

2018

Educating Health Care Professionals to Improve Communication in Advance Care Planning

Laura E. Clubb

Follow this and additional works at: https://scholarworks.umass.edu/nursing_dnp_capstone



Part of the [Medical Education Commons](#), [Nursing Commons](#), and the [Palliative Care Commons](#)

Clubb, Laura E., "Educating Health Care Professionals to Improve Communication in Advance Care Planning" (2018). *Doctor of Nursing Practice (DNP) Projects*. 157.

Retrieved from https://scholarworks.umass.edu/nursing_dnp_capstone/157

This Open Access is brought to you for free and open access by the College of Nursing at ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctor of Nursing Practice (DNP) Projects by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact scholarworks@library.umass.edu.

Educating Health Care Professionals to Improve Communication in Advance Care Planning

Laura Clubb

University of Massachusetts, Amherst

College of Nursing

DNP Capstone Chair: Clare Lamontagne PhD, RN

DNP Project Mentor: Janice Peterson, DNP, FNP, BC

Date of Submission: April 4, 2018

Table of Contents

Abstract.....	4
Introduction	5
Background.....	6
Problem Statement.....	7
Organizational “Gap” analysis of project site.....	7
Literature Review	9
Level of Evidence.....	13
Evidence Based Practice: Verification of Chosen Option.....	13
Theoretical Framework/Evidence Based Practice Model.....	13
Goals, Objectives & Expected Outcomes.....	14
Project Design	15
Project Site and Population.....	15
Setting Facilitators and Barriers.....	16
Implementation Plan/Procedures	17
Measurement Instruments.....	17
Data Collection Procedure.....	18
Data Analysis.....	18
Results.....	18

Interpretation/Discussion.....22

Cost-Benefit Analysis/Budget.....24

Ethical Considerations/Protection of Human Subjects24

Conclusion.....25

References.....26

Appendix.....29

 Appendix A (Comskil Model)29

 Appendix B (Sample Communication Tool)30

 Appendix C (Pre-Intervention Survey)31

 Appendix D (Post-Intervention Survey)32

 Appendix E (Cost Breakdown)33

Abstract

Advanced care planning (ACP) is the planning that individuals undergo to ensure their wishes are respected as they approach the end of life. This can include filling out legal or medical documents that specify desired life-saving interventions. Effective advanced care planning also entails ongoing proactive conversations with family members and health care providers about end of life choices. Health care professionals are in a unique position to educate patients about their choices and the consequences. However, a review of literature indicates that these conversations do not happen as often as they should due to many factors, including a lack of knowledge and comfort on the part of providers. Both patients and health care providers need education to understand this complicated topic. Recent research has indicated that educational interventions for health care providers can increase participation in ACP. This paper will outline the scope of the problem and present a capstone project in a Doctor of Nursing program. The capstone project focused on conducting an educational seminar for healthcare staff to enable providers to facilitate discussions about ACP with their patients and families.

Keywords: advanced directives, advance care planning, end of life, communication

Introduction

Advanced care planning (ACP) describes the planning individuals undergo to ensure they receive the medical care they want in the event they cannot make decisions for themselves. ACP is very important as many patients become very ill at the end of their lives and may not be able to make these important decisions on their own behalf. ACP can take many forms and may include advanced directives (ADs) (Institute of Medicine [IOM], 2014). ADs are legal documents and may include living wills or the adoption of a health care proxy or power of attorney (IOM, 2014). ACP may also include structured medical documents, such as the Physician Order for Life Sustaining Treatment (POLST), which is reviewed in detail with the patient by the provider (IOM, 2014). Without prior documentation of the patient's wishes, healthcare providers do not know how aggressive the patient wants his/her care to be when death is a possibility. This decision is usually deferred to the patient's family, whose members may not know what their loved one's preferences are. They may choose to "do everything", but when a patient is gravely ill, this usually means uncomfortable treatments and being away from home for an extended period (IOM, 2014). Additionally, the long-term implications of choosing aggressive treatment, which may require a long-term ventilator or feeding tube, may not be discussed (IOM, 2014).

Making the decision to limit life-extending treatments requires significant prospective consideration from patients and their families, as well as ongoing conversations when a patient is well, as a patient's preferences may change over time. Health care professionals (HCPs) should be prepared to discuss ACP and patient preferences to facilitate the decision-making process, but this does not always happen, due to time, knowledge, and comfort barriers (IOM, 2014).

Background

It is difficult to determine exactly how many adults have participated in ACP. One national survey indicates that as few as 26% of adults in the United States have completed some type of ACP (Rao, Anderson, Lin, & Laux, 2014). In this survey, adults indicated that a lack of awareness was the biggest reason why they had not formalized ACP planning (Rao et al., 2014). Completion of ACP was positively correlated with older age, being white, more education, higher income, the presence of a chronic disease, and a place to receive routine care (Rao et al., 2014). In this same study, over 75% of respondents stated they would most likely want to talk with their doctor about these issues if they were seriously ill, but 90% indicated their doctor had never asked them about their wishes (Rao et al., 2014).

Primary care professionals (PCPs) are in a unique position to care for patients with serious illnesses before they are admitted to a hospital. PCPs often know their patients, families, and preferences, and have developed trusting relationships with their patients. These relationships are key when considering discussions about goals of care at the end of life. PCPs can coordinate patient and family centered care across multiple disciplines. PCPs also promote continuity of care, which is important when a patient is faced with a chronic, life threatening illness (Institute of Medicine [IOM], 2014). PCPs may also refer their patients to palliative care or hospice services if a patient chooses this option. Time and lack of resources are major barriers to these complicated conversations occurring in the primary care setting (IOM, 2014).

The IOM (2014) recognized efforts that medical schools and healthcare facilities have made to increase provider training on this topic. However, the IOM (2014) also identified three major impediments in effective ACP: curriculum deficits, lack of inter-professional collaboration, and neglect of communication skills. The IOM (2014) recommended that all

healthcare providers who have contact with patients, including doctors, advanced providers, nurses, social workers, and chaplains receive training on communication skills in end of life conversations. The IOM (2014) outlined literature that indicated that communication skills can be taught, but there is certainly a need for more training. Additionally, other research suggests that the use of structured communication tools may increase the frequency of end of life discussions and may increase the effectiveness of these conversations by focusing on the patients' goals of care (Oczkowski et al., 2016).

Problem Statement

There is a risk of inadequate communication regarding end of life issues among well and chronically ill individuals as indicated by high costs and invasive treatments that often occur at the end of life. This results partly from ineffective ACP by both patients and HCPs. Lack of knowledge, time, and comfort contribute to this deficit. This quality improvement project addressed this issue by providing education for providers which included a structured communication tool to guide ACP.

Organizational “Gap Analysis” of Project Site

This quality improvement (QI) project took place in a community setting in Western Massachusetts. This area is considered underserved in the primary care arena by the U.S. Government (Health Resources and Services Administration, 2017) Nineteen percent of the population in this area is over the age of 65, and 95% of the population is white (United States Census, 2017). The median household income in 2015 was \$55,221, with 12% of total persons considered impoverished (United States Census, 2017).

There are five primary care offices within a ten-mile radius of the project site, as well as a community hospital with 89 inpatient beds. These facilities employ over 500 health care workers, including doctors, nurses, advanced practice providers, medical assistants, and social workers. These HCPs have a wide range of experience, from brand new providers to expert practitioners.

Several practice gaps exist in primary care practice regarding ACP. The first practice gap is infrequent conversations about ACP. The best practice is incorporating conversations about ACP into well visits with all patients (IOM, 2014). These conversations often only occur when a patient is diagnosed with a terminal or life limiting illness, or after multiple hospital admissions (M.Killough, personal communication, December 9, 2016). Providing education for HCPs on the best practices may help to close this gap. Additionally, patients could be pre-screened prior to well visits to identify those who desire more information on ACP. A major barrier to discussing ACP in most settings is a lack of time in busy primary care environments (IOM, 2014; L. Appel, personal communication, July 28, 2017). Patients and providers often have more pressing issues to address. Additionally, providers often think these conversations do not need to happen until a patient is diagnosed with a chronic or life-threatening illness (Greuttman et al., 2015; IOM, 2014; L. Appel, personal communication, July 28, 2017).

Another best practice is that these conversations about ACP should span over multiple visits, as patient preferences may change (IOM, 2014; V.Paramasivam, personal communication, February 24, 2017). In reality, these conversations are often brief and use language or phrases that patients may not understand. This is often due to a lack of time or low health literacy about which a provider may not be aware (IOM, 2014; M. Killough, personal communication, December 9, 2016).

Another best practice is incorporating a structured communication tool to help guide conversations to address all relevant points (Oczkowski et al., 2016). This is not done in the selected setting (Dr. Diane Dietzen, personal communication, July 7, 2017). Providers usually use their own style to address these issues, which may not address all key points of end of life preferences. Again, this is often due to lack of time and more urgent patient care issues. Experienced providers may not feel the need to use a structured communication tool (V. Paramasivam, personal communication, February 24, 2017). New providers may not be aware that structured communication tools can promote efficient communication in a time limited setting (L. Appel, personal communication, July 28, 2017). Key stakeholders in the selected setting agree that communication styles of HCPs widely vary and may not always be effective.

The last potential best practice gap is that patients often do not receive information about palliative care or hospice until they have had multiple readmissions for their chronic conditions (IOM, 2014; V. Paramasivam, personal communication, February 24, 2017). This often occurs from a lack of time to discuss patient preferences, and misperceptions about the usefulness of these important end of life services. Patients are often only referred to palliative care or hospice when providers estimate the end of life is near, but this may not align with patient wishes (IOM, 2014; L. Appel, personal communication, July 28, 2017).

Literature Review

Methods

A review of the literature on ACP and HCP preparation included the following databases: PubMed, Cumulative Index of Nursing and Allied Health Literature, and Google Scholar. All databases were searched for the terms “advance directive” and “education”, “advance care planning”, “advance directives” and “primary care”, and “advance directives”, “communication

tool,” and “communication.” Inclusion criteria were as follows: randomized controlled trials, meta-analyses of quantitative or qualitative research, published within the last five years, and published in the English language. This revealed 34 articles. Articles were excluded if they focused on ACP in highly specific settings such as long-term care or pediatrics. After exclusions, 13 articles were left for review.

Importance of Advance Care Planning

A review of the literature indicates that discussions about ADs and end of life care do not occur as frequently as they should. A recent meta-analysis of studies on the effects of ADs found that DNR status and living wills decreased life-sustaining treatment and increased the usage of palliative care and hospice, both of which have been shown to improve quality of life (Brinkman-Stoppelenberg et al., 2015). Additionally, complex advance care planning interventions that occurred over multiple provider encounters increased compliance with a patient’s end of life wishes (Brinkman-Stoppelenberg et al., 2015).

The Institute of Medicine (IOM, 2014) designated advance care planning (ACP) and end-of-life care as a national health priority. Lack of understanding of ACP by patients, families, and providers may lead to frequent hospital admissions and highly invasive care as a person approaches the end of their life (Meghani & Hinds, 2015). The IOM recommends promoting patient and family centered care by offering palliative care to persons with chronic life limiting conditions, as well as improved communication between patients and providers to discuss ACP (IOM, 2014). The IOM also recommends providing professional education and development so providers are more prepared to initiate these discussions with their patients (IOM, 2014).

Over the past decade, there has been a push for patients to complete the Physician Order for Life Sustaining Treatment (POLST). The POLST addresses areas such as resuscitation status,

desire to have life sustaining treatments such as feeding tubes, artificial hydration, or dialysis. However, some consider POLST forms an inadequate way to determine patient's end of life goals (Vearrier, 2016). Vearrier (2016) recommends that providers take an ongoing, communications-based approach to determining goals of care.

Perceived Barriers to Completion of Advance Care Planning

HCPs identify lack of knowledge and comfort about ACP options as barriers to having these conversations. In one study that included 48 HCP and 200 adult patients who were diagnosed with congenital heart disease, nearly all patients wanted these discussions to occur, regardless of the complexity of their diseases (Greuttman et al., 2015). However, providers cited that they believed patients were not ready for these discussions if their life expectancy was longer than five years (Greuttman et al., 2015). Additionally, providers felt uncomfortable having these discussions if they could not reliably estimate the patient's life expectancy (Greuttman et al., 2015). This study indicates a clear discrepancy between patient's wishes and the actions of the HCP.

Preparing Health Care Providers to discuss Advance Care Planning

Chung et al. (2016) conducted a meta-analysis of randomized controlled trials and observational studies that focused on the effectiveness of educational interventions for medical and NP trainees. Educational interventions on ACPs that included didactic training and interactive workshops were found to increase a HCP's perceived self-efficacy, knowledge, and communication score (Chung et al., 2016).

Another study found that communication skills training, which may include didactic training or role-playing, can increase the communication skills of HCP (Moore, Mercado, Artigues, & Lawrie, 2013). While this research focused on patients who have cancer, another

meta-analysis of research on this topic has found that communication interventions applied within this population can successfully be applied to other groups (Barnes et al., 2012).

Lum, et al. (2014) found that interactive, value-based education for medical students resulted in higher levels of self-reported comfort when these medical students considered initiating ACP conversations with patients. This values-based education encouraged the students to focus on their own wishes, and utilized a structured communication tool to facilitate these conversations (Lum, et al., 2014). *The Conversation Starter* (Institute for Healthcare Improvement, 2017) is a free tool available to all that providers can review with their patients to determine their goals of care.

Oczkowski et al. (2016) performed another meta-analysis of randomized controlled trials and prospective observational studies to determine if the use of structured communication tools can facilitate ACP in outpatient settings. This review found that the use of structured communication tools, such *The Conversation Starter*, increases the frequency of end of life discussions and improves concordance between the care that patients want versus what they actually received (Institute for Healthcare Improvement, 2017; Oczkowski, et al., 2016). Based on these findings, Oczkowski et al. (2016) recommend using structured communication tools during these discussions to guide the conversations and address all relevant topics. These communication tools should be tailored to address individual needs and preferences (Oczkowski, et al., 2016).

Reviewing the current literature on ACP demonstrates that this planning does not happen as often as it should, based on suggested best practices (IOM, 2014). Contributing factors are lack of comfort and knowledge on the part of the HCPs. Research has shown that HCPs feel they need more education on this topic, as well as on priorities of care for people who have chronic

illnesses. Education should focus on the need for ACP, barriers to completion, and options that are available to patients. Additionally, education should focus on communication strategies that HCPs can utilize to facilitate these discussions with their patients. While this process may take time, increasing awareness about this issue will help to promote patient centered care as the population ages.

Level of Evidence

The above articles were evaluated using the John Hopkins Nursing Evidence Based Practice Scale (JHNEP) (Newhouse, Dearholt, Poe, Pugh, and White, 2005). According to the JHNEP (Newhouse, et al., 2005), strength of evidence is rated from level I, which is a randomized controlled trial (RCT) or meta-analysis of RCTs, to level V, which is based on non-research evidence. The JHNEP (Newhouse, et al., 2005) also rates the quality of the evidence on a scale of A, B, and C, with A being high quality and C being low quality. Five of the articles were level I, grade A. Three of the articles discussed were level III, grade A. This high-quality evidence consistently demonstrates a need for improvement in advance care planning.

Evidence Based Practice: Verification of Chosen Option

The above literature review indicates that providing tailored education to health care professions about ACP and how to communicate effectively may increase the frequency of these discussions, and ultimately the ACP completion rate. Additionally, using a structured communication tool to guide these conversations may result in increased concordance between the care a person desires versus the care he or she actually receives.

Theory or Conceptual Framework

The Comskil model was outlined in 2008 by Brown and Bylund (Appendix A). This model focuses on identifying specific areas of training for health care providers, so they can

communicate in a flexible manner (Brown & Bylund, 2008). This model stresses that there are many ways to meet a communication goal (Brown & Bylund, 2008). The core components of this model include identifying communication goals, strategies, and skills, setting process tasks that facilitate adequate communication, and cognitive appraisals which include identifying patient cues and barriers to communication (Brown & Bylund, 2008). Communication skills are taught in modules that include didactic lectures and demonstrated skills using videos (Brown & Bylund, 2008). The Comskil model includes tools for post intervention feedback and assessment (Brown & Bylund, 2008).

Applying this conceptual framework to this QI project provided a framework for health care professionals to adhere to when discussing this topic with patients. HCPs should first identify the goal of these conversations and adapt their communication strategies accordingly. This means that HCPs should evaluate the patient's impression of the conversation and may have to try other communication techniques if their goal is not met. HCPs should also be attuned to patient cues and their own behavioral cues. Additionally, this QI project utilized both didactic lectures and interactive discussion to demonstrate effective communication skills.

Goals/Objectives/Outcomes

The goal and expected outcome of this DNP project was to increase providers' self-reported preparedness and comfort levels by 50% when discussing ACP and end of life wishes with patients. The self-reported skills were measured immediately before and immediately after the intervention. The post-intervention evaluation also included a brief program evaluation questionnaire, which will help to improve the teaching for future use.

Project Design and Methods

Project design

This QI project focused on addressing the educational needs of HCPs related to ACP. The QI project took place in a community setting in Western Massachusetts. The educational intervention consisted of a voluntary workshop to which office or hospital staff were invited via posting of fliers and emails sent through to the local provider practices. Interested HCPs were asked to RSVP prior to the workshop due to space limitations. The workshop consisted of a lecture which covered the importance of the issue and common misperceptions of providers and health care staff. Education also focused on communication skills training techniques. This communication skills training consisted of theoretical scenarios that participants could work through as a group to decide what communication techniques were effective. A structured communication tool was provided as a reference (Appendix B).

Project Site and Population

This project took place in a community setting in Western Massachusetts. This area has five primary care offices, as well as a local community hospital. There is also a local community college, which prepares nurses at the associate degree level. There is also a local hospice and palliative care office, which conducts informational sessions for area residents. There are over 500 healthcare providers working in this area, including physicians, nurse practitioners, physician assistants, nurses, and ancillary staff. There are also local specialty practices such as cardiology, pulmonology, and orthopedics. This DNP student hosted the educational session at the local public library. All local HCPs were invited to attend these sessions through community postings and invitations. Participation was voluntary based on interest of the HCPs. This may

have created a selection bias, as those who participated were likely to be interested in the selected topic, or more open to receiving new information. There were no exclusion criteria except for being over 18 years of age. Participation was limited to 30 HCPs due to space limitations. There were eight participants in total.

The county where this DNP project was completed, is considered underserved in the primary care arena by the U.S. Government (Health Resources and Services Administration, 2017). Increasing discussions about ACP in underserved populations is a goal outlined by the IOM (2014).

The healthcare providers in this area range from novice, or HCPs with less than one year of experience, to seasoned, or providers with greater than ten years of experience. All local HCPs were invited, including those who work in acute care and outpatient settings.

Facilitators and Barriers

This DNP student received an engaged, motivated audience with varying experience with end of life issues and communication techniques. This DNP student anticipated this type of audience since participation was voluntary. The HCPs' schedules created time barriers. The program was hosted in the evening in hopes that HCPs would be free from work at this time. However, HCPs have varying schedules so not everyone who wanted to attend was able to. Additionally, not hosting the project at one site meant that the DNP was solely responsible for promoting the event. Fliers were sent to all local offices but notice of the event may not have reached all interested parties.

Implementation Plan/Procedures

Once the initial project proposal was approved, a date and time was secured at the local public library. The DNP student then sent out fliers to local health care facilities inviting interested HCPs to the event. Fliers were mailed via USPS or hand delivered to the facilities one month before the workshop. Participants were asked to RSVP via e-mail or telephone. The DNP student then prepared a PowerPoint presentation to support the discussion. The presentation included three patient care scenarios for discussion. The DNP student also prepared the pre-and post-tests during this time, as well as a flyer that summarized the workshop topic for participants to take home.

Measurement Instruments

In order to measure the outcomes of this DNP project, attendees were asked to complete brief pre- and post- intervention Likert type surveys that focused on knowledge, level of comfort and perceived self-efficacy when speaking to patients about ADs (Appendices C and D). Likert-type surveys are often used to quantify qualitative data in various fields, as the results can be easily tallied and compared (Lozano, Garcia-Cueto, & Muniz, 2008). These surveys have been shown to be both valid and reliable (Lozano, Garcia-Cueto, & Muniz, 2008). The optimal number of response options in a Likert type survey is between four and seven (Lozano, Garcia-Cueto, & Muniz, 2008).

The DNP student designed the surveys to measure three major themes: frequency of conversations during routine visits as well as visits with chronically ill individuals, self-perceived preparedness to hold these conversations, and comfort levels on the part of the HCP.

The DNP student also requested feedback on the effectiveness of the education in a brief survey, to improve future workshops.

Data Collection Procedures

The invitations for the event clearly stated the goal of this project, and the need for both informed consent and evaluation tools. The pre-intervention survey was administered immediately before the intervention and the post-intervention survey was administered immediately after the intervention. The participants were given approximately ten minutes to complete each survey. The pre- and post-surveys were used to calculate before and after scores for comparison.

Data Analysis

To measure the outcomes of this DNP project, the pre-and post-intervention surveys (Appendices C and D) were compared using descriptive statistics and Excel software. The responses were compared question by question to measure change in participants' perceived capability to facilitate these types of conversations.

Results

A total of eight HCPs attended the educational session. These HCPs were all adults working in healthcare in Franklin County, Massachusetts. Many of the participants had backgrounds in nursing. 75% of the participants reported having previous communication skills training. Most of the attendees (75%) reported that they felt able to communicate in an empathetic way prior to the intervention, but nearly all (88%) reported that inadequate time was a barrier to having these conversations. Other barriers to having these conversations included a lack of awareness about the issue (75%), too many other issues to deal with (63%), patients

perceived as too young (50%), patients’ denial about their health condition (38%), and lack of trust in the healthcare system (13%).

The participants were asked how often they hold conversations about ACP at routine encounters with patients. Prior to the intervention, 38% reported inquiring about this topic less than 50% of the time or never, 50% reported inquiring about this topic more than half the time but not always, and 12% reported to always ask about this issue. After the intervention, 75% of participants reported that they will ask patients about ACP issues at least half of the time, and 12% reported that they will always ask at routine visits (Figure 1).

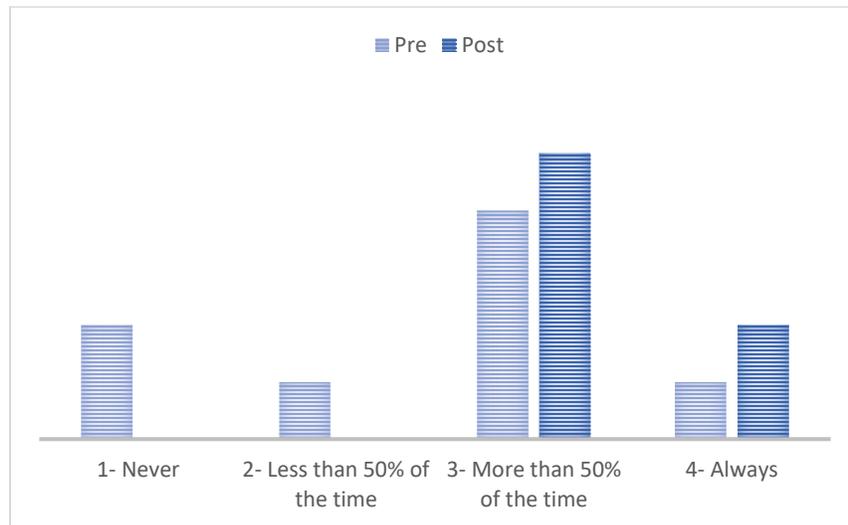


Figure 1. Frequency of conversations about advance care planning during routine visits. This figure represents the participants’ reports of how often they hold conversations with patients about ACP currently versus how often they plan to after the intervention.

Another question for the participants was how often they asked patients with a chronic or life-threatening illness about ACP or palliative care and hospice. Before the intervention, 38% of participants reported that they asked patients less than half of the time. After the intervention, only 12% reported that they would ask less than half the time. After the intervention, 88% of

participants planned to ask patients at least half the time or always, with about 60% of these planning to ask at every encounter (Figure 2).

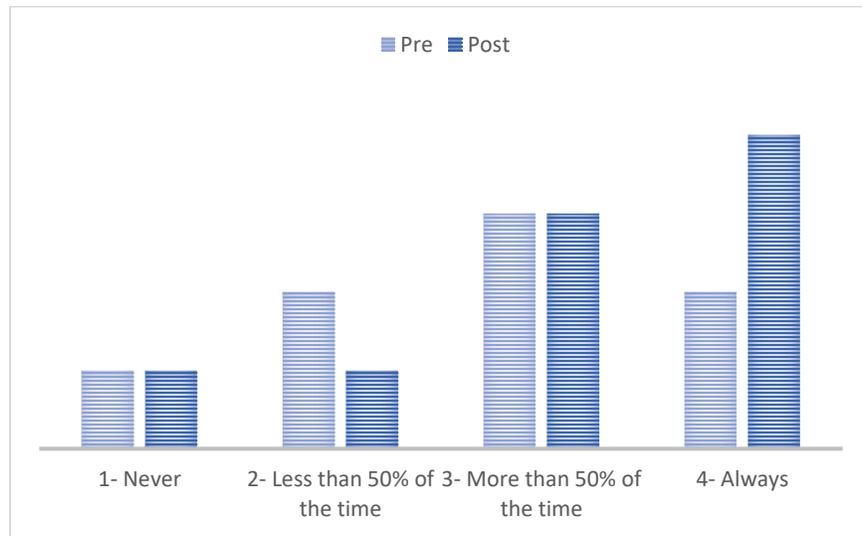


Figure 2. Frequency of conversations about ACP with patients with chronic or life-threatening illnesses. This figure represents the participants’ reports of how often they currently address these topics within this population, versus how often they plan to address the topic after the intervention.

One goal of this QI project was to improve participants’ self-perceived preparedness for holding conversations about ACP. This topic was measured before and after the intervention (Figure 3). Prior to the intervention, 50% of participants reported feeling only somewhat or not at all prepared, while the other 50% reported feeling mostly or very prepared. After the intervention, only one person (12%) reported feeling only somewhat prepared, while the rest reported feeling mostly or very prepared to hold these conversations with patients.

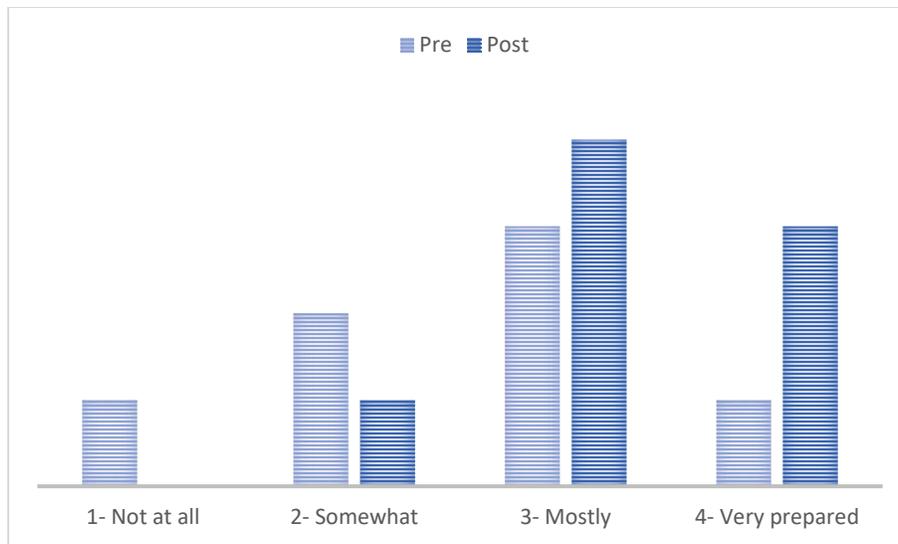


Figure 3. Self-perceived preparedness for ACP discussions. This figure represents the change in participants' responses before and after the intervention.

Another goal of this QI project was to improve participants' comfort levels when discussing these matters with their patients. This topic was also measured before and after the intervention (see Figure 4). Before the intervention, 50% of participants reported feeling not at all or somewhat comfortable when talking with patients about this issue. After the intervention, nearly all (87%) of participants reported feeling mostly or very comfortable when considering holding these conversations with patients.

Lastly, the DNP student provided a structured communication tool for participants (Appendix B). The participants were asked how often they will use the communication tool that was provided in addition to the skills taught. Nearly all participants (87%) anticipated that they would use the skills and the tool itself in future encounters with patients. The one participant who reported being less likely to use the tool and skills also noted that lack of time was still a major factor.

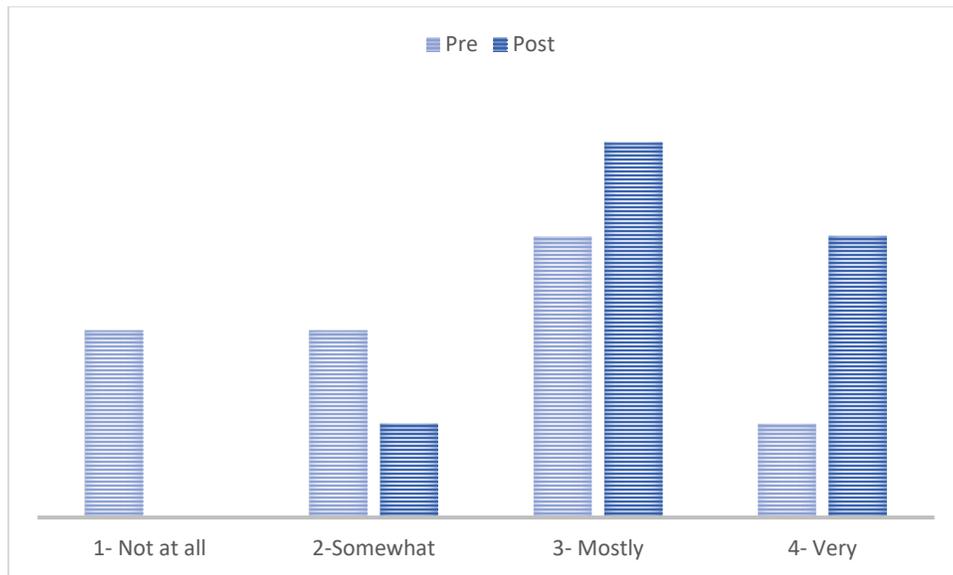


Figure 4. Health care professional comfort levels about advance care planning discussions. This figure demonstrates the improvement in the participants' comfort levels about the topic after the intervention.

Interpretation/Discussion

The intervention proved to be effective in improving HCP's reported levels of comfort and preparedness to hold these conversations with their patients, at least in the selected population. Additionally, most professionals reported that they were more likely to bring up the topic of ACP with their patients, especially patients with chronic or life-threatening illnesses, after the intervention.

While the goal of the presentation was to improve HCPs' self-perceived preparedness and comfort levels by at least 50%, the DNP student did not anticipate that some of the audience already had significant experiences in end of life issues. This likely played a role in not reaching the goal of 50% improvement in these concepts.

It is not clear what exactly was most effective for improving these self-reported measures. Other research suggests that a combination of lecture, discussion, and theoretical scenarios help to improve a HCP's self-perceived efficacy in this patient care matter (Chung et al., 2016; Lum, et al., 2014). The findings of this QI project corroborate this premise and suggest that a combination of educational techniques as well as interaction with other professionals is helpful.

However, a sample size of eight participants does not allow generalization to other populations. This DNP student notes that her participants were engaged and interested in the topic. All participants had some experience with end of life and advance care planning issues.

The DNP student also notes that recruiting for the intervention was difficult. The invitation may not have reached all interested parties, and this was reflected in the small sample size. There was no incentive for attending the seminar aside from personal knowledge gain. In the future, the DNP student may rely on more electronic communications or social media to reach interested parties in addition to posting fliers. However, this may further promote a selection bias.

Lastly, the nature of the educational session, where open discussion was encouraged, also extended the time of the presentation beyond the DNP student's prediction. In the selected setting and population this was not an issue, but more time will be allotted in future sessions to allow for thorough discussions.

The DNP student suggests that future interventions continue to focus on varied educational interventions for HCPs. Recruitment efforts should reach as many individuals as possible. It may be helpful to hold the sessions on multiple dates to accommodate time-limited

schedules. Additionally, offering incentives such as continuing education credits may increase the number of HCPs who attend.

Cost-Benefit Analysis/Budget

Most of the cost involved in this project was time on behalf of the DNP student. The educational session was conducted over one and a half hours. The cost to rent the library community room was \$30, and this included the use of a projector. The DNP student also printed paper versions of the pre-and post-intervention surveys, as well as a take home reference booklet, which cost approximately \$100 (Appendix E). This DNP student hopes that increasing discussions about ACP will save the health care systems thousands of dollars by providing ill patients with less aggressive treatment options. The DNP student also hopes that improved communication about this topic will promote quality of life in ill patients, for which the price cannot be measured.

Ethical Considerations/Human Subjects Protection

The DNP student obtained approval from the university's Institutional Review Board (IRB) prior to initiating the DNP project. The IRB required the DNP student to obtain informed consent from all participants. This requirement was clearly stated on the community fliers, and participants signed informed consent forms immediately prior to the intervention. The DNP student carefully followed the Standards of Practice and confidentiality procedures at the participating organization. No personal information was collected. Any electronic communication between potential participants and the DNP student was deleted. The surveys were nameless. Completed surveys and informed consent are kept in a locked cabinet within the DNP student's personal office space.

Given the nature of this topic, some professionals may have their own notions about quality of life and end of life care. However, the DNP student took care to ensure that the education focused on facilitating the patient's wishes in a non-judgmental matter.

Conclusion

Despite current recommendations that AD planning be incorporated into well patient visits, this often does not happen due to lack of time and provider comfort. While increasing patient's awareness of their options is also key, this capstone project focused on increasing provider knowledge and abilities to facilitate these conversations. The educational interventions that included didactic teaching, presentation of hypothetical scenarios, and discussion improved the participants' self-reported preparedness and comfort levels as they consider facilitating these discussions with their patients. Additionally, providing a structured communication tool may be helpful to guide these conversations. While time will always be a major limiting factor in any patient care scenario, preparing health care professionals to have these conversations may promote efficiency, and ultimately patient satisfaction with care.

References

- Barnes, S., Gardiner, C., Gott, M., Payne, S., Chady, B., Small, N., Seamark, D., & Halpin, D. (2012). Enhancing patient-professional communication about end of life issues in life limiting conditions: A critical review of the literature. *Journal of Pain and Symptom Management, 44*(6), 866-879.
- Booth, A.T., & Lehna, C. (2016). Advanced directives and advanced care planning for healthcare professionals. *Kentucky Nurse, 64*(2), 7-10.
- Brinkman-Stoppelenberg, A., Rietjens, J.C., & van der Heide, A. (2015). The effects of advance care planning on end of life care: A systematic review. *Palliative Medicine, 29*(8), 1000-1025.
- Brown, R.F., & Bylund, C.L. (2008). Communication skills training: Describing a new conceptual model. *Academic Medicine, 83*(1), 37-44.
- Clayton, J.M., Butow, P.N., Waters, A., Laidsaar-Powell, R.C., O'Brien, A., Boyle, F., ... & Tattersall, M.H.N. (2012). Evaluation of a novel individualized communication skills training intervention to improve doctors' confidence and skills in end-of-life communication. *Palliative Medicine, 27*(3), 236-243.
- Chung, H.O., Oczkowski, S.J., Hanvey, L., Mbuagbaw, L., & You, J.J. (2016). Educational interventions to train healthcare professions in end of life communication: a systematic review and meta-analysis. *Biomedicine Central Medical Education, 16*, (131).
- Health Resources & Services Administration. (2017). Data Warehouse: HPSA Find Results. <http://datawarehouse.hrsa.gov/tools/analyzers/Hpsafindresults.aspx>

Institute for Healthcare Improvement. (2017). *Your Conversation Starter Kit*. Retrieved from <http://theconversationproject.org/wp-content/uploads/2017/02/ConversationProject-ConvoStarterKit-English.pdf>.

Institute of Medicine. (2014). Dying in America: Improving quality and honoring individual preferences near the end of life. *National Academy of Sciences*.

Lozano, L.M., Garcia-Cueto, E., & Muniz, Jose. (2008). Effect of the Number of Response Categories on the Reliability and Validity of Rating Scales. *Methodology*, 4, 73-79.

Lum, H.D., Dukes, J., Church, S., Abbott, J., & Youngwerth, J.M. (2014). Teaching medical students about “The Conversation”: An interactive value-based advance care planning session. *American Journal of Hospice & Palliative Medicine*. Advanced online publication. doi: [10.1177/1049909117696245](https://doi.org/10.1177/1049909117696245).

Meghani, S.H., & Hinds, P.S. (2015). Policy brief: The Institute of Medicine report *Dying in America: Improving quality and honoring individual preferences near the end of life*. *Nursing Outlook*, 63, 51-59.

Moore, P.M., Mercado, R.S., Artigues, M., & Lawrie, T.A. (2013). Communication skills training for healthcare providers working with people who have cancer (Review). *Cochrane Database of Systematic Reviews*, 3.

Oczkowski, S.J., Chung, H.O, Hanvey, L., Mbuagbaw, L., & You, J.J. (2016). Communication tools for end-of-life decision making in ambulatory care settings: A systematic review and meta-analysis. *PLoSOne*, 11(4).

Rao, J.K., Anderson, L.A., Lin, F.C., & Laux, J.P. (2014). Completion of advance directives among U.S. Consumers. *American Journal of Preventative medicine*, 46(1), 65-70.

Snyder, S., Hazelett, S., Allen, K., & Radwany, S. (2013). Physician knowledge, attitude, and experience with advance care planning, palliative care, and hospice: Results of a primary care survey. *American Journal of Hospice and Palliative Care*, 30(5), 419-424.

Vearrier, L. (2016). Failure of the current advanced directive planning paradigm: Advocating for a communications-based approach. *HEC Forum*, 28(4), 339-354.

United States Census Bureau. (2017). QuickFacts: Franklin County, Massachusetts.

<https://census.gov/quickfacts/table/PST045215/25011>.

Appendix A

Comskil Communication Model



Appendix A. Visual representation of the Comskil Model communication skills training.

Reprinted from "Communication skills training: Describing a new conceptual model," by R.F.

Brown and C.L. Bylund, 2008, *Academic Medicine*, 83(1), p.40. Reprinted with permission.

Appendix B**Sample Communication Tool**

1) Prepare for discussion (diagnosis, prognosis, cultural factors)
2) Empathetic or compassionate interaction ASAP
3) Evaluate patient's non-verbal communication and cues throughout discussion
4) Explore patient's understanding of condition, treatment plan and prognosis. Evaluate individual goals and quality of life measures.
5) Simplify options, including less aggressive measures
6) Use plain language
7) Provide information in small chunks, no more than three facts or new information before checking in with patient or family
8) Evaluate understanding of information
9) Explore emotions
10) Offer continual support and appropriate referrals
11) Encourage questions
12) Document conversation
13) Follow up at next visit

Clayton et al., 2012.

Appendix C

Pre-Intervention Survey Tool

Have you had any previous communication skills training?			
1- Yes		No	
How often do you include palliative care, comfort care, or DNR via MOLST as treatment options to a patient with a chronic, life threatening illness?			
1- Never	2- Less than 50% of the time	3- More than 50% of the time	4- Always
How often do you ask patients about advance care planning during a routine visit?			
1- Never	2- Less than 50% of the time	3- More than 50% of the time	4- Always
How prepared do you feel when answering questions about end of life care and advance care planning?			
1- Not at all	2- Somewhat	3- Mostly	4- Very prepared
How comfortable do you feel exploring patients' fears, feelings, and priorities about approaching the end of their lives?			
1- Not at all	2- Somewhat	3- Mostly	4- Very comfortable
Do you think you are able to communicate effectively in an empathetic way when discussing advance care planning and end of life care?			
1- Yes		2- No	
What are barriers to completion of advance care planning? (Mark all that apply)			
1- Time	2- Lack of awareness	3- Too many other issues to deal with	4- Lack of trust in healthcare
5- Too young	6- Denial		

Appendix D

Post-Intervention Survey Tool

How often will you elicit conversations about advance care planning and end of life care at routine visits?			
1- Never	2- Less than 50% of the time	3- More than 50% of the time	4- Always
How prepared do you feel when answering questions about end of life care and advance care planning?			
1- Not at all	2- Somewhat	3- Mostly	4- Very prepared
How often will you include palliative care, comfort care, or DNR via MOLST as treatment options to a patient with a chronic, life threatening illness?			
1- Never	2- Less than 50% of the time	3- More than 50% of the time	4- Always
How comfortable do you feel exploring patients' fears, feelings, and priorities about approaching the end of their lives?			
1- Not at all	2- Somewhat	3- Mostly	4- Very comfortable
How often will you use these communication skills to hold empathetic discussions with your patients?			
1- Never	2- Less than 50% of the time	3- More than 50% of the time	4- Always

Feel free to offer any other feedback on this presentation in the space below.

Appendix E**Cost Breakdown**

	Cost
Recruitment	
<i>Paper Postings</i>	\$25
Reference Materials	
<i>Take home booklet</i>	\$25
Evaluation Materials	\$50
Space Rental	\$30
Total	\$130