

## ABSTRACT

### EFFECTS OF A CENTRALIZED EDUCATION MODULE ON ADVANCED PRACTICE CLINICIANS' CONFIDENCE IN END OF LIFE DISCUSSIONS

End of life discussions are noted to be difficult on the patient, family and provider, which can cause delays in transition to hospice (Popcock et al., 2019). Additional education is necessary to increase confidence levels initiating the conversation (Litauska et al., 2013). Little has been done to standardize education across nursing institutions and organizations in end of life care (Hostetter & Klein, 2019). This pilot project sought to determine if a newly developed education module in end of life discussions would impact advanced practice clinician's confidence in identification of hospice appropriateness, cultural considerations and the SPIKES framework for conducting the discussion. The study was conducted at a Medicare Advantage Plan where advanced practice clinicians manage patients with chronic conditions. A pre-education survey using a confidence assessment was sent to the participants. Following the survey, the participants then attended a virtual meeting where the module was disseminated. Finally, the participants repeated the same confidence survey. Correlations were run to determine a relationship between the module and confidence levels. The education module was found to have a positive relationship with relationship building and explanation of medical condition. The results of this study indicate that additional research should be done on a larger scale to determine effectiveness of the module.

Erin Kathleen Alicia O'Hair  
May 2021



EFFECTS OF A CENTRALIZED EDUCATION MODULE ON  
ADVANCED PRACTICE CLINICIANS' CONFIDENCE IN  
END OF LIFE DISCUSSIONS

by

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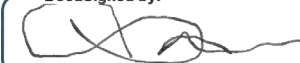
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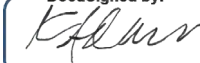
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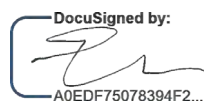
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## TABLE OF CONTENTS

	Page
LIST OF TABLES.....	vii
CHAPTER 1: INTRODUCTION.....	1
Background and Significance.....	2
Purpose .....	3
Problem Statement.....	4
Research Question .....	4
CHAPTER 2: LITERATURE REVIEW .....	5
End of Life Discussions .....	5
Literature Gaps .....	9
Cultural Awareness.....	10
CHAPTER 3: METHODOLOGY.....	12
Study Overview .....	12
Theoretical Framework .....	12
Method .....	13
Sample.....	15
Data .....	15
Setting .....	16
Analysis.....	16
Limitations .....	16
Implications .....	17
CHAPTER 4: RESULTS AND DISCUSSION .....	18
Demographics.....	18
Survey Results .....	18

Quantitative Data .....	19
CHAPTER 5: DISCUSSION .....	23
Limitations .....	23
Recommendations.....	24
Conclusion.....	24
REFERENCES .....	26
APPENDICES .....	32
APPENDIX A: INTRODUCTORY EMAIL.....	33
APPENDIX B: INFORMED CONSENT.....	35
APPENDIX C: PHYSICIAN’S CONFIDENCE IN MEDICAL INTERVIEWING .....	38
APPENDIX D: EDUCATION MODULE .....	40
APPENDIX E: PRE-EDUCATION SURVEY RESULTS.....	59
APPENDIX F: POST EDUCATION SURVEY RESULTS .....	61



## LIST OF TABLES

	Page
<b>Table 1</b> <i>Correlation 1</i> .....	19
<b>Table 2</b> <i>Correlation 2</i> .....	20
<b>Table 3</b> <i>Correlation 3</i> .....	20
<b>Table 4</b> <i>Correlation 4</i> .....	21
<b>Table 5</b> <i>Correlation 5</i> .....	21
<b>Table 6</b> <i>Correlation 6</i> .....	22
<b>Table 7</b> <i>Correlation 7</i> .....	22

## CHAPTER 1: INTRODUCTION

In 2014 there were over 45 million people in the United States older than age 65, 60% of whom were living with chronic illness (Healthy People 2020, 2019). Chronic diseases account for over half of the most common causes of death in the United States (Centers for Disease Control and Prevention [CDC], 2017). Congestive heart failure has a median survival rate of 1.7 years in men (Colucci, 2019). Chronic obstructive pulmonary disease increases mortality with a 5-year survival rate of 43%, compared to 76% for the general population (Van Hirtum et al., 2018).

Medicare regulations allow for hospice based on presence of an end stage chronic disease (CMS.gov, 2019). Due to poor prognosis of chronic diseases, the aging population has a clear need for informed consent regarding expected disease progression and end of life care, yet providers remain hesitant to identify non cancer patients requiring end of life discussions (Popcock et al., 2019). Unlike the progression of cancer, the prognosis of chronic conditions is fluid, complicated by cycles of exacerbation then return to baseline (Schonfeld et al., 2012). In interviews, providers cite uncertainty regarding anticipated disease progression, concerns regarding emotional state of patient and family or lack of patient relationship as additional barriers to initiating end of life discussions (Popcock et al., 2019). Lack of a standard method of delivering poor prognosis may also lead to provider discomfort with end of life discussions (Schonfeld et al., 2012).

Given the prevalence of chronic illnesses in the population and the various barriers to providers initiating end of life discussions, as well as the barriers to patient's positive reception of the discussion, it is clear providers require

additional education. Currently, there is no one framework recommended for providing this initial and continuing education to healthcare providers.

### **Background and Significance**

Due to the prevalence of chronic diseases and mortality associated with such conditions, models need to be put into place to train providers to adequately educate patients and their loved ones regarding options for treatment.

Undoubtedly, a shift to hospice care when terminally ill can help frail patients avoid aggressive measures and navigate the physical and emotional symptoms at end of life, (Deckx et al., 2019). Hospice care offers plentiful benefits through interdisciplinary teams, including nurses, physicians, social workers and caregivers, focused on the quality of life and symptom management in the last six months of life, yet this service is underutilized (Fine, 2018).

In addition to improved symptom management and patient satisfaction, palliative care and hospice programs decrease health care spending. Research shows a decrease the rate of hospital admissions, emergency room visits and intensive care unit stays when patients use these programs (National Association for Home Care and Hospice, 2020). Decreased use results in decreased cost, as in the state of California, the average cost per day per patient in the hospital in California is \$3532 (Kaiser Family Foundation, 2020).

Death is the natural culmination of the human life cycle, however with a wide array of patient religious, socioeconomic and cultural factors, many providers are uncomfortable initiating discussions and making recommendations other than ongoing treatment. Cultural factors, for example, are often overlooked or misunderstood by providers. Increased efforts in cultural competence should be exercised as Caucasian Americans are more likely to use hospice than other

ethnicities (LoPresti et al., 2016). As the American population ages, an increase in ethnic diversity in our older adults is noted, making cultural competence increasingly important (Orlovic et al., 2018).

Finally, there are several misperceptions regarding hospice care that must be addressed by clinicians for patients to have full understanding of the services. Patient and families cite concerns regarding where the services take place, continuity of current medical treatments and cost of services as barriers to enrollment (Tate et al., 2020). Addressing these concerns and educating the patient and family is crucial to a productive discussion.

### **Purpose**

The Commonwealth Fund, a foundation that focuses on research and improvement of health care processes for the elderly and vulnerable, found “part of the reason efforts to improve end-of-life care have not gained wider traction is that providers are often ill equipped to deal with the confusion, distress, anger, or other emotions that accompany discussions about illness and death” (Hostetter & Klein, 2019). It is noted that there are training programs being developed and implemented in educating providers in these skills, but they vary from institution to institution, rather than providing a known, effective series. Hostetter and Klein (2019) do note, however, that there has been success with the use of the SPIKES (setting, perspective, information, knowledge, empathy, summary) protocol, developed in a landmark study by Baile et al. (2000). Additional educational methods that can be scalable across organizations is warranted (Hostetter and Klein, 2019). In implementing an educational module instructing Advanced Practice Clinicians [APCs] in prognostic tools, cultural awareness and SPIKES

framework for difficult discussions, conclusions may be drawn to determine if the module positively impacts confidence levels.

### **Problem Statement**

Hospice offers additional support to patients in the last 6 months of life, yet clinicians are hesitant to refer (Fine, 2018). In interviews, physicians cite uncertainty regarding anticipated disease progression, concerns regarding emotional state of patient and family, or lack of patient relationship as additional barriers to initiating end of life discussions (Popcock et al., 2019). Lack of a standard method of delivering poor prognosis may also lead to provider discomfort with end of life discussions (Schoenfeld et al., 2012). Enrollment in hospice has been found to assist in alleviating end of life symptoms and improves caregiver and family satisfaction (Stemberg et al., 2019). Therefore, education maximizing clinician comfort in identifying patients appropriate for hospice and conducting end of life discussions is necessary (Litauska et al., 2013). Although the available research and the tool that will be utilized refers to physicians, this study will focus on the education of APCs, such as nurse practitioners and physician's assistants, in end of life discussions.

### **Research Question**

Will the implementation of an innovative provider education module improve APC confidence in initiating and conducting end of life discussions?

## CHAPTER 2: LITERATURE REVIEW

### **End of Life Discussions**

Delaying end of life discussion is noted to decrease quality of life, increase utilization of services and healthcare costs, yet there is no standard program in place to instruct clinicians in end of life discussion (Fine, 2018; Hostetter & Klein, 2019). Much of the past research is focused on identifying why the providers are not conducting conversation, as well as screening for prognostic awareness in chronic disease and end of life.

Due to end of life quality initiatives in the UK, Popcock et al. (2019) sought to understand the barriers to initiation of difficult discussions through a qualitative study. Hour long semi-structured interviews were conducted among a group of 15 general practitioners from south west England. Common themes were identified and grouped together. It was discovered that providers struggled with identifying which patients were appropriate for hospice or palliative care in the absence of metastatic cancer, which delayed discussions about end of life and prognostic timeline. Concerns about patient reception of prognosis was also found to be a barrier to initiating difficult discussions. The recommendations following the study were to increase provider education in screening tools and trainings in cultural competence but did not specify education requirements to improve outcomes. The semi structured outline of the study was a strength in that it allowed the providers to openly discuss feelings rather than answering specific questions. Limitations of this study include a small sample size and lack of quantitative data to support the findings.

While chaplains are non-medical personnel, they play an essential role in end of life planning by supporting the patient in end of life. Van Scoy et al. (2018)

sought to identify an effective training method to improve confidence in end of life discussions. This study used a mixture of quantitative and qualitative data to determine effectiveness. A PANAS-X scale was obtained pre- and post-game to obtain quantitative data, while a series of semi structured interviews was conducted post game to obtain qualitative data. The sample of chaplains in training was obtained via convenience sampling: all trainees in the Pennsylvania State clinical pastoral program were required to participate. The independent variable in the study was the application of a role-playing game, while the dependent variable was the confidence scores of the chaplains. Following data collection, the sum of survey scores was gathered and compared to pregame scores. Van Scoy et al. (2018) found positive results improved after each application of the game, while shyness scores reduced. Strengths of the study were application of quantitative data to support the qualitative data, and weaknesses include small sample size of chaplains from the same program, thus potentially similar cultural norms.

Namavar et al. (2019) also sought to understand the relationship between providers' education in end of life discussions and the ability to determine a correct prognosis. The study was conducted at UCLA, with a case study survey sent to 233 providers at the hospital. 104 physicians responded to the survey. The survey listed two case studies and asked a series of questions about the prognosis of the patient in question and to rate their confidence in that prognosis. The independent variable was the survey response, while the dependent variable was the physician education. Namavar et al. (2019) found a correlation between less end of life education and lower confidence levels in the ability to determine prognosis. A limitation of the study is the fluidity of prognosis in the case studies

presented, however, the results were strong among the adequate sample size that a correlation could be made.

Research shows nurses have more time to devote to conversations with their patients, thus nurses must be well educated in conducting the conversation (Tamaki et al., 2019). In a quantitative study Tamaki et al. (2019) sought to determine whether an end of life simulation would increase students' confidence in providing care and psychological care. Sampling included a cohort of 49 third year nursing students from a Japanese college. The students were randomly assigned into groups that would have didactic only versus an opportunity to role play a simulation. The independent variable was the participation in the simulation. Following the simulation or education, the nursing students completed a knowledge questionnaire, and the results from the two groups were compared. The research determined simulation is somewhat useful in improving confidence in end of life care. Strengths of this study included quantitative nature and having a control group. Limitations included a single source of participants, and repeat testing is needed to validate the results.

Steiner et al. (2020) noted advanced care planning was not often performed on adults with congenital heart disease, even though they have a shorter life expectancy than the average person. A convenience sample of 282 providers attending a conference related to the diagnosis were surveyed anonymously to determine comfort level with discussing and referring to palliative care. In this qualitative study, the independent variable applied was the survey. Data was collected and mean comfort levels regarding management of various conditions, advanced care planning and end of life discussions were collected. The survey showed providers felt undereducated in palliative care, uncomfortable discussing end of life and unsure when the timing is correct to conduct the discussion. The



strengths of this study were the large sample size from various regions.

Limitations are the providers who participated may have received palliative care education than providers of other disciplines.

Due to delays in end of life discussions, Deckx et al. (2019) conducted a qualitative study to determine how general practitioners in Queensland, Australia framed the conversations. Thirteen general practitioner physicians and 2 trainees participated in semi structured telephonic interviews. The research found the physicians conducted the discussion over time, rather than during one visit. Physicians considered patient preferences in conversation style and familial presence and reported discomfort with feeling rushed to have the conversation. Deckx et al. (2019) recommended newer physicians be supported by more experienced ones. Study strengths included a variety of physician backgrounds evaluated. Limitations include small sample size, as well as physician self-evaluation rather than unbiased observation.

Noting a lack of end of life care education in medical school, Litauska et al. (2013) performed a quantitative study of 280 physicians from an internal medicine department in New York. Participants included post graduate interns, fellow and attendings. A survey was given evaluating experience and comfort levels with end of life discussions, and responses were rated on a Likert Scale. Like other studies, research showed a correlation between experience and comfort levels with end of life discussions. Additionally, the physicians reported uncertainty regarding hospice criteria and prognosis and deferred to emergency room staff to discuss with the patient (Litauska et al., 2013). Strengths of the study included large sample size, while limitations included lack of specifics on participation palliative care educational background.

Due to poor prognosis of congestive heart failure, Ecartot et al. (2018) conducted a qualitative study to evaluate interdisciplinary attitudes in end of life. Sixteen physicians, 16 nurses, and 5 nurse's aides from a cardiology department in France were interviewed. The research found physicians were largely focused on curing disease, rather than palliative treatments. Physicians who were uncomfortable with end of life discussions reported leaning on more experienced colleagues to initiate the conversation. Based on the nursing responses, nurses were more likely to recognize the appropriateness of palliative care due to patient proximity and must leverage that awareness to communicate with physicians. Limitations of the study include small sample size and being unable to quantify the data.

Dunlay et al. (2015) also studied clinician perspectives on administering end of life discussions. Fifty physicians and 45 nurse practitioners and physician assistants employed by the Mayo Clinic in primary care, tertiary cardiology or community cardiology practices participated in the study. Survey results found that clinicians were more likely to refer to palliative care when the patient decompensated and that clinicians were not routinely reviewing prognosis and advanced care planning with patients. Physicians reported higher confidence levels in end of life discussions than the physician assistants or nurse practitioners. Most of the clinicians surveyed expressed interest in additional education to build conversation skills. Limitations of the study included self-reporting, which may not translate to action in practice.

### **Literature Gaps**

Literature involving confidence in end of life discussions among APCs is minimal. With APCs being viewed as a solution to the primary care provider

shortage (Medical Staff Briefing, 2018), it is crucial the APC is appropriately trained to identify and initiate end of life discussions. To date, literature on confidence levels has been focused on physicians, however those findings may be comparable to APCs. Additional research must be done to evaluate APC confidence levels following their training to validate this comparison. Once confidence levels of APCs are understood better, the education in end of life discussions may be scaled across other organizations and universities to better prepare APCs across the nation.

### **Cultural Awareness**

Death is an emotional milestone, and sensitivity regarding social and cultural beliefs is necessary to provide appropriate care and coaching to the patient and family system. Cultural diversity refers to the differences in race, skin color, social circumstances, geography, religious preference and gender (Saccamano & Abbatiello, 2014). The American Nurses Association (n.d.) supports diversity awareness, defined as “acknowledgement and appreciation of the existence of differences in attitudes, beliefs, thoughts, and priorities in the health-seeking behaviors of different patient populations”.

Saccamano and Abbatiello (2014) reported that the Joint Commission calls for universal cultural assessments, including end-of-life wishes and provided general guidelines regarding various cultures. African Americans may be mistrustful of health care providers and may decline to make end of life decisions. When decisions are made, Black Americans may include religious figures and family members in the decision making. In the Hispanic culture, end of life discussions may be a group decision involving extended family. Like Black Americans, Hispanic may patients defer end of life discussions until close to

death. Chinese Americans, also, are less likely to discuss end of life, but when the discussion occurs it is a decision led by the male members of the family.

Additionally, Chinese Americans may choose not to inform the patient of the prognosis. In the Muslim culture, the patient is likely to be open to prognosis discussions, however, believe only God determines timeframes, and may wish for prayer and family presence. Due to widely varying beliefs, Saccomano and Abbatiello (2014) propose nurse practitioners should be well versed in various cultural differences, asking open ended questions and offering acceptance and support of the patient's values and wishes.

Givler, Bhatt and Maani-Fogelman (2020) stress the importance of cultural awareness when treating pain and providing palliative care. To build a rapport with a patient and their family, health care providers must understand the patient's cultural beliefs. Health care providers should be aware that in some cultures, families may choose to withhold diagnosis and prognosis from the patient. Some cultures are concerned with pain medications altering awareness or accelerating death. Additionally, patient response to pain should be considered, as several cultures patients may be stoic. According to Givler et al. (2020) health care providers should provide education to patients on indications for pain medications and palliative care at end of life, addressing patients concerns and fears. Through cultural competence, the provider can ensure the patient gets the appropriate, preferred care at end of life.

## CHAPTER 3: METHODOLOGY

### **Study Overview**

Due to the lack of research among APC confidence with end of life discussions, an educational module was developed and presented to a group of 37 nurse practitioners and physician's assistants employed by a Medicare Advantage Plan. The APCs voluntarily participated in the study. APCs were surveyed with the Physician's Confidence in Medical Interviewing tool about current level of confidence. Following the survey, the APCs attended an hour-long live WebEx where they were presented with the educational module. The module included current prognostic tools to determine appropriateness of palliative and/or hospice care. A section was introduced basic cultural competence and how beliefs may be navigated to overcome potential barriers. Therapeutic communication and frameworks for conducting difficult discussion was presented to the APCs with the intention of improve underlying skills. Following the module, the participating APCs were sent a repeat survey link. The results of the pre- and post-education surveys were then compared to determine if there is a positive correlation between attendance to the module and confidence levels in end of life discussions.

### **Theoretical Framework**

Joyce Travelbee's Human-to-Human Relationship Model is a nursing theory centered around humanism and the belief that caring was essential to nursing. According to Nelson (2018), the model works in phases, beginning with the nurse understanding each patient to be a unique individual. It is then the nurse's duty to separate that individual from all similar patients and remove personal bias and experiences from the equation. Once the nurse understands that individual, the nurse can develop sympathy for the situation and the feelings of the

patient. From there the nurse can begin to empathize with the patient, experiencing the same emotions as their client. By experiencing the same emotions as the patient, the patient and nurse can forge a relationship and develop a rapport that improves communication (Nelson, 2018).

Identification of appropriateness for palliative measures and initiation of difficult conversations is not intuitive (Popcock et al., 2019). The conversation should be carefully navigated as a nonproductive conversation may increase patient suffering. The Human to Human Relationship model is ideal to a project focused on improving APC communication in conducting difficult discussions, as the theory can give providers a framework to move within. Following the theory will ensure a proper relationship and rapport is developed and maximize understanding and treatment planning.

### **Method**

With the assistance of the educational academy at the Medicare Advantage Organization an initial email was sent to a premade email chain of APCs. The APCs are employees from across the nation, working in the ambulatory care setting, a private home setting or institutions. The majority of the patients cared for by the APCs have chronic diseases. The introductory email (Appendix A) included a statement explaining the purpose of the study and inviting the APCs to participate, as well as an informed consent form (Appendix B). Through the preformed email chain, the APCs received a link to SurveyMonkey where could anonymously complete the Physician's Confidence in Medical Interviewing tool (Appendix C).

The participants then attended a WebEx meeting. As the organization is education focused, it was made clear to the attendees that attendance is optional,

and should the associate attend, there will be no reprimand for attending during work hours. Managers within the organization were urged to encourage their associates attend the education.

The education module was presented in three parts: importance and criteria for hospice, cultural awareness and framework for discussions (Appendix D). In the first section, importance of hospice identification in chronic disease management was explained. Statistics regarding chronic disease, prognosis, and previous literature surrounding provider confidence levels were reviewed. The APCs were then educated on Medicare criteria for referral to hospice based on disease process, including end stage dementia, end stage cardiac disease, end stage pulmonary disease and end stage nephrology.

The second section of the module briefly explained Joyce Travelbee's Human to Human relationship model and how the model indicates individual awareness of the patient is required to develop a rapport. Due to the necessity of individualism, cultural norms at end of life were briefly covered. Preferences for pain management, family support and patient individual knowledge of disease process was reviewed for commonly cared for populations.

Finally, the SPIKES (setting, perspective, invitation/information, knowledge, empathy, summary) was presented to the APCs. Education was given on appropriate settings for discussions, including privacy and appropriate members of the family to be present. Guidance in obtaining the patient's perspective of their current disease process was presented. The APCs were instructed in how to solicit permission to provide information and knowledge on disease process and prognosis. Finally, instructions on empathizing and summarizing the conversation was provided to the APCs.

Following the module, the APCs were again sent the survey link from the education academy to repeat the Physician's Confidence in Medical Interviewing tool. The results of both surveys were entered into SPSS for statistical analysis. The analysis was a correlation, seeking to determine a positive or negative relationship between attendance at the education module and increased confidence levels in end of life care.

### **Sample**

Participation in the study was offered to 249 APCs from four different states. Of those APCs 37 participated in the pre-education survey, and 23 participated in the post education survey. The APCs were gathered with convenience sampling from a managed care plan with a focus on chronic disease management. Due to the providers having similar clinical backgrounds, and lack of access to participant demographics to run a more specific statistical analysis, additional future research will need to be conducted with additional types of providers to validate the findings.

### **Data**

An online survey using the Physicians' Confidence in Medical Interviewing tool was conducted to determine baseline confidence. The tool was a validated tool in evaluating confidence in medical interviewing skills. While the tool specifically states "physician", this tool is applicable to providers offering primary care and chronic disease management. Areas addressed in the tool include initiating the conversation, gathering information, providing structure, relationship building, explanation, planning and summarizing the session. Following the education module, the tool was administered again to evaluate the relationship between the module and confidence with difficult discussions. SurveyMonkey was



used, as it allowed anonymous participation, and data was able to be loaded directly into SPSS.

### **Setting**

This pilot project was implemented at a Medicare Advantage Plan. The organization is in multiple states throughout the country. The APCs employed by the organization practice in a variety of settings: clinics, skilled nursing facilities, assisted livings, board and care homes and private homes. The education series was conducted via WebEx, a video presentation platform, with the assistance of the organization education academy team to coordinate the meeting among the APCs. Internal review board approval for the organization was waived, as patient data would not be used and APC demographics would be accessed. Internal review board approval was obtained from California State University, Fresno.

### **Analysis**

SPSS, a statistical analysis software, was used to evaluate the data. The anticipated outcome was a positive correlation between attending the education module and increased confidence levels. While the results may determine a relationship between the education module and confidence levels, there are external factors such as gender, cultural beliefs, religious beliefs and various levels of prior experience that may have influenced the results. With the APCs practicing in different states and different care settings, prior experience to end of life training may have varied widely.

### **Limitations**

There are noticeable limitations to the study including the subjective model and methods of sampling. In asking providers to self-report in survey form, human

bias was not removed. While a positive relationship between the module and confidence with discussions may have been determined, it is not possible to definitively state that the module is responsible for confidence levels.

Additionally, improved confidence levels may not translate to improved outcomes, as confidence does not equal effectiveness. This limitation may be overcome with a secondary study evaluating hospital and hospice metrics. Convenience sampling is limiting in that each APC is from a similar background with similar experiences. Should the education series be deemed positive for this group of APCs, that does not necessarily translate to effectiveness in other areas of medicine. Exposure to end of life communication should be considered, and the program altered accordingly when implementing this educational module.

### **Implications**

The conclusions of this study may help bridge the gaps in the previous literature. Given that recommendations for specific education requirements have not been stated, determining effectiveness of a standard program may shape the way APCs are educated in the future. Additionally, further research could be conducted to compare hospice conversion rates, hospital utilization and healthcare spending pre- and post-education, which would provide additional objective data regarding the effectiveness of the series.

## CHAPTER 4: RESULTS AND DISCUSSION

This project was implemented to determine if a centralized education module in end of life discussions correlates with improved APC confidence in initiating and conducting the conversation. The participants took a confidential 21 question survey through SurveyMonkey in the two weeks prior to the educational module. The participants then attended a one-hour WebEx “lunch and learn.” Following the module, within a week, the APCs took the same confidential 21 question survey for comparison of confidence levels pre- and post-module.

### **Demographics**

Of the approximately 230 APCs who qualified for the study, 37 APCs chose to participate in the initial survey, and 23 APCs participated in the post module survey. Prior education in end of life discussions, number of years in practice and cultural background of APCs would have been useful data as clinician background impacts confidence levels. However, such demographics were prohibited from being gathered in the organization where the project was implemented. All participants, however, had some level of experience with Medicare eligible patients, delivering primary care or chronic disease management.

### **Survey Results**

The survey was scored on a 4-point Likert scale with options being “not at all confident,” “not so confident,” “somewhat confident,” and “very confident.” The Physician Confidence in Medical Interviewing tool contains 7 sections: initiating the session, gathering information, providing structure, building the relationship, explanation, planning and closing the session. Upon initial survey,

APCs responses fell under “not so confident,” “somewhat confident,” and “very confident” (Appendix E). In the post education survey, most of the responses fell under “somewhat confident” or “very confident” (Appendix F).

### Quantitative Data

As there was not enough data on participants to conduct a paired t test, a statistical analysis to determine a correlation between the education module and increased confidence levels in end of life discussions was completed in SPSS. The Physicians’ Confidence in Medical Interviewing tool questions were categorized into seven sections: initiating the session, gathering information, providing structure, building the relationship, explanation, planning and closing the session. Total confidence levels for the questions in each section were calculated, and a correlation for each section was run.

The first section of the survey addressed referred to initiating the session. It included questions about establishing relationship, determining problem to be addressed and discussing goals for the session (Appendix C). The analysis determined a negative relationship between the module and confidence in end of life discussions with a r value of -0.82, although it is not statistically significant as the p-value is 0.718 (Table 1).

**Table 1**

<i>Correlation 1</i>		Cat1pre	Cat1post
Cat1pre	Pearson Correlation	1	-.082
	Sig. (2-tailed)		.718
	N	36	22
Cat1post	Pearson Correlation	-.082	1
	Sig. (2-tailed)	.718	
	N	22	23

The second section of the survey focused on information gathering. The questions referred to the encouraging the patient to review the history, listening actively and asking clarifying questions (Appendix C). The analysis determined a mild positive relationship, with the r value being 0.139, however, it was not statistically significant as the p value was 0.536 (Table 2).

**Table 2**

		Cat2pre	Cat2post
Cat2pre	Pearson Correlation	1	.139
	Sig. (2-tailed)		.536
	N	36	22
Cat2post	Pearson Correlation	.139	1
	Sig. (2-tailed)	.523	
	N	22	23

The third section of the survey was regarding providing structure to the interview. The questions addressed sharing the timing of interview with the patient, structuring the session and time management (Appendix C). The analysis determined a mild positive relationship as the r value was 0.181, however, it was not a statistically significant relationship as the p value was 0.433 (Table 3).

**Table 3**

		Cat3pre	Cat3post
Cat3pre	Pearson Correlation	1	.181
	Sig. (2-tailed)		.433
	N	34	21
Cat3post	Pearson Correlation	.181	1
	Sig. (2-tailed)	.433	
	N	21	23

The fourth section of the survey concentrated on relationship buildings. The questions centered around appropriate nonverbal cuing, provider response to emotions, facilitating shared decision making (Appendix C). The analysis determined a moderately strong relationship with an  $r$  value of 0.444. This was determined to be statistically significant as the  $p$  value was 0.044 (Table 4).

**Table 4**

		Cat4pre	Cat4post
Cat4pre	Pearson Correlation	1	.444
	Sig. (2-tailed)		.044
	N	34	21
Cat4post	Pearson Correlation	.444	1
	Sig. (2-tailed)	.044	
	N	21	23

\*. Correlation is significant at the 0.05 level (2-tailed).

The fifth section of the survey referred to explanation of the medical condition. The questions revolved around providing knowledge, sharing knowledge at the patient's level and ensuring patient and provider understand the problem on the same level (Appendix C). The analysis determined a moderately positive relationship with an  $r$  value of 0.501. This relationship was determined to be statistically significant as the  $p$  value was 0.021 (Table 5).

**Table 5**

		Cat5pre	Cat5post
Cat5pre	Pearson Correlation	1	.501
	Sig. (2-tailed)		.021
	N	34	21
Cat5post	Pearson Correlation	.501	1
	Sig. (2-tailed)	.021	
	N	21	23

\*. Correlation is significant at the 0.05 level (2-tailed).

The sixth section of the survey focused on care planning. The questions concentrated on shared decision making, development of a plan both provider and patient agree with and evaluating patient acceptance of the plan (Appendix C). The analysis determined a positive relationship with an  $r$  value of 0.314, however, it was not statistically significant with a  $p$  value of 0.165 (Table 6).

**Table 6**

*Correlation 6*

		Cat6pre	Cat6post
Cat6pre	Pearson Correlation	1	.314
	Sig. (2-tailed)		.165
	N	34	21
Cat6post	Pearson Correlation	.314	1
	Sig. (2-tailed)	.165	
	N	21	23

The final section of the survey address closing the medical interview. The questions were regarding clarification future plans, emergency planning and ending the session while thanking the patient appropriately (Appendix C). The analysis determined a slightly positive relationship with an  $r$  value of 0.140, however, it was not statistically significant as the  $p$  value was 0.546 (Table 7).

**Table 7**

*Correlation 7*

		Cat7pre	Cat7post
Cat7pre	Pearson Correlation	1	.140
	Sig. (2-tailed)		.546
	N	34	21
Cat7post	Pearson Correlation	.140	1
	Sig. (2-tailed)	.546	
	N	21	23

## CHAPTER 5: DISCUSSION

According to Hostetter and Klein (2019) “part of the reason efforts to improve end of life care have not gained wider traction is that providers are often ill equipped to deal with the confusion, distress, anger, or other emotions that accompany discussions about illness and death.” Prevalence of chronic diseases, as well as an anticipated increase in the aging population, indicates the need to discuss options at end of life (Mather et al., 2020). With 290,000 nurse practitioners in the United States and over 80% of those accepting Medicare patients, APCs must be prepared to conduct end of life discussions (American Association of Nurse Practitioners, 2020).

### **Limitations**

The statistical method used was a limitation to this study. While a positive correlation between attendance to the module and increased confidence levels is encouraging, it is difficult to quantify the impact. Had access to the demographics of the APC participants been allowed, a more specific statistical analysis may have been run. Unfortunately, in the institution where the project was implemented, responses were required to be completely anonymous, thus a paired t test was unable to be conducted. As correlation does not equal causation, while a relationship may be determined, it is not possible to report the module was the causation of the improved confidence levels. Additionally, due to lack of access to demographics, prior education provided to the APCs and years’ experience in the field were unable to be determined. This data would have been useful to determine if the education module was equally effective among new and seasoned APCs. Finally, out of the 37 initial survey respondents, only 23 participants completed



the post survey. The 14 participants who declined the post education survey may have negatively or positively impacted the results.

### **Recommendations**

While this project is an initial step in determining effectiveness of a centralized education module in end-of-life discussions, additional research is warranted to determine if the relationship is significant. Future research should be conducted in settings where access to participant demographics is allowed, including previous education, cultural bias and employment experience in the field. Should future research determine a statistical significance between the education module and APC confidence levels in initiating and conducting end of life discussions, the module may then be scalable to universities offering nurse practitioner degrees and organizations employing APCs. This may increase the likelihood that APCs will identify patients who qualify for hospice and have discussions offering patients and families the option for these valuable services.

### **Conclusion**

The natural progression of chronic diseases results in death; however, clinicians have been hesitant to initiate discussions due to uncertainty of reception, lack of confidence in identifying hospice appropriate patients and lack of confidence in conducting the emotionally charged conversation. For APCs to feel confident in conducting productive end of life discussions, additional education must be provided. With the population aging we can anticipate APCs to see more patients who are hospice appropriate, in their day to day practice. Attendance to the centralized education module implemented at a Medicare Advantage Plan was found to have a positive correlation with provider confidence levels in identifying end of life situations and conducting difficult discussions. Additional research

must be done to quantify the relationship; however, it is clear the education module has a place in APC continuing education.

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## APPENDICES

## APPENDIX A: INTRODUCTORY EMAIL

**Introductory statement**

To my colleagues at CareMore,

My name is Erin O’Hair, and I am an Advanced Practice Clinician [APC] in the Santa Clara market for the Touch program. I am conducting a study seeking to determine if a centralized education module in end of life discussions improves APC confidence in initiating and conducting end of life discussions and am seeking participants.

Participation in the study includes completion of an electronic survey prior to the education module, attendance during the WebEx module and repetition of the electronic survey following the education module. All APCs employed by CareMore are invited to attend. Your answers to the survey will be kept confidential. Potential risks of participation include emotional triggers due to the sensitive nature of the topic. Anthem EAP is available at 888-650-5748 should that occur. Potential benefits include improved awareness of appropriateness of end of life care and confidence in initiating and conducting difficult discussions. I may be reached at the telephone number and email address below with any questions or concerns.

Thank you,

Erin O’Hair, ANP-C, GNP-C

562-547-9670

Erin.o’[hair@caremore.com](mailto:hair@caremore.com)

## APPENDIX B: INFORMED CONSENT

## INFORMED CONSENT FORM

You are invited to participate in a study conducted by Erin O’Hair, ANP-C, GNP-C and Dr. Tamara McKinnon, DNP, RN, APHN, FAAN. We hope to learn about the effects of a centralized educational module on Advanced Practice Clinician confidence levels with end of life discussions. You were selected as a possible participant in this study due to your employment as an Advanced Practice Clinician by CareMore.

If you decide to participate, you will take part in a 21-question survey on current confidence levels via Survey Monkey, participate in an hour-long educational WebEx meeting, then repeat the previous survey. The survey will be confidential and exclude identifying information of the participants.

Risks of this study include potential psychological distress due to previous poor outcomes on hospice appropriate patients. Participants will be provided with the Anthem Employee Assistance Services contact, should they require support. Participants may withdraw from the study or decline to answer any question without risk of prejudice or penalty.

Potential benefits of this study include improved knowledge of hospice criteria and increased confidence in delivering end of life discussions.

Participant name will not be attached to survey results. Survey results will be electronically deleted by May 31<sup>st</sup>, 2021.

Any information that is obtained in connection with the study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. If you give us your permission by signing this document, we plan to disclose your survey answers for the purpose of statistically analysis pertaining to the research done in this study.

I, \_\_\_\_\_, hereby willingly consent to the participate in the research

project: Effects of a Centralized Education Module on Advanced Practice Clinicians’  
Confidence in End of Life Discussions

I am aware of all the following conditions:

All information is to remain confidential.

After the information is compiled, the original survey results will be destroyed by May 31, 2021.

I have the right to withdraw from this study at any time without prejudice or penalty.

California State University, Fresno has given permission for this study to be conducted.

The procedures for this research have been approved by the Human Subject’s Subcommittee, College of Health and Human Services at California State University, Fresno.

If you have any additional questions, please direct them to [ehair@mail.fresnostate.edu](mailto:ehair@mail.fresnostate.edu) or primary investigator Dr. Tamara McKinnon at [thm4@cruzio.com](mailto:thm4@cruzio.com) or leave a message at 1-831-359-6860, and a reply will be given within 24 hours.

You will be given a copy of this form to keep.

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

APPENDIX C: PHYSICIAN'S CONFIDENCE IN MEDICAL  
INTERVIEWING

 **PsycTESTS™**

doi: <http://dx.doi.org/10.1037/t48395-000>

**Physicians' Confidence in the Medical Interview  
PCMI**

**Items**

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**Initiating the session**

- (1) Establish initial rapport (greet the patient, obtain the patient's name, introduce oneself, etc.).
- (2) Elicit all of patient's problems or reasons for the consultation.
- (3) Negotiate an agenda taking both patient's and physicians' needs into account.

**Gathering information**

- (4) Encourage patient to tell the detailed story of the problem(s) in his/her own words.
- (5) Actively listen, facilitating patient's responses verbally and non-verbally.
- (6) Clarify patient's statements that are unclear, and periodically summarize to organize the information.

**Providing structure**

- (7) Share the flow of the interview with the patient.
- (8) Summarize at appropriate points and structure the interview in a logical sequence.
- (9) Attend to timing and keep the interview on task.

**Building the relationship**

- (10) Demonstrate appropriate non-verbal behavior (showing empathy, note taking, etc.).
- (11) Actively respond to patient emotions verbally.
- (12) Encourage patient to participate in the decision-making process (share own thought processes, intent of the question, and the flow of the consultation).

**Explanation**

- (13) Provide the correct amount and type of information.
- (14) Share information in a way that aids accurate recall and understanding.
- (15) Achieve shared understanding about the problems.

**Planning**

- (16) Encourage patient to participate in decision-making process to the level that they wish.
- (17) Negotiate a mutually acceptable plan.
- (18) Check with patient about whether he/she agrees and is comfortable with the plan.

**Closing the session**

- (19) Summarize the session briefly and clarify the plan of care.
- (20) Assure that there is a plan for unexpected outcomes and follow-up.
- (21) Thank the patient with appropriate parting statements.

**Overall, achieve an interview that is fully satisfactory and accepted by the patient.**

**Note:** Each item was rated on a 4-point scale with higher scores indicating greater confidence.




APPENDIX D: EDUCATION MODULE




### Introduction

- Erin O'Hair, ANP-C, GNP-C, DNPc
- Marymount University- BSN
- 6 years experience in ICU
- University of California, Irvine- MSN
- 8 years experience as a Touch NP
- Expected DNP graduation May 2021



## Study Purpose

To determine if a centralized educational module in end-of-life discussions has an impact on APC confidence levels in initiation and conducting end of life discussions



## Current Literature

- Patient Identification
  - Providers have difficulty identifying patients at end of life (Schonfeld et al., 2012)
- Provider Trends
  - Providers are concerned regarding patient/family perception thus delay discussions (Popcock et al., 2019)
  - Different disciplines have relied on others to initiate conversations or deferred to emergencies (Litasaka et al., 2013)
  - Delaying end of life discussions has been shown to decrease quality of life (Fine, 2018)

## Practice Change

- Less education in end-of-life care correlates with lower confidence levels in initiating discussions (Namavar et al., 2019)
- Lack of a standard method for conducting end of life discussions (Hostetter and Klein, 2019).
- Minimal research about APC confidence
  - More research and education is needed

“Part of the reason efforts to improve end-of-life care have not gained wider traction is that providers are often ill equipped to deal with the confusion, distress, anger, or other emotions that accompany discussions about illness and death”

-Hostetter & Klein, 2019



## Chronic Disease Management

- 60% of people over age 65 have at least one chronic disease
- Chronic diseases are known to have a poor prognosis
- Palliative care and hospice increase patient and family satisfaction and decrease health care spending
- Patients referred to hospice in last weeks to days of life rather than months
  - "35.7% of patients die within 1 week" (Harris et al., 2014)

## What is Hospice?



- Interdisciplinary team of MD, RN, CNA, SW, Chaplain
- Focuses on quality of care at end of life
- May be inpatient or outpatient
- Respite Care is available for caregivers
- Bereavement counseling

## Hospice Misperceptions

Hospice means imminent death

Hospice means giving up hope

Hospice cannot be performed at home

Hospice is expensive

Hospice means forgoing medical care



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## Basic Hospice Criteria

- Prognosis of less than 6 months
- Requesting comfort focused care
- Decreased function
- Frequent hospitalization
- Comorbid conditions
- FAST score 7C
- PPS 40%

### Functional Assessment Scale (FAST)

1	No difficulty either subjectively or objectively
2	Complains of forgetting location of objects. Subjective work difficulties.
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
4	Decreased ability to perform complex task, (e.g., planning dinner for guests, handling personal finances, such as forgetting to pay bills, etc.)
5	Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g., pt may wear the same clothing repeatedly), unless supervised. *
6	Occasionally or more frequently over the past weeks. * for the following: A) Improperly putting on clothes without assistance or cueing. B) Unable to bathe properly (not able to choose proper water temp) C) Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue) D) Urinary incontinence E) Fecal incontinence
7	Ability to speak limited to approximately 5-8 intelligible different words in the course of an average day or in the course of an intensive interview. B) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview. C) Ambulatory ability is lost (cannot walk without personal assistance.) D) Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair.) E) Loss of ability to smile. F) Loss of ability to hold up head independently.

\*Based primarily on information obtained from a knowledgeable informant.  
Psychopharmacology Bulletin, 1988, 24, 573-575

## FAST screening tool

### PPS Screening Tool

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Level of Confusion
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity, some evidence of disease	Full	Normal	Full
80	Full	Normal activity with effort, some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable to do normal work, some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable to do hobby or other leisurework, significant disease	Occasional assist necessary	Normal or reduced	Full or confusion
50	Merely active	Unable to do any work, extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40	Merely in bed	Unable to do any work, extensive disease	Merely assistance	Normal or reduced	Full, drowsy or confusion
30	Totally bed-bound	Unable to do any work, extensive disease	Total care	Reduced	Full, drowsy or confusion
20	Totally bed-bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full, drowsy or confusion
10	Totally bed-bound	Unable to do any work, extensive disease	Total care	Minimal care only	Drowsy or coma
0	Death	—	—	—	—

Palliative Performance Scale (PPS)

## End Stage Cardiac Disease

- NYHA Class IV
  - Fatigue, dyspnea, O<sub>2</sub> use, heart failure medications appropriately maximized
  - Uncontrolled angina
  - Comorbid conditions
    - Hypertension
    - Diabetes
    - History myocardial infarction
    - Valve disease



## End Stage Renal

- Declines dialysis
- Creatinine clearance <15cc/min with comorbid condition (heart failure or creatinine >8.0)
- Functional decline
  - Weakness
  - Fatigue
  - Weight loss
- Signs/symptoms of renal failure





## End Stage COPD

- Dyspnea at rest
- Progressive COPD
- Hypoxemia on room air
- Weight loss

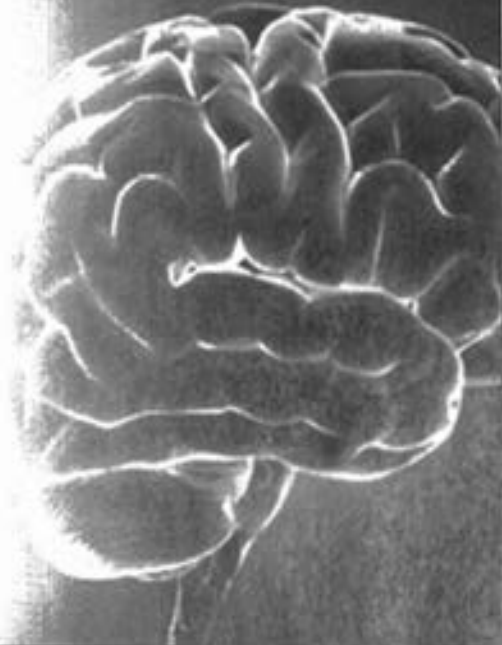


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## End Stage Alzheimer's

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- FAST score 7C PLUS
  - Weight loss
  - Recurrent infections
  - Skin breakdown






## Cancer

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- Disease with metastasis
- Declines treatment

### I human to Human Relationship Model

- Developed by Joyce Travelbee
- Goal is to mitigate suffering and improve coping
- Phased approach
  - Initial encounter
- Individualism
- Empathy
- Sympathy
- Rapport



The American Nurses Association supports diversity awareness, defined as “acknowledgement and appreciation of the existence of differences in attitudes, beliefs, thoughts, and priorities in the health-seeking behaviors of different patient populations”.



## Overview of Cultures

- Diversity based on race, religion, geography, gender, social circumstances
- APCs should be aware of cultural norms
  - Individualize the care





## Prognostication

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- Abstaining from telling the patient the prognosis
- Willingness to discuss terminal prognosis
- Willingness to change to DNR
- "Who should be present for this conversation?"

## Pain Management



- Fear of addiction
- Stoic
- Wishes to be alert
- "How important is staying mentally alert?"
- "What is an acceptable level of pain?"
- "What type of pain medications or alternatives should be considered?"

## Family Presence



- Varying preferences for family presence and/or prayer at end of life
- Patients may defer decisions to family members
- "How does your culture deal with support as your father declines? How can I help make that happen?"

## Frameworks

- SPIKES
- ABCDE
  - Advanced preparation
  - Build a therapeutic environment
  - Communicate well
  - Deal with patient and family reactions
  - Encourage and validate emotions
- BREAKS
  - Background
  - Rapport
  - Explore
  - Announce
  - Kindle
  - Summarize



**SPIKES**

- Setting
- Perspective
- Invitation
- Knowledge
- Emotions
- Summary/Strategy

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**Setting**

- Privacy
- Take a seat
- Ensure appropriate attendance
- Make a connection



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## Perspective

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- "What have you been told about your medical condition?"
- Avoid judgement statements





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## Invitation

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- Ask patients permission to dispense medical knowledge
- "Would you like me to tell you about your condition/lab tests/physical exam?"
- Dispers anxiety on provider's part





## Knowledge

- Use appropriate language
- Paint a picture
- Avoid bluntness



## Emotions

- Be aware
- Empathetic statements
  - "I can see how upsetting this is to you."
- Exploratory statements
  - "Could you tell me what you are worried about?"
- Validating statements
  - "I can understand how you felt that way."



## Strategy/Summary

- Create a plan of care
- Summarize to evaluate for misunderstanding
- Don't be afraid to take a break and regroup another day

## Resources

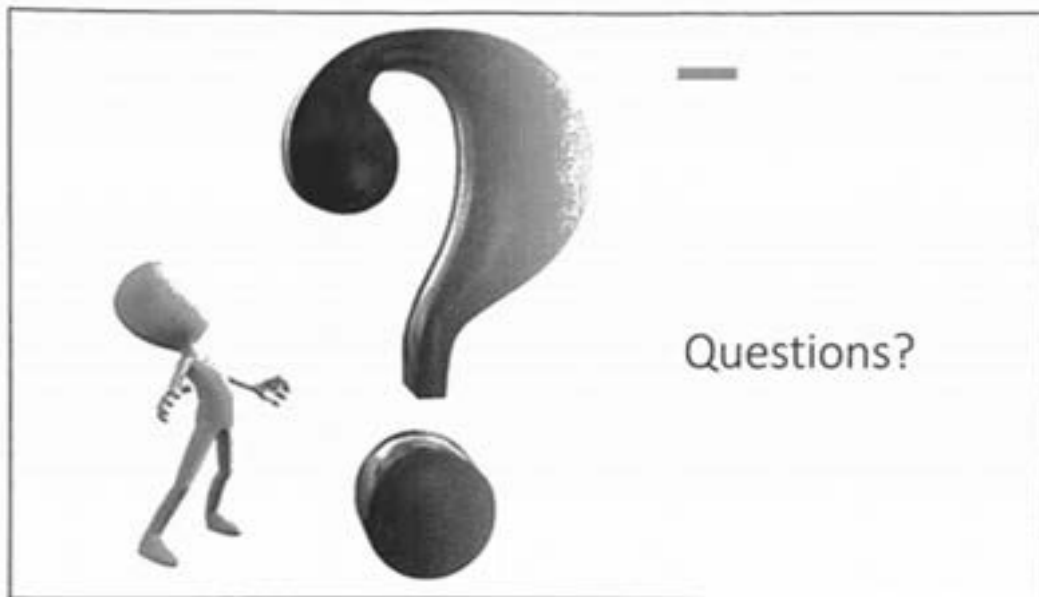
Hospice apps for your phone

Local hospice representatives

CMS.gov

CDC.gov

CAPC



Post Survey

<https://www.surveymonkey.com/r/RJ66KPH>

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## APPENDIX E: PRE-EDUCATION SURVEY RESULTS

Table 1: Pre-Test	Not at all confident	Not so confident	Somewhat confident	Very confident
1. Establish initial rapport (greet the patient, obtain patient name, introduce oneself, etc.)			13.89%	86.11%
2. Elicit all of the patient's problems or reason for consultation		2.78%	38.89%	58.33%
3. Negotiate an agenda taking both patient's and physicians needs into account			55.56%	44.44%
4. Encourage the patient to tell the detailed story of the problem(s) in his/her own words		5.56%	25.00%	69.44%
5. Actively listen, facilitating patient's responses verbally and non-verbally			27.78%	72.22%
6. Clarify patient's statements that are unclear, and periodically summarize to organize the information		2.78%	33.33%	63.89%
7. Share the flow of the interview with the patient		2.94%	58.82%	38.24%
8. Summarize at the appropriate points and structure the interview in a logical sequence		2.94%	64.71%	32.35%
9. Attend to timing and keep interview on task		11.76%	64.71%	23.53%
10. Demonstrate appropriate non-verbal behavior (showing empathy, note taking, etc.)		2.94%	26.47%	70.59%
11. Actively respond to patient emotions verbally		2.94%	41.18%	55.88%
12. Encourage patient to participate in the decision-making process (share own thought processes, intent of the questions and flow of the consultation)		2.94%	38.24%	58.82%
13. Provide the correct amount and type of information	2.94%	8.82%	73.53%	14.71%
14. Share information in a way that aids accurate recall and understanding		17.65%	58.82%	23.53%
15. Achieve shared understanding about the problem		8.82%	50.00%	41.18%
16. Encourage patient to participate in decision-making process to the level they wish			44.12%	55.88%
17. Negotiate a mutually acceptable plan			47.06%	52.94%
18. Check with the patient about whether he/she agrees and is comfortable with the plan			41.18%	58.82%
19. Summarize the session briefly and clarify the plan of care		5.88%	47.06%	47.06%
20. Assure that there is a plan for unexpected outcomes and follow up		14.71%	47.06%	38.24%
21. Thank the patient with appropriate parting statements		5.88%	29.41%	64.71%

## APPENDIX F: POST EDUCATION SURVEY RESULTS

Table 2: Post Test	Not at all confident	Not so confident	Somewhat confident	Very confident
1. Establish initial rapport (greet the patient, obtain patient name, introduce oneself, etc.)		4.35%	21.74%	73.91%
2. Elicit all of the patient's problems or reason for consultation			26.09%	73.91%
3. Negotiate an agenda taking both patient's and physicians needs into account			47.83%	52.17%
4. Encourage the patient to tell the detailed story of the problem(s) in his/her own words			13.04%	86.96%
5. Actively listen, facilitating patient's responses verbally and non-verbally			21.74%	78.26%
6. Clarify patient's statements that are unclear, and periodically summarize to organize the information			17.39%	82.61
7. Share the flow of the interview with the patient			34.78%	65.22%
8. Summarize at the appropriate points and structure the interview in a logical sequence			34.78%	65.22%
9. Attend to timing and keep interview on task			47.83%	52.17%
10. Demonstrate appropriate non-verbal behavior (showing empathy, note taking, etc.)			21.74%	78.26%
11. Actively respond to patient emotions verbally			13.04%	86.96%
12. Encourage patient to participate in the decision-making process (share own thought processes, intent of the questions and flow of the consultation)			21.74%	78.26%
13. Provide the correct amount and type of information			39.13%	60.87%
14. Share information in a way that aids accurate recall and understanding			39.13%	60.87%
15. Achieve shared understanding about the problem			21.74%	78.26%
16. Encourage patient to participate in decision-making process to the level they wish			17.39%	82.61%
17. Negotiate a mutually acceptable plan			21.74%	78.26%
18. Check with the patient about whether he/she agrees and is comfortable with the plan			13.04%	86.96%
19. Summarize the session briefly and clarify the plan of care			21.74%	78.26%
20. Assure that there is a plan for unexpected outcomes and follow up			34.78%	62.22%
21. Thank the patient with appropriate parting statements			17.39%	82.61%

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