



## Enhancing Health Care Communication Skills

Crystal Dea Moore PhD, MSW, MA

To cite this article: Crystal Dea Moore PhD, MSW, MA (2008) Enhancing Health Care Communication Skills, Home Health Care Services Quarterly, 27:1, 21-35, DOI: [10.1300/J027v27n01\\_02](https://doi.org/10.1300/J027v27n01_02)

To link to this article: [http://dx.doi.org/10.1300/J027v27n01\\_02](http://dx.doi.org/10.1300/J027v27n01_02)



Published online: 20 Nov 2008.



Submit your article to this journal [↗](#)



Article views: 190



View related articles [↗](#)



Citing articles: 3 View citing articles [↗](#)

# Enhancing Health Care Communication Skills: Preliminary Evaluation of a Curriculum for Family Caregivers

Crystal Dea Moore, PhD, MSW, MA

**ABSTRACT.** The Communicating Effectively with Health Care Professionals (CE) workshop curriculum is designed for family caregivers to encourage caregiver empowerment, effective health care communication, and advocacy in medical care contexts with the goal of promoting positive health outcomes for care recipients. This mixed-method study employed a cross-sectional quantitative mail survey ( $N = 51$ ) and semi-structured qualitative telephone interviews ( $N = 14$ ) to examine the effectiveness of the curriculum in promoting self-reported changes in caregiver attitudes and communication behavior. Respondents reported increased assertiveness in medical encounters, feelings of empowerment, and preparation and organization of medical information for their care recipients as a result of workshop participation. doi:10.1300/J027v27n01\_02 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2008 by The Haworth Press. All rights reserved.]

---

Crystal Dea Moore is Social Work Program Director and Assistant Professor, Department of Sociology, Anthropology, and Social Work, Skidmore College, 815 N. Broadway, Saratoga Springs, NY 12866 (E-mail: [cmoore@skidmore.edu](mailto:cmoore@skidmore.edu)).

The author thanks the National Family Caregivers Association for their support and assistance in implementing this research, and Jessica Rubin, Joshua Christantiello, Serena Houle, Gretchen Hahn, and Leora Kessler for their help with data collection.

Home Health Care Services Quarterly, Vol. 27(1) 2008

Available online at <http://hhc.haworthpress.com>

© 2008 by The Haworth Press. All rights reserved.

doi:10.1300/J027v27n01\_02

**KEYWORDS.** Communication, curriculum evaluation, family caregivers, caregiver education

### *INTRODUCTION*

Recent national surveys indicate that up to 34% of adults in the United States provide unpaid caregiving services to a family member or friend in the course of a year (AARP, 2001; National Alliance for Caregiving, 2004), and these informal caregiving arrangements are increasingly supported by home health care services (Kadushin, 2004). In addition to routinely providing assistance with basic and instrumental activities of daily living (National Alliance for Caregiving, 2004), family caregivers often help patients utilize and understand health-related information, and provide patient support before, during, and after medical encounters (Glasser, Prohaska, & Gravdal, 2001; Prohaska & Glasser, 1996; Silliman, Bhatti, Khan, Dukes, & Sullivan, 1996). Evidence suggests that family caregivers can and do influence treatment plan implementation and adherence (Beals, Wight, Aneshensel, Murphy, & Miller-Martinez, 2006; Guberman, Lavoie, Pepin, Lauzon, & Montejo, 2006; Silliman et al., 1996; Vivian & Wilcox, 2000), important variables in promoting positive health-related outcomes particularly in the home health care setting.

Caregivers must have a clear understanding of the patient's illness, treatment plan, and their role in patient care delivery to assist with treatment adherence. The foundation for this understanding is open and clear communication with health care team members. Unfortunately, communication among health care professionals, family caregivers, and patients can be difficult and complex. Many health care providers are not routinely trained in communication skills, may overuse professional jargon, be reticent to directly address sensitive issues, or adopt a communication style that does not facilitate patient and family involvement (Agee & White, 2000; Christakis & Lamont, 2000; Fallowfield, Jenkins, Farewell, & Solis-Trapala, 2003; Lee, Back, Block, & Stewart, 2002; Reisfield & Wilson, 2003). In addition, patients and families can contribute to poor communication by not posing questions or asking for clarification during medical visits; they may feel intimidated, not know what to ask, or be overwhelmed with emotion (Moore, 2005). Effective communication in medical encounters include relational development and information exchange skills (Cegala, Coleman, & Turner, 1998; Cegala, McGee, & McNeillis, 1996) which most family caregivers and patients have never been taught.

To promote quality health care communication among professionals, family caregivers, and patients, the National Family Caregivers Association (NFCA) developed a standardized workshop curriculum designed specifically for family caregivers called Communicating Effectively with Health Care Professionals (CE). NFCA is a grassroots nonprofit national organization that “. . . educates, supports, empowers and speaks up for the more than 50 million Americans who care for loved ones with a chronic illness or disability or the frailties of old age” (National Family Caregivers Association, 2006). This article provides an overview of the CE curriculum, describes preliminary evaluation research conducted on its effectiveness, and discusses practice and research implications.

### ***Communicating Effectively with Health Care Professionals Curriculum Overview***

The overall goal of the CE curriculum is to train family caregivers “to use more effective communication techniques with health care professionals, so that [they] can better advocate on behalf of [their] care recipient[s]” (NFCA, 2002). The theoretical foundations of the curriculum include Knowles’ adult learning theory principles (Knowles, 1984) and tenets of social-cognitive theory, specifically the construct of self-efficacy (Bandura, 1997). Knowles’ theory of adult learning focuses more on process and less on content than the typical “teacher-to-learner” or didactic program. According to this perspective, adult learning programs must accommodate certain elements; for example, adults need to know why they need to learn something, to approach learning as problem solving, and to learn experientially. Finally, adults learn best when the topic is of immediate value. Self-efficacy is an individual’s belief about his/her ability to organize and perform certain actions that will manage a given situation; these beliefs can influence coping behavior, amount of effort expended, duration of effort in the face of adversity, and emotional distress (Bandura, 1997). Thus, the CE curriculum emphasizes learning strategies particular to adult learners; self-efficacy enhancement and caregiver empowerment are primary goals whereby proactive coping strategies related to health care communication are promoted and supported.

Through workshop participation and use of the provided written tools and resources, caregivers are introduced to the knowledge and skills that can help them better advocate for their care recipient’s medical needs. Caregiver empowerment is conceptualized through “key principles of effective communication”: establishing presence, participating actively,

building mutual understanding, and encouraging collaboration in medical encounters (NFCA, 2002). Participants are taught that they must establish their presence with health care professionals. Presence is defined as a strong sense of self that helps to develop rapport and working partnerships with medical personnel. Through establishing their presence, caregivers can begin to participate actively during health care encounters, functioning as viable members of the health care team. Active participation in the health care encounter helps to build mutual understanding and collaboration with other members of the team whereby common goals are identified, responsibilities clarified, and problem solving attempted.

More specifically, CE workshop objectives include: (1) development of a realistic understanding of the health care system; (2) creation of a “team approach mentality” to the care recipient’s health care where the caregiver sees him/herself as an integral member of the health care team; (3) identification of the needed skills to assist the caregiver in communicating with the health care team; and (4) communication skills practice. These objectives are met through a combination of teaching and learning strategies that include didactic, interactive, and role-play. Workshop participants are given a detailed 118-page publication (*Workshop and Family Caregiver’s Guide*) that summarizes the standardized workshop content and provides written resources and tools to assist in preparing for, participating in, and following up on their care recipients’ medical visits. Table 1 shows a sample of communication-enhancing tools and their descriptions included in the *Family Caregiver’s Guide*.

To realize workshop objectives, content on the structure of health care systems is discussed and the team approach to health care is explored. The facilitator demonstrates and caregivers are taught basic communication skills including assertiveness (e.g., use of “I” language) and active listening. Caregivers are asked to identify a problematic issue they and their care recipient are experiencing in their communications with medical professionals. Through small group work and consultation with the facilitator, participants develop a “communications planner” for their care recipient’s next medical visit. This written plan includes a prioritized list of what the caregiver needs to say or do to address the identified concerns during the visit. Caregivers are helped to identify appropriate tools in the *Workshop and Family Caregiver’s Guide* to help develop the planner and address their identified needs. Finally, participants engage in role-plays in small groups to practice their use of the communications planner. Emphasis is placed on transference of skill acquisition to actual health care encounters.

TABLE 1. Sample of Tools and Resources Contained in the Family Caregiver's Guide

Tool	Description
<i>Communications planner</i>	Template for summarizing concerns and action steps that caregiver wants to address during next health care visit
<i>Patient file checklist</i>	List of items to include in care recipient's home medical file (e.g., advance directives, insurance information, etc.)
<i>Symptom reporting guide</i>	List of questions to assist in recording care recipients' symptoms between health care visits
<i>Question guide &amp; worksheet</i>	List of suggested questions that caregivers can ask health care professionals about their care recipient's condition
<i>Good communication strategies</i>	Strategies caregivers can use to better communicate with others (e.g., active listening, assertiveness, etc.)
<i>Managing relationship difficulties</i>	Strategies to address problematic communication
<i>Doctor's office visit</i>	Tips for making the most out of doctor's office visits
<i>Emergency room visit</i>	Describes what to expect out of an emergency room visit and how to get the most of ER encounters
<i>Hospital discharge planning</i>	Describes hospital discharge process and questions to ask
<i>Second opinions</i>	Tips for deciding when and how to get a second opinion
<i>Insurance 101</i>	Basic information about insurance coverage

Note: Many of the tools above are available on the National Family Caregivers Association website at the following URL: <http://www.thefamilycaregiver.org/ed/comm.cfm>

Given that many family caregivers have limited time to engage in activities outside of their family and work obligations, the workshop is designed to be implemented in one three- to four-hour session, although the materials are flexible such that the content can be delivered in a series of shorter meetings. Workshop facilitators, typically human service professionals who work with family caregivers, are certified by NFCA as official trainers through the completion of NFCA-sanctioned training in curriculum implementation. During 2003-2004, CE was named a Project of National Significance within the National Family Caregiver Support Program and 10 regional two-day train-the-trainer conferences

sponsored by NFCA were held throughout the United States with funding provided by the U.S. Administration on Aging and the Jacob and Valeria Langeloth Foundation. (The author was the regional conference facilitator in 2004.) The workshop facilitators trained during these regional conferences were screened by NFCA to ensure they had basic facilitation skills and sufficient agency support and resources to successfully implement the curriculum in their communities. In all, approximately 700 workshop facilitators were trained and as of 2006, approximately 10,000 caregivers have participated in CE workshops across the country. Facilitators recruit family caregivers in their local communities to participate in workshops and NFCA provides workshop materials at no charge.

To date, no systematic evaluation of the workshop's impact has been published. The current study examined workshop impact by gathering data from past participants. Specifically, data were collected that examined how well the training met its objectives of enhancing caregivers' health care communication skills by asking caregivers about their perceptions of attitude and behavioral changes. This study helps to fill a gap in the literature and provides an empirical foundation on which to build further research examining how family caregivers can help to promote effective health care communication for their care recipients. To develop evidence regarding the effectiveness of this curriculum, a mixed-methods study was implemented that examined workshop impact on participants' self-reported attitudes and behavior related to health care communication. This will form the basis for a larger, more rigorous examination of curriculum impact on patient health outcomes.

## METHOD

A mixed-method study was conducted to examine the impact of the CE workshop on caregiver attitudes and self-reported behavior consisting of a quantitative mail survey ( $N = 51$ ) and qualitative phone interviews ( $N = 14$ ) with caregiver workshop participants. There was no overlap in participants between the two study components.

*Quantitative mail survey.* Based upon the workshop objectives, mail survey items were developed that addressed: (1) level of assertiveness during medical encounters, (2) frequency of note taking during medical encounters, (3) frequency of document preparation for medical visits, and (4) overall quality of communication with the care recipient's health care provider. All questions were rated on a Likert scale. Attempts were made to keep the survey as short as possible to promote an acceptable

response rate. Participants received the survey after workshop completion and were asked to recall and assess their behavior in each domain *before* taking the workshop and then to rate their behavior *after* taking the workshop (i.e., cross-sectional design). In other words, caregivers provided a retrospective pre-test score on each of the four measures. Table 2 presents exact wording of items.

The participant pool for the mail survey consisted of family caregivers across the United States who had completed the workshop during two seven-month periods. Originally, plans were to distribute the survey during only one time frame. In an attempt to increase the response rate and final sample size, a mailing to a second sample of caregivers was completed. Given the first mailing was larger (fewer workshops were offered during the second time frame), a majority of the final sample was from the first mailing. NFCA-certified trainers that delivered a workshop during these periods were asked to distribute a form to participants giving the researcher permission to contact them by mail. Based on the number of completed permission forms received, a total 223 surveys were mailed over the two time frames (24 surveys were returned as

TABLE 2. Mail Survey Items

	Item Mean	SD	t value
ASSERTIVENESS: How often were you assertive with your care recipient's physician:**			
BEFORE taking the workshop?	2.55	1.01	-4.91
AFTER taking the workshop?	3.28	.75	
NOTE TAKING: How often did you take notes during medical appointments for your care recipient:**			
BEFORE taking the workshop?	2.31	1.13	-6.54
AFTER taking the workshop?	3.18	.94	
DOCUMENT PREPARATION: How often did you prepare documents (for example, lists of medications and/or symptoms) to share with your care recipient's medical professionals:**			
BEFORE taking the workshop?	2.88	1.09	-5.39
AFTER taking the workshop?	3.45	.71	
OVERALL COMMUNICATION QUALITY: How would you rate the overall quality of your communication with your care recipient's main health care provider:***			
BEFORE taking the workshop?	2.71	.87	-5.78
AFTER taking the workshop?	3.39	.50	

\* $p < .001$ .

\*\*Rated on a Likert scale (1 = never to 4 = always).

\*\*\*Rated on a Likert scale (1 = poor to 4 = excellent).



undeliverable) and 51 completed surveys returned resulting in a 26% response rate based on delivered surveys. Nonresponders to the initial mailing received one follow-up mailing. For those in the final sample, there was an average of 18 weeks ( $SD = 5$  weeks) between workshop participation and mail survey completion. Ninety percent of the sample was female and the majority was caring for an aging parent or spouse (55%). The average age of the respondents was 55 years ( $SD = 13$  years). During these two time frames in which the surveys were distributed, 2,994 family caregivers participated in the workshop nationally; thus, the sampling frame of 223 constituted 7% of the total number of family caregivers trained during those two time periods.

*Qualitative phone interviews.* Fourteen caregivers who had participated in a CE workshop participated in telephone interviews and were drawn from a pool ( $N = 30$ ) of workshop participants identified by two experienced NFCA-certified workshop leaders from upstate New York ( $n = 14$ ) and Idaho ( $n = 16$ ). Members of this participant pool were mailed a letter informing them that a researcher would be contacting them by phone to inquire about their interest in being interviewed. In addition, a phone number was provided for the caregiver to call if he/she did not want to be contacted. Of this pool of 30, 14 caregivers agreed to be interviewed; 11 were female and 3 were male with a majority providing care for a relative with an age-related disability (e.g., dementia, heart failure). The upstate New York and Idaho locations were selected due to the experience level of the workshop facilitators who trained these participants. Both facilitators were highly familiar with the curriculum and were adept at delivering the workshop as intended by the train-the-trainer materials. The 30 caregivers were selected by these two facilitators based on their participation in the facilitator's most recent workshop offering. Overall, 1,862 family caregivers were trained across the United States during this time frame, thus the pool of 30 represented 2% of the total trained during that time.

The semi-structured interviews lasted about 15-20 minutes, were audio taped, and conducted by trained research assistants. The interviewers had received course instruction in qualitative interviewing techniques and specialized training on administration of the brief interview schedule. Audiotapes were later transcribed and the data subjected to template analysis, a qualitative data analysis technique that involves creating a set of a priori coding categories (i.e., start list of codes). In this research, the a priori codes were based upon the learning objectives and theoretical framework on which the curriculum is based. These codes were then used to categorize the data into meaningful content groups for data

management (Crabtree & Miller, 1992; Miles & Huberman, 1994). The data associated with each first-level code was examined to identify salient themes within each code.

Participants were asked to comment on the following content domains which were chosen due to their connection to the workshop's objectives and theoretical framework: overall reactions to the workshop, usefulness of the written communication tools contained in the Family Caregiver's Guide, perceived impact of the training on interactions with health care professionals, the degree to which the workshop impacted how the caregiver cared for their care recipient, and suggestions for future workshops.

## RESULTS

### *Quantitative Mail Survey*

For the cross-sectional mail survey, paired sample t-Tests ( $N = 51$ ) were conducted on the questions that assessed self-reported assertiveness, note taking, document preparation, and overall communication. Tests showed significant increases in ratings (perceptions of behavior before versus after workshop completion) for all four variables: assertiveness,  $t = -4.91$ ,  $p < .001$ ; note taking,  $t = -6.54$ ,  $p < .001$ ; document preparation,  $t = -5.39$ ,  $p < .001$ ; and overall quality of communication,  $t = -5.78$ ,  $p < .001$  (see Table 2 for descriptive statistics).

### *Qualitative Phone Interviews*

Results from the qualitative interviews indicated that all fourteen participants were very positive in their overall reactions to the workshop. When asked about the impact that the workshop had on their quality of communication with health care professionals, 12 participants said that the workshop had enhanced their communication and only two indicated that the workshop had no effect. Four themes emerged from the template analysis: caregiver empowerment, increased assertiveness, preparation and organization of medical information, and workshop's positive impact on caregiving experience. A majority of participants discussed more than one benefit. The caregiver quotations illustrate these themes and provide additional context for the quantitative data.

One such benefit was feelings of enhanced empowerment in the context of medical encounters. One participant said, "If I were to take

anyone to the doctors . . . that aren't able to speak for themselves. . . . I don't know if I really would say the 'right,' but I think that's the best way to describe, you know, that I would have the right to stand in for that particular person." Another interviewee discussed the CE concept of establishing presence as it related to empowerment, "I think the best thing was the attitude that we present to the doctors and introducing ourselves as a person, not just someone who happens to be there with the patient."

Other participants disclosed that they were able to be more assertive with health care providers after taking the workshop. One said, "So, yes, basically it's helped my mother substantially, really, because we will say, 'I'm sorry, we need answers here now.' And I don't go away until we get them, whether it's a phone conversation or I'm standing in the doctor's office." Another said of what she learned, "I think the one part that really, really helped me was, you know when you go to a doctor and you're always kind of hesitant to ask questions? And that part really helped me, because it was like, okay, wait a minute, you know [medical professionals] are human. And I need to have these questions answered. So there's no harm in asking them. That's what they're there for. So it was just kind of a, a change of mindset."

The third emergent theme was related to caregiver preparation and organization of medical information. One caregiver said a central concept that came out of the workshop for her was, "Just having your questions actually written down ahead of time probably is the best thing." Others spoke of keeping lists of questions and medications, "Now I make lists that answer questions and have a list of all of his medications in kind of like a journal that I take with me." Another said, "I went into the emergency ward last night, took my father in there at four a.m. and I had just copied off a list of all of his new medications. . . . I had it listed what he takes and how much he takes and how many times he takes it and they were just really pleased. They said, 'You have no idea how much this helps us, that you have this with you, with him.' " Finally, other caregivers shared that they had begun taking notes during health care encounters as was instructed in the workshop, something they had not done in the past.

The final theme pertained to the workshop's positive impact on the caregiving experience. For example, one respondent discussed her and her sister's care for their mother, "We feel more confident, taking care of my mother." Another caregiver noted, "It has given me encouragement that I need, that I am doing the right thing. I make mistakes . . . that comes along with it . . . it was a learning process for me and for my

mother and I struggled with a lot of things but [the workshop leader's] concern . . . has helped a great deal. . . . You keep going." Two other participants said that the workshop helped them communicate better with their care recipients, "It's effective in a lot of ways. Because before I used to get angry and mad [at my care recipient], and now I just kind of look the other way and then when it's the right time, then I try to discuss with her calmly." Another participant said she is now more focused on her care recipient's health concerns and symptoms, "Well, I'm able to focus a little bit more on the health side . . . being able to understand it and work with the doctors better. Then that, in turn, helps mother in the long run." Finally, one participant noted that the workshop encouraged her to take care of herself which helped her to better care for her loved one, "I've learned about my father's illness and about how to care for myself along with caring for them, because if I don't take care of myself and feel good about what I'm doing and understand what I'm doing, then I can't care for them. I didn't realize how stressful it would be. I didn't realize how difficult it would be. And the class that I took from her taught me to, to take care of myself and learn how to cope and learn to go to places to help me take care of them."

### *DISCUSSION*

The Communicating Effectively with Health Care Professionals (CE) curriculum is a unique strategy that targets family caregivers to address the challenges associated with clear communication among patients, health care providers, and family members. The goal of this educational intervention is to empower caregivers and train them in basic communication skills so they can be more effective advocates for their ill family members. Although numerous interventions have been designed to promote effective communication between patients and providers (Post, Cegala, & Miser, 2002), no other intervention aimed at enhancing family caregiver communication in health care contexts could be identified in the literature. This evaluation research suggests that the CE curriculum can be effective in promoting self-reported attitude and behavioral changes consistent with caregiver empowerment and clear communication in health care settings and makes a meaningful contribution to the literature on which to build.

Previous research indicates that family caregivers are often present during medical encounters (Glasser et al., 2001; Prohaska & Glasser, 1996) and other work points to the various roles these individuals play

during those visits (Adelman, Greene, & Charon, 1987; Beisecker, 1989). Kahana and Kahana (2003) details a conceptual model of health care communication among health care partners that include patients, physicians, and “health significant others” (e.g., family caregivers). This model suggests that health significant others have considerable influence on the health behaviors of family members by assisting them in communicating with physicians, supporting treatment plans and lifestyle changes, sharing in the decision-making process, and acting as an advocate for the patient. On the other hand, Adelman et al. (1987) and Beisecker (1989) point out that the presence of a family caregiver during medical encounters has the potential to negatively influence communication between health care professionals and patients when the caregiver adopts an antagonistic, passive, or surrogate patient role. Considered together, this body of work indicates that family caregivers can indeed be helpful in supporting positive health outcomes for patients but interventions are needed to promote more effective and proactive caregiver involvement. The current research suggests that the CE curriculum can provide caregivers with communication tools and an increased sense of empowerment that leads to behaviors that help them both advocate for the patient and support the treatment plan.

Family caregivers can be a powerful and effective link between the formal and informal care systems, and given the fragmented health care delivery system in the United States, they are increasingly needed to help coordinate and manage patient care. The current study describing and evaluating the CE curriculum is an important and meaningful beginning to the empirical exploration of strategies to help family caregivers be viable and effective members of the care recipient’s medical team. It builds on the body of research on patient-provider communication interventions, while acknowledging the centrality of family caregiver involvement in patient health outcomes and well-being.

Practice implications of this research are numerous. The National Family Caregivers Association (NFCA) provides a website with abundant resources for family caregivers, including tools from the CE curriculum (NFCA’s URL is <http://www.thefamilycaregiver.org>). Home health care professionals can either refer patients and families to this website or download the posted tools for use in the context of their home care practice with patients and families. For example, home care professionals can utilize the worksheets that address symptom reporting to teach caregivers to accurately monitor the effects of treatment between home visits. In addition, the underlying principles of the curriculum, namely caregiver empowerment, cooperative health care team

member participation, and collaborative communication strategies can be instructive for health care professionals, too. In what ways can health care providers encourage caregivers to participate as viable members of the health care team? What messages do health care professionals send family caregivers, either overtly or covertly, about the caregiver role on the health care team? What communication strategies can providers utilize to promote rapport and trust with patients and caregivers an important component in the communication equation? The lessons of CE can be incorporated into professional practice to provide the context for family-centered health care.

Although the results of this study are positive and promising, there are numerous limitations associated with this research including a small, nonrandom sample, low response rate, and the reliance on retrospective, self-report data which are susceptible to social desirability bias (Hill & Betz, 2005). Thus, readers should exercise caution when generalizing these findings. To provide further evidence related to CE effectiveness, researchers are encouraged to evaluate the curriculum utilizing other more rigorous research methods and larger samples. This study underscores the challenge of conducting evaluation research in applied settings with family caregivers; the low response rate observed could be partially due to family caregivers' reticence to take on yet another task related to caregiving, even if it is just the completion of a short survey. Increasing response rates among this population is challenging. In one of the author's current studies, the use of an incentive (e.g., gift cards) has proven to be a helpful method to increase caregiver participation. In addition, asking caregivers to complete evaluation instruments as part of the workshop experience would produce better response rates rather than waiting to collect data at a later time when their attention is focused on more pressing matters. Although there are legitimate factors that compromise generalizability of the findings, the research was conducted in settings where the intervention is being widely disseminated, a factor that leads to some degree of external validity. The mail survey has content validity, reflecting not only workshop objectives but underscores what caregivers found as important learning components of the CE curriculum.

Future research plans include an examination of feasibility and effectiveness of CE curriculum delivery in the context of health care systems (including the VA system), comparison of different curriculum delivery modalities (workshop format, individual intervention, multimedia materials) on caregiver attitudes and behavior, an investigation of family functioning as it relates to caregiver role performance in facilitating health care communication for older patients, and the impact of the curriculum

on patient health outcomes. In the near future, a prospective evaluation of the curriculum will be implemented in the context of a health care system to corroborate the findings of this research using a more rigorous research design that addresses some of the methodological concerns of this study, namely the use of retrospective pre-test. The principles embodied by the CE curriculum and their implementation as an educational intervention is a forward-thinking strategy in promoting a smooth and effective interface between the formal and informal systems of care.

## REFERENCES

- AARP. (2001). *Caregiver identification study*. Washington, DC: AARP.
- Adelman, R. D., Greene, M. G., & Charon, R. (1987). The Physician-Elderly patient companion triad in the medical encounter: The development of a conceptual framework and research agenda. *The Gerontologist*, 27(6), 729-734.
- Agee, A., & White, P. (2000). Service providers' modes of interacting with frail elders and their families: Understanding the context for caregiving decisions. *Journal of Aging Studies*, 14(3), 313-333.
- Bandura, A. (1997). *Self-efficacy: The exercise of control*. New York, NY: W.H. Freeman & Company.
- Beals, K. P., Wight, R. G., Aneshensel, C. S., Murphy, D. A., & Miller-Martinez, D. (2006). The role of family caregivers in HIV medication adherence. *AIDS Care*, 18(6), 589-596.
- Beisecker, A. E. (1989). The influence of a companion on the doctor-elderly patient interaction. *Health Communication*, 1(1), 55-70.
- Cegala, D. J., Coleman, M. T., & Turner, J. (1998). The development and partial assessment of the medical competence scale. *Health Communication*, 10(3), 261-288.
- Cegala, D. J., McGee, D. S., & McNeilis, K. S. (1996). Components of patients' and doctors' perceptions of communication competence during a primary care medical interview. *Health Communication*, 8(1), 1-27.
- Christakis, N. A., & Lamont, E. B. (2000). Extent and determinants of error in doctors' prognoses in terminally ill patients: Prospective cohort study. *British Medical Journal*, 320, 469-473.
- Crabtree, B. F., & Miller, W. (1992). A template approach to text analysis: Developing and using codebooks. In B. Crabtree & W. Miller (Eds.), *Doing Qualitative Research* (pp. 93-109). Newbury Park, CA: Sage.
- Fallowfield, L. J., Jenkins, V., Farewell, V., & Solis-Trapala, I. (2003). Enduring impact of communication skills training: Results of a 12-month follow-up. *British Journal of Cancer*, 89, 1445-1449.
- Glasser, M., Prohaska, T. R., & Gravdal, J. (2001). Elderly patients and their accompanying caregivers on medical visits. *Research on Aging*, 23(3), 326-348.
- Guberman, N., Lavoie, J.-P., Pepin, J., Lauzon, S., & Montejo, M.-E. (2006). Formal service practitioners' views of family caregivers' responsibilities and difficulties. *Canadian Journal of Aging*, 25(1), 43-53.

- Hill, L. G., & Betz, D. L. (2005). Revisiting the retrospective pretest. *American Journal of Evaluation, 26*, 501-517.
- Kadushin, G. (2004). Home health care utilization: A review of the research for social work. *Health & Social Work, 29*(3), 219-232.
- Kahana, E., & Kahana, B. (2003). Patient proactivity in enhancing doctor-patient-family communication in cancer prevention and care among the aged. *Patient Education and Counseling, 50*, 67-73.
- Knowles, M. (1984). *Andragogy in action*. San Francisco, CA: Jossey-Bass.
- Lee, S. J., Back, A. L., Block, S. D., & Stewart, S. K. (2002). Enhancing physician-patient communication. *Hematology, 464*-483.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. Thousand Oaks, CA: Sage.
- Moore, C. D. (2005). Advance care planning. In K. K. Kuebler, M. Davis & C. D. Moore (Eds.), *Palliative practices: An interdisciplinary approach*. St. Louis, MO: Elsevier Mosby.
- National Alliance for Caregiving. (2004). *Caregiving in the U.S.* Washington, DC: National Alliance for Caregiving and AARP.
- National Family Caregivers Association. (2006). *About NFCA*. Retrieved November 30, 2006 from [http://www.thefamilycaregiver.org/about\\_nfca/](http://www.thefamilycaregiver.org/about_nfca/).
- National Family Caregivers Association. (2002). *Communicating Effectively with Health Care Professionals: Workshop guide*. Baltimore, MD: NFCA.
- Post, D. M., Cegala, D. J., & Miser, W. (2002). The other half of the whole: Teaching patients to communicate with physicians. *Family Medicine, 34*(5), 344-352.
- Prohaska, T. R., & Glasser, M. (1996). Patients' views of family involvement in medical care decisions and encounters. *Research on Aging, 18*(1), 52-69.
- Reisfield, G. M., & Wilson, G. R. (2003). Ambiguity in end-of-life communications. *Journal of Terminal Oncology, 2*(2), 61-66.
- Silliman, R. A., Bhatti, S., Khan, A., Dukes, K. A., & Sullivan, L. M. (1996). The care of older persons with diabetes mellitus: Families and primary care physicians. *Journal of the American Geriatrics Society, 44*(11), 1314-1321.
- Vivian, B. G., & Wilcox, J. R. (2000). Compliance communication in home health care: A mutually reciprocal process. *Qualitative Health Research, 10*(1), 103-116.

RECEIVED: 12/13/06

REVISED: 02/19/07

ACCEPTED: 03/27/07

doi:10.1300/J027v27n01\_02