

Research Article

Educational Intervention Increases Primary Care Providers' Comfort in Discussing Advance Care Planning

Margaret Nolan DNP, GNP-C, Clinical Assistant Professor*

Department of Nursing, NYU College of Nursing, USA

***Corresponding author:** Margaret Nolan, Department of Nursing, NYU College of Nursing, USA, 3636 Greystone Ave 5E, Bronx, NY, 10463, USA, Email: Margaret.nolan3636@gmail.com

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Abstract

Background: Advances in medicine have made end-of-life difficult for older adults without prior advance care planning (ACP). Benefits of ACP include decreasing family stress, allowing death with dignity and cost saving at end of life. Despite the benefits, less than a third of the population has ACP. Older adults want their primary care provider to initiate conversations on ACP. Primary care providers rate their own comfort level with ACP discussions as low. The purpose of this project was to increase primary health care providers' including Physicians, Nurse Practitioners, and Physician Assistants (PCP) comfort in discussing ACP with their older adult patients.

Method: An 8 step educational intervention on best practice for discussing ACP using the Medical Orders for Life Sustaining Treatment (MOLST) Model was conducted in PCP's offices.

A convenience sample of 64 primary care providers (PCP) from NYC who care for patients over 65 years of age were surveyed using a descriptive repeated measures design. The pre and posttest instrument is a Communication Strategy Questionnaire for ACP that uses an 14-item Likert scale, with scores ranging from 14-56, measuring comfort in discussing ACP.

Results: The MOLST intervention significantly improved comfort in discussing ACP for PCP with their patients ($p < 0.001$).

Conclusion: A simple 8-step educational intervention demonstrates significant improved comfort level amongst PCPs when discussing end-of-life preferences with patients. Primary care providers can make an impact on older adult's end-of-life by discussing advance care planning.

Keywords: Advance care planning; End-of-life; Communication; Older patients; MOSLT

Introduction

There is a trend to attempt to limit the high cost end-of-life care as the population of older adults continues to rise. The larger concern must be the quality of life at the end of life. Advance care planning (ACP) has been shown to have a profound impact on assisting individuals to be in control of their care at the end of their lives. ACP can help delineate treatment goals, decrease cost at end of life, and assist individuals and their families during a very stressful time [1]. Most important, ACP can assist individuals in experiencing a more peaceful death with dignity.

ACP provides an individual with the opportunity to make end-of-life decisions even if they later become unable to make their wishes known. ACP is not limited to a do not resuscitate, or DNR decision. It consists of a 'Health Care Proxy and/or a Living Will'. A Health Care Proxy appoints another person to make medical decisions if the patient becomes unable to make or express those decisions. The Living Will discusses specific treatment decisions should the patient become critically ill. A person can have a Health Care Proxy, a Living Will, or both [1]. Older adults are waiting for guidance from their primary health care providers, e.g. physicians, advanced practice nurses and physician assistants [2]. Primary care providers have reported feeling

unprepared to have end-of-life conversations with their patients [3] and have asked for assistance in developing better communication skills in regard to end-of-life issues and ACP.

The purpose of this study was to develop an educational method to increase primary care providers' comfort in discussing ACP with their older adult patients. Increasing providers' comfort may help them initiate and conduct ACP conversations, and older adults are more likely to complete ACP when discussions have been initiated by their health care providers during routine office visits [2].

Background

The Patient Self Determination Act (PSDA) of 1991 transferred decision making from health care providers to responsible family members and patients [4]. The PSDA emphasizes the need for counseling patients about ACP [1,5]. When the PSDA was passed, 75% of Americans said they supported it, yet only 20% had any form of ACP. Recent studies show little improvement and it is estimated that less than a third of the population have ACP today [6]. The New York City Department of Health and Mental Hygiene have stressed the need for health care providers to address ACP with all patients and document their wishes [1].

By 2030, the United States will see a substantial increase in the

number adults over 65, to 71.5 million people [7]. In 2000, the federal government spent a little over one-third of its budget, or 615 billion dollars, on services for people over 65 [8]. By the end of 2010, it is anticipated that one half of the total federal budget will be spent on this group. Federal healthcare expenditures such as Medicare and Medicaid have risen to over \$800 billion, from \$1,600 per person in 1994 to \$2,650 per person in 2008 [8].

The health care cost burden on the states has increased from \$190 billion in 1994 to \$300 billion in 2008 and is projected to continue to rise [9]. Medicare, the largest health insurance plan, is influencing end-of-life care because of the number of its members who die each year [8]. According to one estimate, Medicare spends 10-12% of its total budget on end-of-life care, and more is spent in the last year of life than any other year [8].

Patients with ACP have significantly decreased health care expenditures at end-of-life. Decreasing the number of days spent in the hospital by even one day can decrease Medicare costs by billions of dollars [10]. While PSDA has required hospitals, nursing homes, and other health care institutions to provide information about ACP upon admission to the facility, it has excluded doctors and other health care providers from the process [11]. The most common practice puts the focus of ACP at transitions in health care. Patients are transferred to acute care setting in crisis and families and individuals are then asked to make their wishes known regarding end-of-life [12].

Patient issues

The PSDA has made goals of care the patient's choice, not the health care provider's. But, if a family or individual comes in contact with ACP for the first time during a critical illness or event, the PSDA can create dilemmas and cause stress and conflict among family members [4].

Many factors, such as cultural beliefs, religious beliefs, family beliefs and patients not being asked about end-of-life during routine care all complicate these choices. Therefore, an integral component of collaborative care planning is an understanding of personal, ethnic and cultural values that underpin an individual's medical decision making, although little research has focused on this aspect [13]. Further, an integrative review of healthcare professional's knowledge, attitudes and behaviours in relation to capacity and consent issues identified widely inconsistent practices and decision-making as a result of their socio-cultural, religious and demographic characteristics [14]. Having ACP has been found to have a positive impact on families by decreasing family disagreements, reducing guilt and avoiding costly medical expenses borne by the family [15].

Many reasons are cited in the literature for why patients are not completing ACP. These include procrastination, cultural differences, denying death and superstition. Others feel that ACP is costly to prepare, that their families will deal with it for them and that their health care providers will make the decisions for them when the time comes [6].

While conversations with physicians have been helpful for patients in the completion of ACP, patients report that health care providers are not initiating these conversations [16]. ACP can become the opportunity for patients, families and their health care providers to think prospectively and plan for end-of-life [1]. ACP is important

for all patients, and is best addressed when the person is healthy and competent. Ideally end-of-life should be discussed with older adults when they are in relatively good health in a non-threatening manner [17]. While patients may not be eager to discuss ACP their reluctance might be overcome by sensitive, appropriate discussions from their health care providers. Patients want their health care providers to be better communicators [2].

Provider issues

The health care provider has an important responsibility in preparing patients and their families in making difficult decisions, helping them understand prognosis and working in a partnership to develop a sound and ethical treatment plan based on the patient's prognosis, value and preferences [18]. Having conversations with patients about end-of-life wishes has been shown to decrease cost at end-of-life [19]. In a study by Billings [20], only physicians with increased clinical experience providing end-of-life care reported an increase in self-perceived competence.

Health care providers are not routinely addressing prognosis, dying and spirituality [21]. Many health care providers rate their communications skills training as inadequate. Issues cited by providers include deficiencies in education [22], time constraints in office visits [23], feeling the patient should bring up the topic first [24], lack of familiarity with ACP tools and paperwork and lack of compensation [23]. Medical education tends to place more emphasis on skills and higher technical abilities and less on communication skills [22]. Some providers deliberately withhold information to preserve hope [21]. Paternalistic roles for health care providers used to be the norm, and patient-directed care is a deviation from that older norm [25]. However, the integrative review by Lamont et al [32] could not determine to what extent autonomous patients, in control of their own health care decisions, had in fact replaced paternalistic health care and the culture of deference once shown to healthcare professionals.

There is limited literature demonstrating improved competencies in communication among health care providers, and there is increased interest in enhancing physician communication [26]. Despite widespread endorsement of competency-based assessment of practicing physicians, methods for identifying those competencies and strategies for remediation of the deficiencies are not standardized [3]. It is unclear how lack of competence should be addressed, and in this way it lags behind other areas of education in development of strategies for remediation [3].

Preparation for practice requires a careful balance between autonomy and supervision [27]. Individuals vary in the way in which they learn and the different learning styles should be addressed [26]. Continuing education must be available in a safe and confidential environment to enhance the educational experience and increase confidence in ACP conversations with patients [28].

Method

Sample and setting

The convenience sample of sixty-four primary care providers (PCPs) who work in the New York City area and care for patients over 65 years of age was recruited by letters of invitation sent to 350 PCPs. The PCPs were identified using the phone book and the Internet using

Appendix A

Communication Strategy related to End-of-life decisions	Confident: I don't need to improve	Confident: but I believe I need to improve	Not very confident: believe I need to improve	Not very confident: not a priority to improve
1. Explaining end-of-life treatment options to your patient in a manner that ensures a high level of understanding by your patient.	1	2	3	4
2. Helping your patient cope with their worries regarding end of life decisions by explaining the current medical problem that facilitates coping.	1	2	3	4
3. Explaining the possible benefits and risks to your patient or recommended tests, procedures, medication. regarding end-of-life decisions	1	2	3	4
4. Offering your patient specific advice to resolve common health problems at the end of life.	1	2	3	4
5. Identifying and pursuing verbal cues given by your patient	1	2	3	4
6. Identifying and pursuing non-verbal cues given by your patient.	1	2	3	4
7. Communicating effectively with your more difficult patients about end of life care planning.	1	2	3	4
8. Actively involving your patient in the process of making treatment-related decisions.	1	2	3	4
9. Expressing your concerns and preferences about possible treatment options to your patient.	1	2	3	4
10. Discussing alternative or complimentary therapies with your patient.	1	2	3	4
11. Securing the patient's commitment to try to follow the treatment plan that you developed with your patient.	1	2	3	4
12. Using the last few minutes of the visit to summarize the important issues discussed during the visit.	1	2	3	4
13. Conveying empathy to your patient regarding their decisions about end-of-life.	1	2	3	4
14. How comfortable are you in conducting an end of life discussion with your older adult patients	1	2	3	4

Appendix B

8-Step ACP Protocol (BC/BS 2009)

1. Prepare for discussion
 - Review what is known about patient and family goals and values
 - Understand the medical facts about the patient's medical condition and prognosis
 - Review what is known about the patient's capacity to consent
 - Retrieve and review completed Advance Care Directives and prior DNR documents
 - Determine who key family members are, and (if the patient does not have capacity), see if there is an identified "Agent" (Spokesperson) or responsible party
 - Find uninterrupted time for the discussion
2. Begin with what the patient and family knows
 - Determine what the patient and family know regarding condition and prognosis
 - Determine what is known about the patient's views and values in light of the medical condition
3. Provide any new information about the patient's medical condition and values from the medical team's perspective
 - Provide information in small amounts, giving time for response
 - Seek a common understanding; understand areas of agreement and disagreement
 - Make recommendations based on clinical experience in light of patient's condition / values
4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations
 - Negotiate and try to reconcile differences; seek common ground; be creative
 - Use conflict resolution when necessary
5. Respond empathetically
 - Acknowledge
 - Legitimize
 - Explore (rather than prematurely reassuring)
 - Empathize
 - Reinforce commitment and non-abandonment
6. Use ACP to guide choices and finalize patient/family wishes
 - Review the key elements with the patient and/or family
 - Apply shared medical decision-making
 - Manage conflict resolution
7. Have patient complete ACP
 - Get verbal or written consent from the patient or designated decision-maker
 - Get written consent from the treating physician, and witnesses
 - Document conversation
8. Review and revise periodically

NYC zip codes and searching for primary care providers. A pre-test was initiated, see Appendix A. The intervention was an educational program on communication strategies for ACP, was delivered orally

by the investigator in each provider's office; the entire intervention with posttest took approximately 45minutes, see Appendix B. PCPs are defined as physicians, nurse practitioners, and physician assistants that identify themselves as primary care providers.

Instrument

A data collection tool for demographic data was developed specifically for this study. The demographics were used to provide profiles of the participants. Data were obtained on the age of patients, whether the provider practices primary care, the provider's gender, age, years in practice, specialty, if any, and discipline.

A communication strategy questionnaire to assess Primary Care Providers (PCP) communication skills was administered to all participants. The instrument had been reviewed by a panel of experts and pre-tested with 40 general/family practitioners [29]-(Appendix A). It is a 14-question tool with a 4-point Likert scale that assesses competencies in:

1. Explaining end-of-life treatment options to patients in a manner that ensures a high level of understanding.
2. Explaining to patients the possible benefits and risks of recommended tests, procedures, and medication typically encountered at the end of life.
3. Identifying and pursuing non-verbal cues given by patients.
4. Communicating effectively about end of life care planning with patients perceived by the PCP as 'difficult'.
5. Actively involving the patient in the process of making treatment-related decisions.
6. Discussing alternative or complementary therapies.

The scores on each item range from 1, most confident to 4, least confident and having no interest in improving. Total scores range from 14-58, with 14 indicating no need for improvement in communication skills for ACP conversations to a score of 58, indicating the least confidence. Only those who scored above 14 were offered the intervention.

Table 1: PCP Demographics.

	Frequency	Percent	Valid Percent	Cumulative
Male	51	79.7	79.7	79.7
Female	18	20.3	20.3	100
	Minimum	Maximum	Mean	Std Dev
Age	31	80	58.98	10.431
Years of experience	6	50	28.61	9.583
Disciplines	Frequency	Percent	Valid Percent	Cumulative
MD	58	90.6	90.6	90.6
DO	6	9.4	9.4	100
Specialty				
	Frequency	Percent	Valid Percent	Cumulative
Internal	26	40.6	40.6	40.6
Pulmonary	9	14	14	54.6
Family	8	12.5	12.5	67.1
Women's	6	9.3	9.3	76.4
GI	5	7.8	7.8	84.2
Cardiology	5	7.8	7.8	92
Other	4	6.2	6.2	98.2
Geriatrics	1	1.5	1.5	99.7

Procedure

Rogers [30] "Diffusion of Innovation Theory" has guided this research, and the researcher serves as the innovator, changing practice through education. The eight-step intervention to prepare PCPs to have discussions on ACP with their patients is based on the Medical Orders for Life Sustaining Treatment (MOLST) Model [1] (Appendix B).

The eight steps consist of:

1. Prepare for discussion.
2. Begin with what the patient and family know.
3. Provide any new information about the patient's medical condition and values from the medical team's perspective.
4. Try to reconcile differences in terms of prognosis, goals, hopes and expectations.
5. Respond empathetically.
6. Use ACP to guide choices and finalize patient/family wishes.
7. Have patient complete ACP.
8. Review and revise periodically.

These 8 steps were discussed individually with each of the PCP in the study in an approximate 15-minute discussion.

Data analysis

Descriptive statistics were utilized to characterize the demographic data. A *t*-test was used to examine baseline differences in the demographic variables between the PCPs. Separate mixed between-within subject analysis of variance was used to determine the effect of the intervention, of the MOST education, on the demographic variables. *P* values had to be < .05 to be considered significant. The

Table 2: Paired *T* test.

	N	Minimum	Maximum	Mean	Std. Dev
Pretest scores	64	15	40	27.37	7.560
Posttest scores	64	14	27	17.98	3.416

Table 3: ANOVA- Transformed Variable Average.

Source	Type III Sum of Square	df	Mean Square	F	Sig.
Intercept	2821.883	1	2821.883	202.5701.00	.000
Error	877.617	63	13.930		

primary outcome of this study was overall scores on the comfort level for communication about ACP after the intervention compared with the pretest.

Results

PCP demographics

Of the 64 subjects (Table 1), 79.7% were male and 20.3% female. The inclusion criteria were met, that 100 percent of the sample practiced primary care with patients over 65 years of age. The mean age of the participant was 58.9860. The mean years of practice were 28.61.29. Medical Doctors (MDs) made up 90.6 % of the population and Doctors of Osteopathic Medicine (DOs) 9.4 %. The specialties represented were internal medicine 40.6%, pulmonary medicine 14%, family medicine 12.5%, women's health 9.3%, GI medicine and cardiology both at 7.8%, other 6.2%, and geriatrics 1.5%.

Results

A paired-sample *T*- test (Table 2) was conducted to evaluate the impact of the intervention when measuring the posttest scores on the comfort level scale when discussing ACP. The minimum pretest score was 15 and maximum was 40 (mean 27.37, SD 7.560). The posttest minimum score was 14 and maximum was 27 (mean 17.98, SD 3.416). There was a statistically significant increase in comfort score from the pretest to the posttest, with a T -32= 14.233, $p < 0.001$. The mean decrease in the comfort level score was 9.39, with a 95 % confidence interval ranging from 25.48 to 29.375.

Mixed between-within subject analysis of variance A mixed between-within subject analysis of variance (Table 3) was conducted to determine the effect of the intervention on the demographics variables on pre and posttest scores on confidence levels in discussing ACP. Subjects were divided into groups based on their age, years of experience, discipline of specialty, $F=202.570$. $p=.000$. Post-hoc comparisons using the Tukey HDS test indicated the mean scores for each group on the pretest did not differ significantly from any of the other groups, $F=23.177$, $p=.000$.

Findings

The post intervention scores were statistically significant. PCP had increase comfort in the discussion of ACP with their older adult patients. There is no correlation to whether this increase in comfort will be brought to actual practice of discussing advance care planning with older adult patients. There needs to be another follow up study to determine whether this education was indeed successful in achieving that. Other difficulties in generalization are that only MDs and Dos were represented in PCP group, and no NPs or PAs were part of the intervention group. Some explanation for this is that currently in NYC, no midlevel providers (NPs and Pas) have their own practice.

The identification of PCPs was through the computer and phone listings, which omitted names of other PCP in offices. The Nurse Practitioner can play a valuable role is assisting all PCP serving as the innovator, helping to change practice through education.

Conclusion

The MOSLT intervention significantly improved comfort with communicating ACP among primary care providers. No participant scored 14 on the pretest, indicating that all participants felt they could improve on communication and ACP. Older adults need to be educated about ACP so that they can implement health care proxies and living wills. At the same time, health care providers need more effective training to empower and encourage them to initiate end-of-life and ACP discussions with their patients. Providing education about MOLST guidelines will increase comfort level for providers in having conversations about ACP. This increased comfort level may help increase the frequency of discussions between health care providers and their patients about wishes for end-of-life care. The more comfortable health care providers become with end-of-life conversations and ACP, the better able they will be to tailor it for the individual. As patients feel their wishes are being made known, respected and being translated into their care, the more satisfied both patients and families will be [31]. Discussions on end-of-life not only prevent costly and aggressive treatment that is not desired by the patient; they also strengthen the provider-patient relationship [32]. End-of-life conversations allow individuals the time to plan for a dignified end.

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