60–62,66,69,76,87 | 33,44,59 | (n = 3)       | 43,45,46,58,73,75,83,94 |
| **Cost-effectiveness (economic evaluations)** | 13                   | 16,31,33,35,44,47,58 | 39,56 | (n = 7)       |             | 30,54,55,57   |
| **Total outcomes reported**       | n = 203              | n = 74   | n = 91           | n = 3         | n = 35       |

<sup>a</sup>Significant effect towards control.
<sup>b</sup>Includes any other type of health professional contact (e.g. doctor, nurse, occupational therapy, social worker, speech therapy, rehabilitation, skilled nursing facility or clinics).
Kane et al.\textsuperscript{53} found significant changes in referrals for physical, occupational and speech therapy, and podiatry, while Houweling et al.\textsuperscript{65} found that the percentage of patient referred back to the GP on the last months was significantly higher in the CNS intervention group.

Five studies reported the use of laboratory test or images as an outcome, of which four did not find or report statistical significant changes.\textsuperscript{39,40,43,47} In an exception to this pattern, the fifth study\textsuperscript{53} found that CNS requested significantly more blood samples compared to surgeons when following up colorectal cancer patients.

Medication prescriptions were significantly increased in the intervention group in two studies\textsuperscript{17,59} and medication uptake/use by patients was raised in another three studies.\textsuperscript{25,28,34} A study of a CNS-led supportive care intervention for patients with head and neck cancer found that in the intervention group, there was a statistically significant chemotherapy treatment completion and dose reduction compared to the control group.\textsuperscript{53} Four studies either did not find or did not report significant levels on this outcome.\textsuperscript{18,38,43,69}

Table 3 summarizes the components of resource use: studies that reported a statistically significant effect towards the intervention group (or after the intervention in ‘before and after’ studies) on specific outcomes were classified as effective (a total of 74 outcomes were reported as effective in the included studies). However, studies that reported a significant effect favouring the control group, or those reported non-significant outcomes, were classified as non-effective interventions (91 outcomes). Some of the studies did not report any significant level (or it was not clear after reading the article). In this case, papers were classified as not clear for that specific outcome (35 outcomes). A small number of papers (5 out of 92) did not compare outcomes between groups, and reported a specific value in specific outcomes (e.g. cost of intervention); these were classified as descriptive.

**Study quality**

A summary of the quality of the included studies is presented in Figure 4(a)–(c). The RCTs scored well on most quality indicators including randomization procedures, statistical analysis, clear description of interventions and measurement of outcomes using reliable instruments. The quasi-experimental studies had greater variability in quality. Although, in general, statistical methods used were clearly described and outcomes were measured in a reliable way for both groups, randomization procedures were not always described and it was not always clear whether an intention to treat analysis was performed or whether the groups were treated similarly other than the intervention. There was variation in RCTs and quasi-experimental studies on whether participants or allocators were blinded to treatment group allocation and whether control and intervention groups were comparable at entry to the trial. Economic evaluation studies were of good quality as well, having clear research questions and descriptions of the way costs were calculated. Weaknesses were lack of reporting of adjustments of cost for differential timing and variability in whether sensitivity analysis was performed.

The service evaluation and other studies had variable quality. They had some limitations regarding the description and inclusion in analysis of outcomes of people who withdrew from the study, strategies to identify and deal with confounding factors and sufficient length of follow up. Please refer to Supplementary Material Appendix 3 for more information about each specific study.

In general, because of the nature of the studies was reviewed, some criteria, such as concealing treatment groups and blinding participants, were not applicable to all the studies. In many cases, the CNS interventions were not well described, so it was difficult to evaluate...
whether the groups treated identically other than for the named intervention.

**Discussion**

**Summary of evidence**

This systematic review suggests that CNS interventions for patients with PC needs may be effective in reducing health care costs. In total, 13 out of 46 studies reported statistically significant reductions in costs, and 6 concluded that the intervention significantly increased costs. However, many of the studies were limited in terms of the length of follow-up. We therefore know little about the long-term cost implications: even if costs are increased short term by a CNS intervention, CNS-led care may lead to health care costs being off-set over time. This may be due to a decrease in preventable events and better satisfaction/quality of care experience; greater access to treatment care. Moreover, the methodology used to calculate costs in each study was different and often not clearly described, which might affect the final conclusion.

The evidence regarding resource use shows that CNS interventions may also be effective in reducing specific outcomes, specifically hospitalizations and re-hospitalizations/admissions, as well as LOS. Very few studies concluded that the intervention significantly increased these outcomes, while an important proportion of them reported positive effects in reducing them. Similarly, 6 out of 10 studies showed significant increase in prescription and usage of medications, suggesting that CNS interventions may enhance this outcome.

However, there is insufficient evidence to make conclusions regarding ED and ICU visits, as well as doctor and nurse specialist visits, referrals and labs/exams/images.

Overall, the evidence regarding the cost-effectiveness of CNS interventions is inconclusive. Although 7 out of 13 economic analyses reported some grade of cost-effectiveness, 4 more were inconclusive and 2 more concluded that the intervention was more expensive.

**Limitations**

Although an attempt was made to include research relating to interventions exclusively performed by CNS for patients with PC needs, or in which CNS had a clear defined role, the boundaries between what the CNSs did and the input of other contributors were often hard to assess when deciding about study inclusion. All the interventions described in the studies included in the review were complex: they had various interacting components, and frequently involved flexible activities on the part of the CNSs delivering care to patients.11

A variety of different interventions were reported in the included studies. Nevertheless, it was not always clear what the nurses’ roles (specific activities) were. For example, when using words such as ‘patient assessment or care’, or when a CNS was introduced into an existing in-hospital service and specific tasks were not clearly described. In
those papers in which the role was described in more
detail, we found that the nurses’ activities could be mainly
clinical, supportive or administrative/care coordination.

Although some authors developed their own inclusion
criteria and definitions, we found an extensive variety of
terms to describe a ‘CNS’ and a frequent lack of specification
of their experience and training. This has made it challenging
to consolidate evidence related to cost-effectiveness.

Moreover, we used a broad definition of patients with
PC needs to reflect the reality of the range and complexity
of patients with different diseases and different phases of
illness who can benefit from PC. This gave rise to chal-

lenges in comparing and contrasting the studies. The appli-
cability of this evidence is further limited by the
preponderance of research from resource rich countries
(especially the United States and the United Kingdom),
with diverse health care systems and funding.

The quality of included studies is variable. Many were
not randomized and did not use a control group, affecting
the validity and reliability of the results. In total, 46 (9 of
which were economic analyses) out of the 92 included
studies were RCTs, and they included multiple outcomes,
patients and interventions. In some, the study population
was small and approaches to statistical analysis were not
clear; some did not report statistical significance.

Conclusion

This review provides an insight into the wide range and
complexity of engagement of CNSs with patients with
PC needs, in many different settings of care. However, it
highlights important limitations in the evidence base that
should be considered when developing further research,
and when considering from a strategic planning perspec-
tive whether CNSs may be able to contribute to the pro-

vision of PC at scale, given the range and complexity of
patients in need in contemporary health care systems
and the unlikelihood of being able to ensure that every
person in need access a dedicated specialist PC
service.

Our review suggests that CNSs may have an important
role in PC provision, but this is a role that is currently
poorly recognized and rarely clearly articulated. In terms
of cost and cost-effectiveness, it is clear that CNSs may
have the potential to enhance quality at neutral or lower
costs to health care system while enhancing or delivering
similar clinical or patient-reported outcomes but that new
studies are necessary that address characteristic methodo-

logical shortcomings. Future research of the CNS con-
tribution to PC should ensure that the CNSs’ expertise,
training and specific intervention(s) are clearly described,
focus on patient-perceived benefits and include longitudi-
nal study of economic impact. In the meanwhile, consid-
eration should be given to the inclusion of CNS-led care in
national and international policies aimed at integrating PC
into wider health care and thus enabling more people to
benefit from a PC approach at all stages of illness.

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References

1. Langton JM, Blanch B, Drew AK, et al. Retrospective
studies of end-of-life resource utilization and costs in
cancer care using health administrative data: a systematic
review. Palliat Med 2014; 28(10): 1167–1196.
2. Smith S, Brick A, O’Hara S, et al. Evidence on the cost
and cost-effectiveness of palliative care: a literature
review. Palliat Med 2014; 28(2): 130–150.
3. Connor SS and Bermedo MCS. Global atlas of pal-
liative care at the end of life. Worldwide Palliative Care
Alliance, 2014, http://www.who.int/nmh/Global_Atlas_
of_Palliative_Care.pdf
4. Dy SM, Aslakson R, Wilson RF, et al. Closing the quality
gap: revisiting the state of the science (vol. 8: improving
health care and palliative care for advanced and serious
illness). Evid Rep Technol Assess 2012; 208: 1–249.
5. Donald F, Kilpatrick K, Reid K, et al. A systematic review
of the cost-effectiveness of nurse practitioners and clinical
nurse specialists: what is the quality of the evidence? Nurs
Res Pract 2014; 2014: 896587.
6. Delameire M and Lafortune G. A description and evalua-
tion of experiences in 12 countries (Contract No. 54).
Nurses Adv Roles. Epub ahead of print 8 July 2010. DOI:
10.1787/5kmbrcfm35g7-en.
7. International Council of Nurses. ICN framework of com-
petencies for the nurse specialist. Geneva: ICN, 2009.
8. Seymour J, Clark D, Hughes P, et al. Clinical nurse spe-
cialists in palliative care. Part 3. Issues for the Macmillan
Nurse role. Palliat Med 2002; 16(5): 386–394.
9. Normand C. Setting priorities in and for end-of-life care:
challenges in the application of economic evaluation.
Health Econ Policy Law 2012; 7(4): 431–439.
10. Taylor CJ. Demonstrating the value of Macmillan clinical
nurse specialists. Macmillan cancer support, 2011, http://
www.macmillan.org.uk/aboutus/healthandsocialcarepro-
fessionals/newsandupdates/macvoice/demonstratingthe-
evalueofmacmillancnss.aspx
11. Craig P, Dieppe P, Macintyre S, et al. Developing and eval-
uating complex interventions: the new Medical Research
Council guidance. Int J Nurs Stud 2013; 50(5): 587–592.
12. Kilpatrick K, Kaasalainen S, Donald F, et al. The effect-
iveness and cost-effectiveness of clinical nurse specialists
in outpatient roles: a systematic review. *J Eval Clin Pract* 2014; 20(6): 1106–1123.

13. NHS National Cancer Action Team. Quality in nursing excellence in cancer care: the contribution of the clinical nurse specialist, 2010, http://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancer-care/thecontributionoftheclinicalnurseexpert.pdf

14. The Cochrane Collaboration. Cochrane handbook for systematic reviews of interventions version 5.1.0, 2011, http://handbook.cochrane.org

15. Institute JB, Joanna Briggs Institute reviewers’ manual: 2014 edition. Solito Fine Colour Printers, 2014, https://joanna-briggs.org/assets/docs/sumari/ReviewersManual-2014.pdf

16. Adlbrecht C, Huelsmann M, Berger R, et al. Cost analysis and cost-effectiveness of NT-proBNP-guided heart failure specialist care in addition to home-based nurse care. *Eur J Clin Investig* 2011; 41(3): 315–322.

17. Andersen MK, Markenvard JD, Schjott H, et al. Effects of a nurse-based heart failure clinic on drug utilization and admissions in a community hospital setting. *Scand Cardiovas J* 2005; 39(4): 199–205.

18. Blue L, Lang E, McMurray JJV, et al. Randomised controlled trial of specialist nurse intervention in heart failure. *BMJ* 2001; 323(7315): 715–718.

19. Blum K and Gottlieb SS. The effect of a randomized trial of home telemonitoring on medical costs, 30-day readmissions, mortality, and health-related quality of life in a cohort of community-dwelling heart failure patients. *J Card Fail* 2014; 20(7): 513–521.

20. Brandon AF, Schuessler JB, Ellison KJ, et al. The effects of an advanced practice nurse led telephone intervention on outcomes of patients with heart failure. *Appl Nurs Res* 2009; 22(4): e1–e7.

21. Bryant R and Gaspar P. Implementation of a self-care of heart failure program among home-based clients. *Geriatr Nurs* 2014; 35(3): 188–193.

22. Chen YH, Ho YL, Huang HC, et al. Assessment of the clinical outcomes and cost-effectiveness of the management of systolic heart failure in Chinese patients using a home-based intervention. *J Int Med Res* 2010; 38(1): 242–252.

23. Cleland JG, Louis AA, Rigby AS, et al. Noninvasive home telemonitoring for patients with heart failure at high risk of recurrent admission and death: the Trans-European Network-Home-Care Management System (TEN-HMS) study. *J Am Coll Cardiol* 2005; 45(10): 1654–1664.

24. Cockayne S, Pattenden J, Worthy G, et al. Nurse facilitated Self-management support for people with heart failure and their family carers (SEMBAPFORS): a randomised controlled trial. *Int J Nurs Stud* 2014; 51(9): 1207–1213.

25. Dahle J and Penque S. The effects of an advanced practice nurse-directed heart failure program. *Nurse Pract* 2000; 25(3): 61–62, 65–68, 71–74 passim.

26. Heisler M, Halasyamani L, Cowen ME, et al. Randomized controlled effectiveness trial of reciprocal peer support in heart failure. *Circ Heart Fail* 2013; 6(2): 246–253.

27. Jaarsma T, Van Der Wal MHL, Lesman-Leegte I, et al. Effect of moderate or intensive disease management program on outcomes in patients with heart failure: Coordinating Study Evaluating Outcomes of Advising and Counseling in Heart Failure (COACH). *Arch Intern Med* 2008; 168(3): 316–324.

28. Lowery J, Hopp F, Subramanian U, et al. Evaluation of a nurse practitioner disease management model for chronic heart failure: a multi-site implementation study. *Congest Heart Fail* 2012; 18(1): 64–71.

29. Nayler MD, Brooten DA, Campbell RL, et al. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial (Erratum appears in *J Am Geriatr Soc* 2004; 52(7): 1228). *J Am Geriatr Soc* 2004; 52(5): 675–684.

30. Patel H, Shafazand M, Ekman I, et al. Home care as an option in worsening chronic heart failure – a pilot study to evaluate feasibility, quality adjusted life years and cost-effectiveness. *Eur J Heart Fail* 2008; 10(7): 675–681.

31. Postmus D, Abdul Pari AA, Jaarsma T, et al. A trial-based economic evaluation of 2 nurse-led disease management programs in heart failure. *Am Heart J* 2011; 162(6): 1096–1104.

32. Stauffer BD, Fullerton C, Fleming N, et al. Effectiveness and cost of a transitional care program for heart failure: a prospective study with concurrent controls. *Arch Intern Med* 2011; 171(14): 1238–1243.

33. Stewart S, Blue L, Walker A, et al. An economic analysis of specialist heart failure nurse management in the UK: can we afford not to implement it? *Eur Heart J* 2002; 23(17): 1369–1378.

34. Thompson DR, Roebuck A and Stewart S. Effects of a nurse-led, clinic and home-based intervention on recurrent hospital use in chronic heart failure. *Eur J Heart Fail* 2005; 7(3): 377–384.

35. Turner DA, Paul S, Stone MA, et al. Cost-effectiveness of a disease management programme for secondary prevention of coronary heart disease and heart failure in primary care. *Heart* 2008; 94(12): 1601–1606.

36. Williams G, Akroyd K and Burke L. Evaluation of the transitional care model in chronic heart failure. *Br J Nurs* 2010; 19(22): 1402–1407.

37. Bakitas M, Lyons KD, Hegel MT, et al. Effects of a palliative care intervention on clinical outcomes in patients with advanced cancer: the Project ENABLE II randomized controlled trial. *JAMA* 2010; 19(22): 1402–1407.

38. Bakitas MA, Tosteson TD, Lyons KD, et al. Early versus delayed initiation of concurrent palliative oncology care: patient outcomes in the ENABLE III randomized controlled trial. *JAMA Oncol* 2015; 33(13): 1438–1445.

39. Beaver K, Hollingsworth W, McDonald R, et al. Economic evaluation of a randomized clinical trial of hospital versus telephone follow-up after treatment for breast cancer. *Br J Surg* 2009; 96(12): 1406–1415.

40. Bohnenkamp SK, McDonald P, Lopez AM, et al. Traditional versus telenursing outpatient management of patients with cancer with new ostomies. *Oncol Nurs Forum* 2004; 31(5): 1005–1010.

41. Faithfull S, Corner J, Meyer L, et al. Evaluation of nurse-led home care ineffectiveness in cancer care: the contribution of the clinical nurse specialist. *Circ Heart Fail* 2013; 6(2): 246–253.
53. Strand E, Nygren I, Bergkvist L, et al. The outcome and cost-effectiveness of nurse-led care in people with rheumatoid arthritis: a multicentre randomised controlled trial. *Ann Rheum Dis* 2013; 72(11): 1975–1982.

54. Paez KA and Allen JK. Cost-effectiveness of nurse practitioner management of hypercholesterolemia following coronary revascularization. *J Am Acad Nurse Pract* 2006; 18(9): 436–444.

55. Bellary S, O’Hare JP, Raymond NT, et al. Enhanced diabetes care to patients of south Asian ethnic origin (the United Kingdom Asian Diabetes Study): a cluster randomised controlled trial. *Lancet* 2008; 371(9626): 1769–1776.

56. Berkhof FF, Hesselink AM, Vaessen DL, et al. The effect of an outpatient care-on-demand-system on health status and costs in patients with COPD. A randomized trial. *Respir Med* 2014; 108(8): 1163–1170.

57. Davies M, Dixon S, Currie CJ, et al. Evaluation of a hospital diabetes specialist nursing service: a randomized controlled trial. *Diabet Med* 2001; 18(4): 301–307.

58. Douglas SL, Daly BJ, Kelley CG, et al. Chronically critically ill patients: health-related quality of life and resource use after a disease management intervention. *Am J Crit Care* 2007; 16(5): 447–457.

59. Goldie CL, Prodan-Bhalla N and Mackay M. Nurse practitioners in postoperative cardiac surgery: are they effective? *Can J Cardiovasc Nurs* 2012; 22(4): 8–15.

60. Hernandez C, Casas A, Escarrabill J, et al. Home hospitalisation of exacerbated chronic obstructive pulmonary disease patients. *Respir Rev* 2003; 21(1): 58–67.

61. Houweling ST, Kleestra N, Hateren KJ, et al. Diabetes specialist nurse as main care provider for patients with type 2 diabetes. *Neth J Med* 2009; 67(7): 279–284.

62. Hurwitz B, Jarman B, Cook A, et al. Scientific evaluation of community-based Parkinson’s disease nurse specialists on patient outcomes and health care costs. *J Eval Clin Pract* 2005; 11(2): 97–110.

63. Inglis S, McLennan S, Dawson A, et al. A new solution for an old problem? Effects of a nurse-led, multidisciplinary, home-based intervention on readmission and mortality in patients with chronic atrial fibrillation. *J Cardiovasc Nurs* 2004; 19(2): 118–127.

64. Kotowycz MA, Cosman TL, Tartaglia C, et al. Safety and feasibility of early hospital discharge in ST-segment elevation myocardial infarction – a prospective and randomised trial in low-risk primary percutaneous coronary intervention patients (the Safe-Depart Trial). *Am Heart J* 2010; 159(1): 117.e1–117.e6.

65. Krein SL, Klamerus ML, Vijan S, et al. Case management for patients with poorly controlled diabetes: a randomized trial. *Am J Med* 2004; 116(11): 732–739.

66. Litaker D, Mion L, Planavsky L, et al. Physician – nurse practitioner teams in chronic disease management: the impact on costs, clinical effectiveness, and patients’ perception of care. *J Interprof Care* 2003; 17(3): 223–237.

67. Sawatzky JA, Christie S and Singal RK. Exploring outcomes of a nurse practitioner-managed cardiac surgery follow-up intervention: a randomized trial. *J Adv Nurs* 2013; 69(9): 2076–2087.

68. Sorknaes AD, Bech M, Madsen H, et al. The effect of real-time teleconsultations between hospital-based nurses and patients with severe COPD discharged after an exacerbation. *J Telemed Telecare* 2013; 19(8): 466–474.

69. Srithar M, Taylor R, Dawson S, et al. A nurse led intermediate care package in patients who have been hospitalised with an acute exacerbation of chronic obstructive pulmonary disease. *Thorax* 2008; 63(3): 194–200.
74. Strong V, Waters R, Hibberd C, et al. Management of depression for people with cancer (SMaRT oncology 1): a randomised trial. *Lancet* 2008; 372(9632): 40–48.

75. Uitdehaag MJ, Putten PG, Eijck CH, et al. Nurse-led follow-up at home vs. conventional medical outpatient clinic follow-up in patients with incurable upper gastrointestinal cancer: a randomized study. *J Pain Symptom Manage* 2014; 47(3): 518–530.

76. Verschuur EM, Steyerberg EW, Tilanus HW, et al. Nurse-led follow-up of patients after oesophageal or gastric cardiac cancer surgery: a randomised trial. *Br J Cancer* 2009; 100(1): 70–76.

77. Young W, Rewa G, Goodman SG, et al. Evaluation of a community-based inner-city disease management program for postmyocardial infarction patients: a randomised controlled trial. *CMAJ* 2003; 169(9): 905–910.

78. Carey N, Courtenay M, James J, et al. An evaluation of a Diabetes Specialist Nurse prescriber on the system of delivering medicines to patients with diabetes. *J Clin Nurs* 2008; 17(12): 1635–1644.

79. Cossette S, Frasure-Smith N, Nand Lespérance F. Clinical implications of a reduction in psychological distress on cardiac prognosis in patients participating in a psychosocial intervention program. *Psychosom Med* 2001; 63(2): 257–266.

80. David D, Britting L and Dalton J. Cardiac acute care nurse practitioner and 30-day readmission. *J Cardiovasc Nurs* 2015; 30(3): 248–255.

81. Duangbupha S, Hanucharurnkul S, Pookboonmee R, et al. Chronic care model implementation and outcomes among patients with COPD in team care with and without advanced practice nurses. *Pac Rim Int J Nurs Res* 2013; 17(2): 102–116.

82. Jeangsawang N, Malathum P, Panpakdee O, et al. Comparison of outcomes of discharge planning and post-discharge follow-up care, provided by advanced practice, expert-by-experience, and novice nurses, to hospitalized elders with chronic healthcare conditions. *Pac Rim Int J Nurs Res* 2012; 16(4): 343–360.

83. Kane RL, Keckhafer G, Flood S, et al. The effect of Evercare on hospital use. *J Am Geriatr Soc* 2003; 51(10): 1427–1434.

84. Naylor MD, Bowles KH, McCauley KM, et al. High-value transitional care: translation of research into practice. *J Eval Clin Pract* 2013; 19(5): 727–733.

85. Naylor MD, Hill-Milbourne VR, Knoble SR, et al. Community-based care model for high-risk adults with severe disabilities. *Home Health Care Manag Pract* 2007; 19(4): 255–266.

86. Neff DF, Madigan E and Narsavage G. APN-directed transitional home care model: achieving positive outcomes for patients with COPD. *Home Healthc Nurse* 2003; 21(8): 543–550.

87. Noble AJ, McCrone P, Seed PT, et al. Clinical- and cost-effectiveness of a nurse led self-management intervention to reduce emergency visits by people with epilepsy. *PLoS ONE* 2014; 9(6): e90789.

88. Poole PJ, Chase B, Frankel A, et al. Case management may reduce length of hospital stay in patients with recurrent admissions for chronic obstructive pulmonary disease. *Respirology* 2001; 6(1): 37–42.

89. Reynolds H, Wilson-Barnett J and Richardson G. Evaluation of the role of the Parkinson’s disease nurse specialist. *Int J Nurs Stud* 2000; 37(4): 337–349.

90. Hall MH, Esposito RA, Pekmezaris R, et al. Cardiac surgery nurse practitioner home visits prevent coronary artery bypass graft readmissions. *Ann Thorac Surg* 2014; 97(5): 1488–1493; discussion 93–95.

91. Lukas L, Foltz C and Paxton H. Hospital outcomes for a home-based palliative medicine consulting service. *J Palliat Med* 2013; 16(2): 179–184.

92. Pandian V, Maragos C, Turner L, et al. Model for best practice: nurse practitioner facilitated percutaneous tracheostomy service. *ORL Head Neck Nurs* 2011; 29(2): 8–15.

93. Park HK, Branch LG, Bulat T, et al. Influence of a transitional care clinic on subsequent 30-day hospitalizations and emergency department visits in individuals discharged from a skilled nursing facility. *J Am Geriatr Soc* 2013; 61(1): 137–142.

94. Skinner H, Skoyles J, Redfearn S, et al. Advanced care nurse practitioners can safely provide sole resident cover for level three patients: impact on outcomes, cost and work patterns in a cardiac surgery programme. *Eur J Cardiothorac Surg* 2013; 43(1): 19–22.

95. Meyer SC and Miers LJ. Cardiovascular surgeon and acute care nurse practitioner: collaboration on postoperative outcomes. *AACN Clin Issues* 2005; 16(2):149–158.

96. Neal CP, Garcia GG and Sutton CD. The role of the nutrition clinical nurse specialist in reducing the incidence of catheter-related sepsis. *Br J Intensive Care* 2007; 17(2): 62–65.

97. Smith M and Irving JB. Managing heart failure in the community; role of the nurse specialist. *Health Bull* 2001; 59(5): 340–342.

98. Alfakih K, Melville M, Nainby J, et al. Nurse specialist-led management of acute coronary syndromes. *Br J Cardiol* 2009; 16(3): 132–134.

99. CravenO, Hughes CA, Burton A, et al. Is a nurse-led telephone intervention a viable alternative to nurse-led home care and standard care for patients receiving oral capetabinate? Results from a large prospective audit in patients with colorectal cancer. *Eur J Cancer Care* 2013; 22(3): 413–419.

100. Henrick A. Cost-effective outpatient management of persons with heart failure. *Prog Cardiovasc Nurs* 2001; 16(2): 50–56.

101. Prasad S, Dunn W, Hillier LM, et al. Rural geriatric glue: a component of integrated treatment within the continuum of care (134th session of the World Health Assembly, Strengthening of palliative care from diagnosis to death. *BMJ* 2017; 356: j878.

102. World Health Assembly. *Strengthening of palliative care as a component of integrated treatment within the continuum of care* (134th session of the World Health Assembly, EB134.R7 May 2014). *WHO*, 2014, http://apps.who.int/ gb/ebwha/pdf_files/EB134/B134_R7-en.pdf

103. Temel JS, Greer JA, Muziaknsky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med* 2010; 363(8): 733–742.