Assessing for Barriers Prior to Advance Directive Execution: A Descriptive Study of Social Work Practice Behaviors

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Assessing for Barriers Prior to Advance Directive Execution: A Descriptive Study of Social Work Practice Behaviors

by

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MSW Clinical Research Paper

Presented to the Faculty of the School of Social Work St. Catherine University and the University of St. Thomas St. Paul, Minnesota in Partial Fulfillment of the Requirements for the Degree of Master of Social Work

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The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University - University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrate facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master’s thesis nor a dissertation.
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ABSTRACT

Existing research indicates that social workers are active, interdisciplinary participants in the facilitation of advance directives (Black, 2005). Despite policies designed to increase completion rates, only 36% of adults report having an advance directives (Rao, Anderson, Lin, & Laux, 2014; U.S. Department of Health and Human Services, 2008). There are known barriers at the patient level that ultimately prevent advance directive documentation (Shickedanz et al., 2008). This study aimed to understand whether social worker awareness of patient-level barriers influence perceptions of advance directives and related practice behaviors. Social work setting, expectations, and sense of competency were also assessed for mediating influence. This study surveyed 56 medical social workers at five Minneapolis-St.Paul metropolitan-area hospitals. Data was collected through a self-administered 55-item questionnaire designed by the researcher. This study found that social workers who felt a greater sense of personal responsibility and competence around facilitating advance directives were significantly more likely to assess for patient barriers to advance directive completion. Based on this research, it is recommended that medical settings provide comprehensive advance directive training targeted to social workers. This research also suggests that settings ought to clarify the responsibility social workers have to facilitating advance directives so as to improve assessment of and responsiveness to patient-level barriers.
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Introduction

The American Bar Association describes a health care advance directive as “the general term for any written statement you make while competent concerning your future health care wishes.” (American Bar Association, 2016b, para 1). An advance directive (AD) is comprised of two components: a living will and designation of a health care power of attorney. Simply, a living will is written instruction to health care providers regarding the kinds of medical care an individual does or does not want if they are unable to speak for themselves. This document includes preferences regarding how a provider may use, withhold, or withdraw life-sustaining treatment (Benson & Aldrich, 2012). An AD is a document designed to honor individual preferences, preserving autonomy when a person has lost the capacity to speak for themselves (U.S. Department of Health and Human Services, 2008). While ADs are often a component of planning for end of life, medical professionals recommend ADs for adults of all ages regardless of diagnoses or prognoses (Thompson, 2015). ADs are becoming more widely visible, with high-profile legal cases like Terri Schiavo highlighting the risks of failure to formally document treatment preferences. Determined to be in a persistent vegetative state, Terri Schiavo continued to receive life-sustaining interventions for fifteen years, with conflicting accounts of whether or not she would have chosen to receive such treatment.

The Patient Self-Determination Act (PSDA) is a policy-level intervention designed to increase rates of ADs. The PSDA (1991) mandates Medicare and Medicaid-funded medical settings to provide information about advance directives. Approaches to implement this mandate vary by setting. Despite the PSDA, only 36% of American adults report having an AD (Rao, Anderson, Lin, & Laux, 2014; U.S. Department of Health and Human Services, 2008). Advance planning and documentation behaviors vary drastically among individuals, with
sociodemographic characteristics holding powerful effect. As such, a one-size-fits-all approach appears to be insufficient as an intervention (Kwak & Haley, 2005).

Social workers, an integral part of interdisciplinary health care teams, have the skill set necessary to bolster AD interventions. This research is informed by Black’s (2005) conceptualization of AD as a result of seven discrete communication steps: (1) initiation of the topic; (2) disclosure of information; (3) identification of a surrogate decision-maker; (4) discussion of treatment options; (5) elicitation of patient values; (6) interaction with family members and significant others; and (7) collaboration with other health care professionals (p. 43). Black (2005) found social workers actively involved throughout the process. Using Black’s (2005) seven stages as a conceptual model of the discrete behaviors leading to AD completion, this research conceptualizes movement through the steps using Prochaska’s (1997) transtheoretical model (TTM), “stages of change.” Shickedanz et al (2009) suggest that clinicians ought to anticipate and respond to individual barriers at every stage of advanced planning to create a more targeted intervention.

**Research Question**

This research was developed to attend to an identified gap in the present literature. There is a paucity of research that clarifies the role of social work in facilitating ADs (Black, 2005). Additionally, interventions aimed to increase AD completion have focused primarily on documentation itself, rather than engagement in the steps leading up to documentation (Sudore et al., 2008). Given the current recommendations and lack of clarity around actual practice behavior, this research asks the question: to what extent do patient-level barriers influence the perceptions and practice of medical social workers as they facilitate advance directives?
Through a variety of survey questions, this researcher will attend to possible influences of social work setting, expectations, and sense of competency.

**Hypothesis 1.** Social workers who consider ADs to be a process, rather than a singular event, will be more likely to a) expect patient barriers, and b) assess for those barriers.

**Hypothesis 2.** This research expects that social workers in an inpatient setting will report a) a greater sense of personal responsibility to assess for barriers; b) higher feelings of competence to facilitate ADs, and c) more assessment behaviors.

**Hypothesis 3.** This research anticipates that social workers who report a greater sense of personal responsibility for facilitating ADs at every step will be more likely to assess for patient barriers at the preparatory steps leading up to documentation.

**Hypothesis 4.** Social workers who anticipate that patients will experience barriers at any of the steps leading up to AD documentation are predicted to report a greater number of assessment behaviors.

**Hypothesis 5.** This research expects to find that social worker perception of personal competence will be positively correlated with assessment of barrier behaviors.

**Literature Review**

The U.S. Department of Health and Human Services (2008) defines life-sustaining treatment as “medical procedures that replace or support an essential bodily function” (U.S. Department of Health and Human Services, 2008, p. 7). A living will also may include contextual preferences, such as how an individual’s future level of functioning or prognosis would influence consent to life-sustaining treatment, pain control, comfort care, or end-of-life preferences (American Bar Association, 2016a).
An individual designates a health care power of attorney (HCPOA) to make medical decisions on their behalf. This designee is referred to as “proxy,” “decision maker,” or “medical power of attorney.” If a patient cannot give consent, the HCPOA acts as an advocate, assisting in medical decision-making in accordance with the patient’s wishes. Responsibilities may include giving consent or refusing medical treatments or procedures, including life-sustaining treatment, pain management, or comfort care. The HCPOA may also make decisions outside of circumstances listed in the living will, such as authorization of discharge or transfer to medical facilities for continued or long-term care (American Bar Association, 2016d).

**Purpose of Advance Directives**

Many Americans find themselves in a position of vulnerability, with a medical illness or condition that renders them unable to make decisions (Silveira, Kim, & Langa, 2010). Initially, advanced directives were a way to prevent extending life through unwanted medical interventions (Wilkinson, Wenger, & Shugarman, 2007). Historically, there has been the expectation that physicians or other medical providers will act in the patient’s best interest in these circumstances. However, “the patient’s best interest” has proven to be interpreted differently by medical providers, ethicists, policy makers, patients and families. The contexts of autonomy, quality of life, and withdrawal of care add particular ethical complexity (Rao et al., 2005). Individual preferences and values, in conjunction with particular medical circumstances, invariably make the “right” decision unique in every case. Given the medical culture of extending lives at all cost, documenting preferences becomes particularly important for individuals who want to avoid aggressive treatment or life-sustaining measures (Benson & Aldrich, 2012).

**Benefits of Advance Directives**
The American Bar Association (2016e) suggests that preferences documented in an advance directive are more likely to be honored than informal verbal communication. Another benefit associated with completing advanced directives includes reduced stress for providers, patients, and their families (LoBuono, 2002). This reduced pressure may be unsurprising given the reality that families often do not feel confident in their ability to comprehend relevant medical information needed to make informed decisions (U.S. Department of Health and Human Services, 2008). And without guidance, HCPOAs tend to choose treatment options more aggressive than the patient would have wanted (Wilkinson, Wenger & Shugarman, 2007).

**Patient Self-Determination Act**

The aptly named Patient Self-Determination Act (PSDA) is a federal law enacted with the purpose of increasing completion of ADs. The PSDA (1991) requires all health care facilities that receive reimbursement through Medicare or Medicaid to ask patients if they have an AD, provide the patient with information regarding the facility’s policies about ADs, and document in the medical record if the patient has an AD. Additionally, the PSDA (1991) mandates education to both health care facility staff and the community about health care decision-making (American Bar Association, 2016c).

Despite the implementation of the PSDA (1991) over twenty-five years ago, the rate of adult completion of ADs remains underwhelming. Estimates of AD completion range from 18-36% (U.S. Department of Health and Human Services, 2008). This limited rate is not for lack of preference around end-of-life care, as a study by Steinhauser et al. (2000) indicates that patients do assign great importance to many issues implicated in end-of-life, ranging from specific treatment preferences to “not feeling like a burden.” Even adults without ADs report they have
preferences about their medical treatment in the event they could not speak for themselves (Pollack, Morhaim, & Williams, 2010).

**Advance Care Planning**

Much of the related literature conceptualizes ADs as a component of advance care planning. Kolarik, Arnold, Fischer, and Tulsky (2002) define advance care planning as “a process by which patients may anticipate and discuss future health states and treatment options” (p. 698), ultimately resulting in clarified goals and preferences of care.

One way to approach improving rates of AD completion is to look at the behaviors that often occur naturally prior to documentation. For example, Schickendanz et al. (2009) conceptualize ADs as the final of four discrete advanced care planning steps: a) contemplation of values and future treatment wishes; b) discussions with family with friends; c) discussions with clinicians; and d) documentation [advance directives]. While these steps are fewer than those outlined by Black (2005), both result in AD documentation. The conceptualization of specific steps or behaviors occurring prior to AD documentation is significant because, as Schickendanz et al. (2009) confirm, patients can and do face barriers at any of these steps. While executing an AD does not necessarily require detailed advanced care planning, Briggs and Colvin (2002) recommend that an individual have advance care planning conversations with their providers prior to documenting preferences around future medical decisions.

**Barriers to Completing an Advance Directive**

The low rate of AD completion is incongruent with the preference of Americans to have ADs. To some extent, this inconsistency may be explained by PSDA (1991) which creates varied interpretation of hospital policies. However, research indicates that there are barriers at the level of the individual that prevent engagement at all levels of advance care planning
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(contemplating wishes, discussion with family and friends, discussion with doctors) and ultimately AD documentation (Schickendanz et al., 2009). Similarly, Kahana, Dan, Kahana, and Kercher (2004) found that, in a study of 231 older adults, motivation to make advance care plans correlated more strongly with personal variables than with circumstances of health.

**Policy level.** The PSDA (1991) does not require a medical facility to designate a specific professional responsible for facilitating ADs. In a report to Congress, the Department of Health and Human Services (2008) suggests that “An entire set of barriers to advance care planning arises from the fact that responsibility for initiating the discussions needed for advance care planning does not fall to any specific part of the traditional health care system… The substantial time commitment required for advance care planning is not an expectation of any particular venue of care and no mechanism exists to compensate clinicians to carry out the task” (p.26). Indeed, because the PDSA does not appoint a responsible party for advanced care planning or ADs, the patient experience is inherently varied across healthcare facilities in terms of care provider responsibility for initiation of the topic, informal and formal discussion, and documentation. These responsibilities are often shared among physicians, patient representatives, nurses, and social workers (Westley & Briggs, 2004). It is perhaps unsurprising that ADs are often not treated as an extension of advanced care planning, instead addressed as a singular event in themselves (Fried et al., 2010; Wilkinson, Wenger & Shugarman, 2007).

**Provider communication.** In many hospitals, admissions clerks are the party responsible to distribute written material about ADs or PSDA (1991) (Mezey, Leitman, Mitty, Bottrell, & Ramsey, 2000). For patients without previous exposure to ADs, this initial interaction between patient and clerk might shape AD judgments and future behaviors. While past studies have found that individuals do need more information about ADs, providing written
information alone is ineffective as an intervention (Silveira, DiPiero, Gerrity, & Feudtner, 2000; Tamayo-Velázquez et al., 2010). Pollack, Morhaim, and Williams (2010) found that adults without an AD would prefer to receive information from their physicians, although very few did. Physicians may be less willing or able to initiate discussions about advanced care plans due to lack of time or perceived urgency of conversation (Curtis, Patrick, Caldwell, & Collier, 2000). This lack of physician willingness or ability is particularly problematic given that most adults without an AD expect physicians to initiate those discussions (Wetle, 1994). Patients also cite a lack of time with providers as a barrier to advance care planning and AD execution (Shickedanz et al., 2009).

**Patient-level barriers.** Sociodemographic variables which decrease the likelihood of having an AD include low levels of education, Medicaid-insured or uninsured, and low income, with the level of education found to have the most significant effect on AD execution (Mezey, Leitman, Mitty, Bottrell, & Ramsey, 2000). It has been hypothesized (Mezey, Leitman, Mitty, Bottrell, & Ramsey, 2000) that individuals with higher educational attainment may be more likely to complete ADs due to a stronger sense of self-efficacy, both in terms of accessing health care and requesting the information needed to make informed decisions, and a sense of trust in the system.

**Race.** Race has been identified as a predictive demographic variable, with Black adults less likely than Whites to have ADs (Kahana, Dan, Kahana, & Kercher, 2004; Pollack, Morhaim, & Williams, 2010). Differences between Blacks and Whites in advanced planning behaviors are attributed to differences in culture, communication patterns, and general perceptions influencing advance care planning, such as distrust in the medical system (Hopp & Duffy, 2000; Kwak & Haley, 2005; Wilkinson, Wenger, & Shugarman, 2007).
**Internal variables.** Researchers note several intrinsic factors prevent participating in advance care planning and therefore completion of an AD. For example, the perception that advance care planning is irrelevant or feeling “too healthy,” is often identified as a reason not to pursue an AD (Pollack, Morhaim, & Williams, 2010; Schickedanz et al., 2009). This may explain why some adults waiting until they have a terminal diagnosis to pursue advance care planning (Kahana, Dan, Kahana & Kercher, 2004). Other barriers to advanced planning and documentation include emotional discomfort with the process and the expectation that completing an AD would take too much time, effort, and money (Pollack, Morhaim, & Williams, 2010; Schickedanz et al., 2009).

**Lack of information.** A study by Pollack, Morhaim and Williams (2010) indicates adults are unfamiliar with ADs. Many self-report they lack information necessary to complete an AD or have trouble with AD forms (Mezey, Leitman, Mitty, Bottrell, & Ramsey, 2000; Pollack, Morhaim, & Williams, 2010; Schickedanz et al., 2009). This supports a previous study by Silveira, DiPiero, Gerrity, and Feudtner (2000), which found that individuals do not accurately comprehend or are unaware of end-of-life treatment and care options. Together, these studies suggest that adults often lack information about ADs, which directly implicates their ability to articulate care preferences.

Rosen and O’Neill (1998) suggest that the rates of advance directive completion are inherently low due to the contextual dynamics of initial exposure: patients are often in a vulnerable state when first given information about their rights related to advance directives. In such cases, both patients and their families are typically overwhelmed by medical issues, or in the case of nursing homes, cognitive impairment. The decisions required to complete an AD require reflection on personal values and quality of life. For these reasons, Rosen and O’Neill
(1998) posit that it is often a poor time to expect consideration or completion of advance directives.

**Facilitators to Completing an Advance Directive**

**Patient-level variables.** Concurrently, there are sociodemographic variables which predict greater AD success. For example, English speakers have been found to have more knowledge about ADs, and higher rates of completion (Mezey, Leitman, Mitty, Bottrell, & Ramsey, 2000). When compared to other races or ethnicities, Whites tend to be more informed about ADs and have higher rates of completion (Kwak & Haley, 2005). Higher levels of education also consistently correspond with rates of AD in multiple studies (Carr & Khodyakov, 2007; del Pozo Puente et al., 2014; Mezey, Leitman, Mitty, Bottrell, & Ramsey, 2000). Research around age as a predictive variable is mixed, but a study by Kahana, Dan, Kahana, and Kercher (2004) found that the oldest respondents were most likely to have a discussion with family and make formalized advanced care plans, perhaps because of the imminence of life’s end.

Social context also seems to influence an individual’s decision to pursue advanced planning. Personal experience with a medical condition or diagnosis or a friend with illness or injury have also found to be motivating factors to complete an AD (Carr & Khodyakov, 2007; Lambert et al., 2005; Pollack, Morhaim, & Williams, 2010). Additionally, patients who report greater isolation or live alone are also more likely to complete ADs (del Pozo Puente et al., 2014).

Research has also revealed that some aspects of AD execution are particularly motivating. One study conducted by Mezey, Leitman, Mitty, Bottrell, and Ramsey (2000) surveyed 1,016 individuals who had been discharged from the hospital, to determine whether or not they had completed an AD and the reasoning behind their decision. The most frequent
responses for individuals who had completed an AD were “wanting to make up your own mind (92%); felt it would help your family if they knew what you wanted” (89%); felt it would give you peace of mind (85%); and don’t want to be kept alive with tubes, wires and in a coma (81%)” (p.167).

Certain behaviors also seem to have predictive value. For example, having informal conversation about end-of-life planning seems to be a critical step to predicting AD documentation (Schickendanz et al., 2009), with one study finding that such discussions increased the likelihood of formal planning by up to seven times (Carr & Khodyakov, 2007).

**Provider level.** There are characteristics within the medical setting that may encourage AD completion. For example, a longer duration of relationship with physicians predicts formalization of ADs, as well as higher numbers of specialized medical consultations, both of which may reflect more opportunity to gain understanding (del Pozo Puente et al., 2014). Indeed, having conversations with physicians about advanced planning and documentation is known to influence an individual’s decision-making around ADs (Wenger et al. 2001 as cited in del Pozo Puente et al., 2014).

Tamayo-Velázquez et al. (2010) conducted a meta-analysis of systematic reviews and found that interventions which utilize multiple, direct interactions between patient and care provider result in higher rates of AD completion. That it would take multiple encounters to complete an AD successfully is reasonable, given that individuals have to both identify a personal health care agent and translate personal values into treatment wishes prior to documentation. Interventions that provide AD-relevant informative material in conjunction with direct interactions are most successful, as well as interventions that had an expert available to answer questions and assist with AD completion (Tamayo-Velázquez et al., 2010).
Role of Social Work

Social workers are uniquely situated to facilitate the advanced care planning process and ADs. Given their clinical training and background, social workers are able to navigate family dynamics, initiate emotionally charged conversation, and work from a place of cultural sensitivity. In medical settings social workers often act as members of interdisciplinary health care teams. Coordinated care of physicians, nursing staff, and other care providers enables social workers to contribute their skills to comprehensive treatment of the patient. That said, in the process of advance care planning as well as AD completion, the role of social work remains somewhat ambiguous (Black, 2005). As stated, the PSDA (1991) does not nominate a specific party as responsible for executing an advance directive. However, in many settings, social workers are deeply embedded in AD processes and have been found to exhibit moderate to high knowledge about ADs (Baker, 2000).

In a study designed to analyze the roles of different medical disciplines in advance directive communication practices, Black (2005) surveyed 135 medical professionals from multiple hospitals, with respondents including physicians, nurses, and social workers. Respondents reflected on their participation across all seven communication practices of the AD process: (1) initiation of the topic; (2) disclosure of information; (3) identification of a surrogate decision-maker; (4) discussion of treatment options; (5) elicitation of patient values; (6) interaction with family members and significant others; and (7) collaboration with other health care professionals (p. 43).

Black (2005) found statistically significant interdisciplinary differences in practice behaviors related to ADs. First, social workers reported significantly greater disclosure of AD-related information, identified as “the purpose of advance directives, patient rights to formulate
or modify the documents, parameters about specific directives such as the do-not-resuscitate order, and the need to document patient directives in the medical record” (Black, 2005, p. 46).

Secondly, when compared to physicians and nurses, social workers were significantly more likely to assist patients with considering and ultimately choosing a surrogate decision maker. Social workers were also more likely to discuss with patients artificial nutrition and hydration and comfort measures as treatment options. Social workers also reported greater engagement in the elicitation of patient values. Black (2005) states that social workers more frequently “urged patients to think about their values in living as they consider the impact of potential treatment options on the ability to be functionally independent, the potential for placement at a nursing home or extended rehabilitation, costs associated with treatment options, and the overall probability of resuming life as lived prior to treatment decisions” (p. 47).

Social workers reported significantly more interaction with patient family members and significant others, often at the request of another medical professional. Unsurprisingly, the social workers in Black’s (2005) study identified themselves as active collaborators on their interdisciplinary teams, and reported significant greater collaboration practices than both physicians and nurses. Interestingly, Black (2005) also found that social workers were able to discuss topics related to death and dying more easily than other providers, which she relates to the strong interpersonal skills required in the field. The value of social workers as mental health professionals also extends to their demonstrated ability to elicit patient values and navigate family dynamics, which are often particularly complicated at end of life (Black, 2000).

Indeed, social workers play an integral role in promoting AD communication and completion. As time constraints are known to be a limiting factor for both patients and physicians, addressing AD issues with a social worker would allow patients to maximize time
with their other care providers (Curtis, Patrick, Caldwell & Collier, 2000; Shickedanz et al, 2009). Informed by research that patients do endorse barriers at multiple stages leading up to an AD, Shickedanz et al. (2009) advise clinicians to anticipate and individually assess for barriers at every step as a way to individualize interventions. Reducing barriers would facilitate progression towards AD documentation. Additionally, anticipation of barriers to AD execution would allow social workers to target particular populations. For example, the knowledge that younger adults are less likely to have an AD, as well as awareness that adults self-endorse the belief that they are “too young” to have an AD may inform an intervention to make it more successful and efficient (Pollack, Morhaim, & Williams, 2010).

**Transtheoretical Model**

Prochaska’s (1997) transtheoretical model (TTM) conceptualizes change in behavior as a process rather than a singular event. Behavior change is a progression through six stages: precontemplation, contemplation, preparation, action, maintenance, and ultimately termination. Using the TTM has been proven successful in understanding and intervening in health behaviors such as smoking cessation, change in exercise and dietary habits, and increased contraception use (Zimmerman, Olsen, & Bosworth, 2000). Targeting an intervention based on assessed readiness to change is congruent with the social work adage to “meet client where they are.”

Within the context of AD preparation and execution, the stages are operationalized as followed: pre-contemplation would be indicated by a patient lacking awareness or desire to complete an AD. Contemplation would be a patient considering values and how they might align with future treatments. The preparation stage is exhibited by the preparatory communication steps outlined by Black (2005). Finally, the action stage would be documentation of the AD.
Anchored by TTM, clinicians can understand AD documentation as the result of previous stages. TTM has been suggested as an approach compatible with advance care planning and ADs, as literature indicates completing an AD is rarely a discrete event (Westley & Briggs, 2004). This researcher considers the preparatory steps to be nonlinear, but preparation must occur before action. According to this conceptual model, clinicians who wish to facilitate AD documentation ought to a) recognize that barriers at any stage of change halts forward progress; and b) respond to barriers to facilitate movement to the next stage. This conceptual application was adapted from Sudore et al. (2008).

Also hopeful, research finds brief interventions to be equally effective as longer therapeutic encounters, making this an approach compatible with the limited time available in a medical setting (Zimmerman, Olsen, & Bosworth, 2000). Beginning with the initial PSDA (1991) requirement to ask individuals whether they have an AD, there is an evolving need for information, emotional support, and support around advance care planning. With a clinician able to tailor each brief encounter to an individual’s presenting stage of change, the progression through the stages may be more likely result in a completed AD.

Methods

Sampling Frame

The sampling frame targeted five hospitals located in the Minneapolis-St. Paul metro area. Social work supervisors were contacted about the purpose of the study, and letters of permission to recruit participants were required prior to recruitment, per requirement of the St. Thomas IRB. Supervisors were provided with an email to circulate to staff social workers. The email included a brief synopsis of the research and the two inclusion criteria, that respondents have direct contact with patients/clients and that they work with adults in activities related to
advance directives. Participants were told their participation was optional, their survey responses would be anonymous, and they could expect the survey to take between ten and 15 minutes.

Respondents

A total of 56 social workers responded to the survey (N=56). Forty-seven respondents (83.9%) reported working with adults, 1 respondent (1.8%) reported working with adults on advance directive for children, and 5 respondents (8.9%) stated they worked with both adults and children. Three respondents (5.4%) did not answer the question. As this study aimed to collect data related to adult advance directives, the 1 respondent who indicated s/he worked with adults on advance directives for children were ineligible. S/he was thanked and directed to the end of the survey.

A total of 52 respondents responded to the question asking them to distinguish their primary setting as inpatient or outpatient (response rate of 92.86%). Of those, 27 respondents identified their setting as medical inpatient (51.9%), and 15 (28.9%) respondents reported medical outpatient. Nine respondents (17.3%) reported working in both inpatient and outpatient settings. One respondent (1.9%) identified inpatient, outpatient, and dialysis as primary population.

Respondents were asked to give a weekly estimate of the number of consults or meetings they had related to advance directives. There were 43 respondents who answered this question (response rate of 76.8%). This item was self-report, with responses including both a single number estimate or an estimated range. For ease of reporting and analysis, the range of responses have been collapsed into categories. Fifteen respondents (26.8%) reported between 0 and 1 advance directive-related meetings or consults per week. Twenty respondents (36%) estimated between 2 and 5 meetings or consults per week. Six respondents (11.5%) estimated between 6
and 10 meetings or consults weekly. One respondent (1.8%) reported 15 weekly meetings or consults, and 1 respondent (1.8%) estimated 40 weekly meetings or consults related to advance directives.

Respondents also differed characteristically on unit setting. Thirty respondents (53.6% response rate) answered the survey item identifying one or more primary units of employment. Of those, 21 respondents (37.5% of total survey respondents) identified one primary unit of employment. Nine respondents (16.1% of total respondents) identified multiple primary settings.

Seventeen respondents (34.7% of total item responses) identified medical-surgical unit as a primary setting, followed by primary care ($n = 12, 24.5%$), transplant ($n = 7, 14.3%$), transitional care ($n = 6, 12.24%$), intensive care unit ($n = 6, 12.2%$), palliative ($n = 5, 10.2%$), oncology ($n = 4, 8.2%$), emergency department ($n = 3, 6.1%$), OB/GYN ($n = 6, 12.2%$), home care ($n = 2, 4.1%$), mental health ($n = 2, 4.1%$), and hospice ($n = 1, 2%$).

**Measures**

**Survey**

The study utilized a self-administered questionnaire designed by the researcher for this study. The survey was comprised of 55 total items (See Appendix A). The items were presented as 27 separate questions, with five of those including sub-questions. The survey was built using Qualtrics software, chosen for its security and encryption capabilities. Respondents were able to access the survey through an online link. The survey requested information regarding advance directive practices within respondent settings, as well as self-reporting personal perceptions about advance directives. Completion of the survey was voluntary and took about fifteen minutes. Respondents had the option to skip questions they did not wish to answer.
Broadly, the survey was designed to measure the extent to which social workers facilitate patient preparation leading up to advance directive documentation. Steps of preparation were operationalized as the seven communication behaviors developed by Black (2005).

As the research could not control who received the survey link, the first two survey items assessed for exclusionary criteria. Respondents who answered “No” to Item 1: “Do you directly work with patients/clients in tasks related to advance directives?” were excluded from the survey. Item 2 asked “As it relates to advance directives, what is your primary client/patient population?” Respondents who reported working only on advance directives for children were excluded from the study.

Survey items 3 and 4 are related to respondent setting: item 3 determines whether setting is inpatient or outpatient, and item 4 asks respondent to designate a primary population or unit. Item 5 measures occupational exposure to advance directives, asking participants to estimate the number of advance directive-related consults they have on a weekly basis.

Subsequent survey items were designed to operationalize respondent practice behaviors and perceptions of advance directives. Questions assessing advance directive practice behaviors were measured on a sliding scale from “Never” to “Always.” Questions assessing respondent perceptions of advance directives and patient-level barriers were also on a sliding scale, with some questions ranging from “Strongly Disagree” to “Strongly Agree” or “Extremely Unlikely” to “Extremely Likely.” Sliding scale measurements were used whenever possible to allow for accurate and nuanced interpretation of responses.

**Scoring**

**Scales.** Four scales were developed in this study. The Expectation of Barriers Scale ($\alpha = .667$) included questions designed to measure respondent expectation that patients experience
barriers prior to documenting an AD. The second scale, Sense of Responsibility ($\alpha = .644$), aimed to operationalize the extent to which respondents feel personally responsible for facilitating preparatory AD steps. The Assessment Behaviors Scale ($\alpha = .759$) was designed to measure whether respondents are formally or informally assessing for barriers when patients have not yet completed an AD. The Perception of Competency Scale ($\alpha = .862$) was measured the extent to which respondents feel competent to facilitate advance directives and assess for patient level barriers within their setting.

**Expectation of Barriers Scale.** The Expectation of Barriers Scale ($\alpha = .667$) consists of 11 items. Of total respondents (n=56), 18 (32.1%) responded to all 11 items of the scale. In conducting reliability coefficients, responses from those 38 respondents (67.9%) failed to answer all 11 scale items were excluded from analysis. To be noted, Question 11d (“S/he isn’t ready”) was excluded from the scale post-survey to increase the internal consistency reliability.

Question 11 asked participants to consider a patient without an AD, offering five possible explanations for why the patient has not completed documentation. Respondents are asked to individually assess how likely each of those explanations would be, with responses ranging from “unlikely” to “likely” on a sliding scale. Three of the listed explanations (s/he doesn’t think it’s relevant; s/he doesn’t have enough information; s/he is experiencing a barrier) are barriers identified by a previous study (Shickedanz, 2009); respondents who rate those items as a likely explanation are probably more likely to expect barriers. Another discrete item within the scale designed to measure expectation of barriers asks respondents to answer, on a sliding scale, whether they anticipate patients to “get stuck” at any step prior to AD completion (Question 17). Responses are designated on a sliding scale from “disagree” to “agree,” with responses closer to “agree” indicating greater expectation of barriers.
The last six items included in the Expectation of Barriers Scale corresponds with question 27. Question 27 lists discrete sociodemographic categories known to influence rates of AD completion (race, socioeconomic status, level of education, gender, age, and health status). Respondents are asked to rate the extent to which they consider each category influential in the patient experience of ADs from “Not at all influential” to “Very Influential.” Responses that identify a given sociodemographic category as more influential are, in this study, suggested to predict respondent expectation of patient barriers. Accordingly, these items are positively coded and increase respondent score on Expectation of Barriers Scale.

With the exception of question 11E, all items are positively coded and scored. 11e is reverse coded because it suggests that a patient would probably not have an AD due to lack of readiness. This is not supported in the literature. After reverse coding, scale items are summed. A higher average Expectation of Barriers Scale score indicates greater respondent expectation of patient barriers that prevent ADs.

**Sense of Responsibility Scale.** The Sense of Responsibility Scale ($\alpha = .644$) consists of 10 items. Of total respondents (n=56), 25 (44.6%) responded to all 10 items of the scale. In conducting reliability coefficients, responses from those 31 respondents (55.4%) who failed to answer all 9 scale items were excluded from analysis. The first seven items (Question 12) presents each of Black’s (2005) seven discrete preparation behaviors and asks respondents to indicate the extent to which each item is considered within his/her job’s scope. Answers for each are ranked on a sliding scale from “Strongly Disagree” to “Strongly Agree.” Responses are positively coded; respondents who indicate a given behavior is within their job scope (closer to “Strongly Agree”) suggest a greater sense of responsibility to facilitating patient ADs. The last three items (Questions 14, 15, and 16) within the Sense of Responsibility Scale each ask
respondents to consider a patient without an AD. Using a sliding scale, respondents identify the extent to which the patient’s doctor (Question 14), nurse (Question 15), or respondent (self) (Question 16) is responsible for initiating further conversation. When scoring the Sense of Responsibility Scale items, question 15 and 17 are reverse coded, because a positive answer suggests patient conversation is the responsibility of the doctor or nurse. Scale items are then summed, with higher scale scores suggesting greater sense of respondent responsibility.

Assessment Behaviors Scale. The Assessment Behaviors Scale (α = .759) consists of 9 items. Of total respondents (n=56), 17 (30.4%) responded to all 9 items of the scale. In conducting reliability coefficients, those 39 respondents (69.6%) who did not answer all 9 survey items were excluded from analysis due to missing items. Question 8 (“I ask if a patient has an advance directive), question 9 (“If a patient says s/he does not have an advance directive, I ask why”) and question 10 (“If a patient says s/he does not have an advance directive, I move on) are included in this scale. Response is measured on a sliding scale, from “Never” to “Always.”

Question 18, 19, 20, 21, 22, and 23 are also included in the Assessment Behaviors Scale. These items measure the extent to which respondents informally or formally assess for barriers when patients do not have an AD. Question 18 states “If a patient has not yet completed an advance directive, I anticipate that s/he will tell me what s/he needs to move forward.” On a sliding scale, respondents can rate from “Strongly Disagree” to “Strongly Agree.”

Question 19 asks respondents to rank from “Never” to Always” whether s/he would assesses for specific barriers that prevent a patient from moving forward in the AD process. Questions 20-23 asks if, in the event a patient has not yet completed an advance directive, respondents consider patient relationship issues (#20), patient personal perceptions of advance directives (#21), patients’ difficult feelings (#22), or patient issues with a health care provider
(23). Each of these four considerations reflects known patient barriers from existing research (Shickedanz et al., 2009).

To score, questions 8, 9, 19, 20, 21, 22, and 23 are positively coded. Items 10 and 18 are reverse coded. Responses to question 10 are reverse coded because a positive answer (“I would move on”) indicates a lack of assessment behavior. Question 18 is reverse coded because assessment requires a clinician to elicit from the patient any barriers to AD completion. Items are summed and average, with a higher Assessment Behaviors Scale score indicating respondents are more likely to assess for patient barriers to completing an AD.

**Perception of Competency Scale.** The Perception of Competency Scale (α = .862) consists of 9 items. Of total respondents (n=56), 38 (67.9%) responded to all 9 items of the scale. In conducting reliability coefficients, those 18 respondents (32.1%) who failed to complete all 9 survey items were excluded from analysis.

Question 13 asks respondents to rank how competent they feel engaging in each of the seven AD communication steps (Black, 2005). Responses for each are placed on sliding scale from “strongly disagree” to “strongly agree.” As question 13 is positively phrased (“I feel competent”), responses closer to “strongly agree” contribute to a greater scale score, suggesting the respondent exhibits a higher rate of perceived competence.

The last two items within the Perception of Competency Scale ask respondents to consider the adequacy of training provided at their job as it relates to facilitating the actual documentation of ADs (question 24) and having AD-related conversations with patients (question 25). Responses to both items are marked on a sliding scale from “strongly agree” (indicating adequate training) to “strongly disagree” (inadequate training). To score, all items
within the Perception of Competency Scale are positively summed, with a higher score suggesting greater feelings of competency.

Results

This study conducted an analysis of the data collected through the questionnaire. Broadly, this study examined how setting, respondent’s sense of competency, and expectation of patient-level barriers influenced actual assessment behaviors.

The first descriptive analysis measured how many respondents perceived advance directives to be important in their setting. This nominal variable was operationalized by offering the statement “In your setting it is important that everyone have an advance directive” with respondents answering yes or no. Fifty-two respondents answered this question (response rate of 92.9%). The findings in Table 1 show that 46 respondents (82.1%) said they felt it was important that everyone have an advance directive within their setting. Six respondents (10.7%) stated it was not important that everyone have an advance directive.

Table 1

<table>
<thead>
<tr>
<th>Distribution of Perceived Advance Directive Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>Valid</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Missing</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>
The second descriptive analysis examined whether respondents feel completing an advance directive is one step or a process. This nominal variable is operationalized with the item (7) “Which is more true?” Respondents could choose between the statements “Completing an AD is one step” or “Completing an AD is a process.” Fifty-two respondents (response rate of 92.9%) answered this item. Eleven respondents (19.6%) consider the act of completing an advance directive to be a single step, while 41 respondents (73.2%) consider it to be a process. Figure 1 offers a visual dispersion of answers.

![Figure 1](image)

*Figure 1. Distribution of advance directives as a single step or process.*

**Effect of Perception of Advance Directives as a Process on Expectation of Patient Barriers and Assessment of Barriers**

**Hypothesis 1.** Social workers who consider ADs to be a process, rather than a singular event, will be more likely to a) expect patient barriers, and b) assess for those barriers.
To determine whether respondents’ personal perceptions of ADs (as a single event vs. a process) influence expectation of barriers (operationalized as Expectation of Barriers Scale score) a Mann-Whitney U test was conducted. This test was used because the data did not meet the assumptions required for a t test. The Mann-Whitney U test compared the mean rank Expectations of Barriers Scale and Assessment of Barriers Scale scores for those respondents who considered ADs to be a single event to those who considered ADs to be a process. See Table 2 for the difference in mean ranks and sum of ranks for the two groups in their scale scores. This test did not find a statistically significant difference in the mean rank Expectation of Barriers Scale scores for those who said completing an AD is one step ($M = 6.5, N = 4$) and those who said completing an AD is a process ($M = 10.36, N = 14$), $U = 16.0, p = .202$ (See Table 4).

The Mann-Whitney U test also did not find a statistically significant difference in the mean rank Assessment Behaviors Scale scores for those who said completing an AD is one step ($M = 6, N = 4$) and those who said completing an AD is a process ($M = 9.92, N = 13$), $U = 14.00, p = .174$ (See Table 3).

Table 2

<table>
<thead>
<tr>
<th>In your setting, which is more true?</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectation of Barriers Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completing an advance directive is one step.</td>
<td>4</td>
<td>6.50</td>
<td>26.00</td>
</tr>
<tr>
<td>Completing an advance directive is a process.</td>
<td>14</td>
<td>10.36</td>
<td>145.00</td>
</tr>
</tbody>
</table>
Table 3

Independent Samples Mann-Whitney U Test Comparing Respondents Who Consider Advance Directives to be Process versus Singular Event on Expectation of Barriers and Assessment Behaviors Scale Scores

<table>
<thead>
<tr>
<th>Expectation of Barriers Scale</th>
<th>Assessment Behaviors Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann-Whitney U</td>
<td>16.000</td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.202</td>
</tr>
<tr>
<td></td>
<td>14.000</td>
</tr>
<tr>
<td></td>
<td>.174</td>
</tr>
</tbody>
</table>

**Effect of Respondent Setting on Sense of Responsibility, Feelings of Competence, and Assessment Behaviors**

**Hypothesis 2.** This research expects that social workers in an inpatient setting will report:

a) a greater sense of personal responsibility to assess for barriers, b) higher feelings of competence to facilitate ADs, and c) more assessment behaviors.

Data was analyzed to determine if respondent setting (medical inpatient or medical outpatient) predicted a greater sense of respondent responsibility for facilitating ADs in their setting. Respondent sense of responsibility is operationalized as their Sense of Responsibility
Scale score. A Mann-Whitney U test was conducted rather than a t test because the data did not meet the assumptions required for a t test. The Mann-Whitney U test compared the mean rank Sense of Responsibility, Perception of Competency, and Assessment Behaviors Scale scores of respondents in a medical inpatient setting to those in a medical outpatient setting. See Table 4 for the difference in mean ranks and sum of ranks for the two groups in their scale scores. The Mann-Whitney U did not find a statistically significant difference among any of the ranked scale scores based on respondent setting with statistical findings reported in Table 5.

Table 4

Mean Ranks of Responsibility, Perception of Competency, and Assessment Behavior Scale Scores Based on Setting

<table>
<thead>
<tr>
<th>Respondent Setting</th>
<th>N</th>
<th>Mean Rank</th>
<th>Sum of Ranks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsibility Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical inpatient</td>
<td>12</td>
<td>9.83</td>
<td>118.00</td>
</tr>
<tr>
<td>Medical outpatient</td>
<td>7</td>
<td>10.29</td>
<td>72.00</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perception of Competency Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical inpatient</td>
<td>16</td>
<td>12.75</td>
<td>204.00</td>
</tr>
<tr>
<td>Medical outpatient</td>
<td>13</td>
<td>17.77</td>
<td>231.00</td>
</tr>
<tr>
<td>Total</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment Behaviors Scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical inpatient</td>
<td>11</td>
<td>7.00</td>
<td>77.00</td>
</tr>
<tr>
<td>Medical outpatient</td>
<td>2</td>
<td>7.00</td>
<td>14.00</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 5

*Mann-Whitney U Test Comparing Responsibility, Perception of Competency, and Assessment Behavior Mean Rank Scale Scores Based on Respondent Setting*

<table>
<thead>
<tr>
<th></th>
<th>Responsibility Scale</th>
<th>Perception of Competency Scale</th>
<th>Assessment Behaviors Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mann-Whitney U</td>
<td>40.000</td>
<td>68.000</td>
<td>11.000</td>
</tr>
<tr>
<td>Asymp. Sig. (2-tailed)</td>
<td>.866</td>
<td>.114</td>
<td>1.000</td>
</tr>
<tr>
<td>Exact Sig. [2*(1-tailed Sig.)]</td>
<td>.902(^b)</td>
<td>.121(^b)</td>
<td>1.000(^b)</td>
</tr>
</tbody>
</table>

**Relationship Between Respondent Sense of Responsibility and Assessment Behaviors**

**Hypothesis 3.** This research anticipates that social workers who report a greater sense of personal responsibility for facilitating ADs at every step will be more likely to assess for patient barriers at the preparatory steps leading up to documentation.

To determine if there is a relationship between respondents’ overall sense of responsibility to facilitate ADs and their tendency to assess for patient barriers, a Pearson Correlation was conducted. The test found a strong positive correlation between Sense of Responsibility Scale scores and Assessment Behavior Scale scores, \( r = .673, p = .016 \). The strength of correlation is significant at the .05 level (See Table 6).
Table 6

*Correlation Between Assessment Behaviors Scale Scores and Responsibility Scale Scores*

<table>
<thead>
<tr>
<th></th>
<th>Assessment Behaviors Scale</th>
<th>Responsibility Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment Behaviors</td>
<td>Pearson Correlation 1</td>
<td>.673*</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td>.016</td>
</tr>
<tr>
<td>N</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Responsibility Scale</td>
<td>Pearson Correlation .673*</td>
<td>1</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.016</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>12</td>
<td>25</td>
</tr>
</tbody>
</table>

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

**Relationship Between Respondent Expectation of Barriers and Assessment Behaviors**

**Hypothesis 4.** Social workers who anticipate that patients will experience barriers at any of the steps leading up to AD documentation are predicted to report a greater number of assessment behaviors.

To determine if the expectation of patient barriers is associated with greater assessment behaviors throughout the AD process, a Pearson Correlation was used to measure the relationship between respondents’ Expectation of Barriers Scale scores and Assessment Behaviors Scale scores. The Pearson Correlation indicated the scores are not significantly related, $r = .106$, $p = .757$ (See Table 7).
Table 7

Correlation Between Expectation of Barriers Scale Scores and Assessment Behaviors Scale Scores

<table>
<thead>
<tr>
<th></th>
<th>Expectation of Barriers Scale</th>
<th>Assessment Behaviors Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expectation of Barriers Scale</td>
<td>Pearson Correlation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.757</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>18</td>
</tr>
<tr>
<td>Assessment Behaviors Scale</td>
<td>Pearson Correlation</td>
<td>.106</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.757</td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>11</td>
</tr>
</tbody>
</table>

Relationship Between Respondent Perception of Own Competence and Assessment Behaviors

Hypothesis 5. This research expects to find that social worker perception of personal competence will be positively correlated with assessment of barrier behaviors.

To determine if respondents’ perception of their own competence is associated with their tendency to assess for barriers that prevent patients from completing ADs, a Pearson Correlation was used to assess the relationship between Perception of Competence Scale Scores and Assessment Behavior Scale Scores. The correlation revealed a strong positive relationship between the two scale scores, significant at the 2-tailed level, $r = .841, p = .000$ (See Table 8).
Table 8

Correlation Between Perception of Competency Scale Scores and Assessment Behaviors Scale Scores

<table>
<thead>
<tr>
<th>Perception of Competency Scale</th>
<th>Perception of Competency Scale Correlation</th>
<th>Assessment Behaviors Scale Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception of Competency Scale</td>
<td>1</td>
<td>.841**</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>38</td>
<td>14</td>
</tr>
<tr>
<td>Assessment Behaviors Scale</td>
<td>.841**</td>
<td>1</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td>.000</td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>14</td>
<td>17</td>
</tr>
</tbody>
</table>

**. Correlation is significant at the 0.01 level (2-tailed).

Discussion

This study surveyed 56 social workers employed in medical settings within the Minneapolis-St. Paul area. Research suggests that in medical settings, social workers are largely responsible for facilitating the advance directive process (Black, 2005). All of the social workers included in this study self-identified as working directly with adult patients in tasks related to advance directives. This survey was designed and implemented under the assumption that social workers influence the patient experience of completing an AD, and to some extent, the broad rate of AD completion. This study aimed to determine the extent to which social workers anticipate patient barriers to ADs and assess for barriers within the AD facilitative process. Additionally, the study expected that personal sense of responsibility and competence related to facilitating ADs would mediate AD-related perceptions and practice behaviors.
Assumptions around the steps required to complete an AD were based on the multiple phases identified within research (Black, 2005; Schickendanz et al., 2009). Respondents in this survey generally supported this conceptualization of AD as a process, with the vast majority of social workers finding ADs to be a process rather than a single-step.

Within this study, social workers who felt a greater sense of personal responsibility to facilitate ADs were significantly more likely to report assessing for barriers preventing patients from completing advance directives. As the PSDA (1991) does not appoint a specific party or position responsible for ADs, this finding suggests that units, teams, or medical centers, which clearly delineate responsibility to social workers, would have greater success in responding to patient barriers.

Social workers’ assessment behaviors were also significantly correlated with their perception of competence in this facilitative role in this study. This suggests the importance of providing comprehensive training around ADs and their facilitation. Providing training around common patient barriers and sociodemographic characteristics that correlate with certain AD outcomes would allow for more informed practice.

**Limitations**

Despite the survey’s total response rate of 56, many respondents skipped survey items. Because of the survey software design, respondents could move forward in the survey without answering all previous items. Many respondents submitted their responses with multiple items incomplete. Consequently, if a respondent missed any item within one of the scales (Sense of Responsibility, Sense of Competency, Assessment Behaviors, or Expectation of Barriers) all of his/her other item responses within that scale were exempt from analysis. The missed responses in various scales reduced statistical power, since fewer fully completed scales were available for
analysis. Given that the majority of the hypotheses included scale scores in their analyses, only the data from respondents who answered all items on any given scale were included in hypothesis testing, making it less likely for findings to be significant as well as limiting generalizability of findings.

Beyond missed responses, this survey was also limited in its representative population of social workers. This study only offers a perspective of social work practice under Minnesota laws regarding advance directives. Recruitment was limited to Minneapolis-St. Paul metropolitan area, thereby excluding social workers employed in rural areas within the state. Recruiting from hospitals also excluded social workers employed in nursing homes, long-term care centers, and many transitional care units, which typically exist separately from hospitals. Patients in these settings characteristically differ in their age, medical status or prognosis, and existing ability to make decisions for themselves. Social workers in these settings would likely vary in their perceptions of advance directives as well as assessment practices. Among those social workers surveyed, some settings were represented far less than others, with the populations least represented including hospice (n=1), mental health (n=2), home care (n=2), and dialysis (n=2).

The voluntary nature of the study likely skewed the nature of respondents in other ways. For example, busy social workers may be less willing to take the time required to complete a survey. Social workers who have negative personal perceptions of advance directives or generally less experience may also have been less likely to participate.

**Future Studies**

It may be misguided to assume that individual social workers are able to individualize interventions enough to substantially improve the AD facilitation process or broadly increase the
rates of advance directives. It may be more prudent to focus efforts on the level of policy, which has greater influence on the policies and procedures of AD facilitation. This research suggests that social workers who feel more responsible for the facilitation of ADs are more likely to assess for patient barriers to advance directives, suggesting that too much dispersion of AD responsibility within a medical setting might make it less likely that clinicians identify and respond to individual barriers. To this end, future research ought to focus on the shortcomings of the PSDA (1991) as they relate to advance directive completion. Assessment of clinician perceptions or experiences across the advance directive process would highlight the incongruence between the PSDA’s (1991) treatment of the AD as a single step and the reality that ADs are a multi-phase process requiring a substantial time commitment from clinicians.

This research has implications for the training practices of medical settings, given this study’s finding that assessment behaviors are correlated with perceptions of competence around ADs. As prior research suggests social workers are actively engaged in the AD process, hospitals ought to offer comprehensive AD-related trainings. Furthermore, some training ought to be targeted specifically to social workers, and informed by sociodemographic patterns of patient population so social workers are better equipped to anticipate patient barriers.
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Appendix A

Survey Questions

Do you directly work with patients/clients in tasks related to advance directives? This can include anything from having advance directive-related conversations to assisting in form completion.

Yes
No (Routes to end of survey: Thank you for participating. I appreciate your time.)

2. As it relates to advance directives, what is your primary client/patient population?

I work with adults
I work with adults regarding advanced directives for children (Routes to end of survey: Thank you for participating. I appreciate your time.)
Both

3. What is your setting? (Check all that apply)

Medical inpatient
Medical outpatient
Other (please specify)

4. If you are in a medical setting, which of the following best describes your unit or population? If multiple apply to your role, please select all that apply:

Primary care
ICU
Emergency department
Med/Surg
Transitional care
Long term care
OB/GYN
Mental Health
Oncology
Home care
Palliative
Hospice
Dialysis
Transplant
5. Please estimate the number of consults or meetings you have each week that directly relate to advance directives.

____

As you answer the following questions, please consider your current setting and designated role.

6. In my setting it is important that everyone have an advance directive.

   Yes
   No

7. Which is more true

   Completing an AD is one step
   Completing an AD is a process

The following questions will ask for your response on a sliding scale. The far left indicates a behavior you never do, while the far right indicates this is a behavior you always do.

8. I ask if a patient/client has an advance directive.

   Never-----------------Always

9. If a patient/client says s/he does not have an advance directive, I ask why.

   Never-----------------Always

10. If a patient/client says s/he does not have an advance directive, I move on.

    Never-----------------Always

11. If a patient/client says s/he has considered an advance directive but doesn’t have one, it may be the case that...

    a. S/he doesn’t think it’s relevant.
       Unlikely----------------Likely
    b. S/he doesn’t have enough information.
       Unlikely----------------Likely
    c. S/he is experiencing a barrier.
       Unlikely----------------Likely
    d. S/he isn’t ready.
       Unlikely----------------Likely
e. S/he doesn’t want one.
   *Unlikely*-----------------*Likely*

12. I consider it to be within my job’s scope to do the following tasks:
a. Initiating the topic of advance directives
   *Disagree*-----------------*Agree*
b. Facilitating patient/client disclosure of information related to advance directives
   *Disagree*-----------------*Agree*
c. Talking with patients/clients about their medical issues that might affect their advance directives
   *Disagree*-----------------*Agree*
d. Talking with patients/clients about their relationship with friends and family
   *Disagree*-----------------*Agree*
e. Talking with patients/clients about personal values and thoughts related to advance directives
   *Disagree*-----------------*Agree*
f. Talking with patients/clients about choosing a surrogate decision maker
   *Disagree*-----------------*Agree*
g. Collaborating with other health care professionals about a patient/client’s advance directive-related issues
   *Disagree*-----------------*Agree*

13. I feel competent doing the following tasks:

a. Initiating the topic of advance directive
   *Disagree*-----------------*Agree*
b. Facilitating patient/client disclosure of information related to advance directive
   *Disagree*-----------------*Agree*
c. Talking with patients/clients about their medical issues that might affect their advance directives
   *Disagree*-----------------*Agree*
d. Talking with patients/clients about their relationship with friends and family
   *Disagree*-----------------*Agree*
e. Talking with patients/clients about personal values and thoughts related to advance directives
   *Disagree*-----------------*Agree*
f. Talking with patients/clients about choosing a surrogate decision maker
   *Disagree*-----------------*Agree*
g. Collaborating with other health care professionals about a patient/client’s advance directive-related issues

Disagree----------------Agree

As you answer the following questions, please consider your current setting and designated role.

14. If a patient/client is unsure about an advance directive, it is the doctor’s responsibility to have further conversation.

Disagree----------------Agree

15. If a patient/client is unsure about an advance directive, it is the nurse’s responsibility to have further conversation.

Disagree----------------Agree

16. If a patient/client is unsure about an advance directive, it is my responsibility to have further conversation.

Disagree----------------Agree

17. I anticipate a patient/client will probably face issues or “get stuck” at any of the steps leading up to advance directive documentation.

Disagree----------------Agree

18. If a patient/client has not yet completed an advance directive, I anticipate that s/he will tell me what s/he needs to move forward.

Disagree----------------Agree

19. If a patient/client has not yet completed an advance directive, I talk to him/her and try to assess for specific barriers that might be preventing him/her from moving forward.

Never---------------Always

20. If a patient/client has not yet completed an advance directive, I consider relationship (friends, family) issues that might be preventing him/her from moving forward.

Never---------------Always

21. If a patient/client has not yet completed an advance directive, I try to assess for personal perceptions of advance directives that might be preventing him/her from moving forward.

Never---------------Always

22. If a patient/client has not yet completed an advance directive, I consider if there are any difficult feelings that might be preventing him/her from moving forward.
23. If a patient/client has not yet completed an advance directive, I try to determine if there are issues with a health care provider that might be preventing them from moving forward.

Never-------------------Always

24. I have received adequate training in my setting to facilitate the actual documentation of advance directives.

Disagree-------------------Agree

25. I have received adequate training in my setting to have conversations with patients about their advance directives (for example, how a directive can align with their values, answer questions about life-sustaining treatments, etc).

Disagree-------------------Agree

26. If a patient/client is not ready to complete an advance directive, I would probably move on to the next topic because… Please check all that apply.

- It is not part of my role to figure out why they don’t have an advance directive.
- Their doctor will probably bring it up when the time is right for them.
- I do not want to push them.
- I do not feel comfortable talking extensively about advance directives.
- They probably do not want one.
- When they’re ready I will be able to help them document.
- Time constraints prevent me from continuing the conversation.
- This is not me, I would stay on the topic of advance directives.

27. How influential do you believe the following variables are as patients/clients prepare for or document an advance directive?

- Race
  Not influential-------------------Very influential
- Socioeconomic status
  Not influential-------------------Very influential
- Level of education
  Not influential-------------------Very influential
- Gender
  Not influential-------------------Very influential
- Age
  Not influential-------------------Very influential
- Health status
  Not influential-------------------Very influential