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Perceived Outcomes and Barriers of Advance Care Planning from Healthcare Professionals

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ABSTRACT

Advance care planning (ACP) is the process of aligning patients' values and preferences to their future medical care. ACP is important in promoting patient autonomy and helping patients and their families prepare for end-of-life conversations. Healthcare teams, made up of physicians, nurses, or social workers, carry the responsibility to engage patients into such conversations. The purpose of this study was to explore the perceptions and experiences of healthcare professionals regarding ACP outcomes and barriers. This cross-sectional study used survey responses of a convivence sample of 18 allied healthcare professionals and 4 physicians in a not-for-profit, faith-based hospital system in West Texas to measure willingness, confidence, and participation in ACP, and barriers related to those outcomes as professionals. This study found moderate to high mean ratings for ACP outcomes for physicians and allied healthcare professionals. The regression analysis showed allied healthcare professionals who perceived higher barriers in their roles had lower confidence in engaging in ACP with patients. From the current study and analyzed literature, the researcher suggests healthcare professionals need to have opportunities to expand their knowledge and confidence in ACP conversations to promote better patient outcomes in end-of-life care.

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I dedicate this thesis to my parents, Terry and Tammy Parsons, for the unconditional love, constant prayers, and never-ending encouragement to pursue my passions in life. I could not have done this without you two by my side

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CHAPTER I

INTRODUCTION

Problem Statement

End-of-life (EOL) care is a topic being discussed all over the world in healthcare. Every day, vulnerable patients are left voiceless in their medical care and suffer due to the lack of advance care planning (ACP) conversations and education among patients, families, and healthcare professionals. ACP is the process of clarifying patient preferences and goals regarding future medical care, and engaging patients in EOL conversations (Brinkman-Stoppelenburg et al., 2014). Research (e.g., Detering et al., 2010) shows the ACP process improves overall EOL care, increasing patient and family satisfaction through offering support and guidance in difficult conversations. The target population for ACP is older adults due to being frail and at a higher risk for worsening physically and even mentally (Clegg et al., 2013). Due to the rise in the aging population over the next decade, ACP becomes important in engaging conversations for wishes and goals to influence EOL care.

Existing Knowledge About ACP From Healthcare Professionals

To address the problem of EOL care and planning ahead, a literature review was conducted to explore ACP from healthcare workers to identify needs that can be addressed by a new study. ACP, summed up, is having open conversations on a patient's preferences for their future care. ACP allows patients and families to consider treatment options and make informed plans in line with the patient's wishes (Brinkman-

Stoppelenburg et al., 2014). ACP involves completing documents such as medical power of attorneys, out-of hospital do-not-resuscitate orders and living wills. While these documents are helpful and important steps towards ACP, literature suggests that the social process of the planning has become more important in addressing EOL care in a person-in-environment framework (Dixon et al., 2018). Different models and interventions that continue and expand the conversation of ACP have shown improved outcomes in EOL care rather than just the completion of advance directives (Brinkman-Stoppelenburg et al., 2014; Detering et al., 2010; Lall et al., 2021). Research even addresses reoccurring ACP conversations help prevent costly and unwanted treatments in the future of a patient's care (Friend & Alden, 2021).

Given the importance of addressing suffering at EOL and to plan in advance for these conversations, programs such as Supportive and Palliative Care are created to implement interventions encouraging ACP for terminally or chronically ill patients. These programs are staffed with an interdisciplinary team of professionals specifically trained and educated on EOL care conversations to assist patients with identifying their goals of their treatment (CAPC, 2021). Other interventions related to ACP include models such as Five Wishes, Let Me Decide, and Respecting Choices. Each of these models engage and promote ACP conversations to ensure EOL wishes are upheld for a patient (Hickman et al., 2005).

Several studies have been done on the importance of ACP and the willingness of patients and families to participate in them (Friend & Alden, 2021; Lall et al., 2021; Toro-Flores et al., 2017). Furthermore, research has also been done on the barriers of physicians in participating in ACP with their patients (Coleman, 2012; Fulmer et al.,

2018; You et al., 2015). Since there is a lack of research on ACP factors from all healthcare workers, this study attempts to better understand ACP outcomes and barriers from all healthcare professionals.

Research Gap

While there is research on the improved patient outcomes from specific ACP interventions, there is a lack of research in healthcare professionals' outcomes in implementing and engaging conversations for ACP. It is known that physicians play important roles in implementing ACP conversations, helping their patients clarify their understanding of their illness and treatment options from a medical lens. They can also offer guidance and encouragement in continuing the conversation of ACP. Research shows that physicians and patients believe ACP is beneficial (Detering et al., 2010), yet little research is done on the outcomes and barriers for all healthcare workers participating in these conversations beyond just physicians. If healthcare workers—such as nurses, social workers, and even doctors—lack the knowledge, willingness, and confidence of ongoing ACP conversations, patients and families are put at a disadvantage to clarify and discuss goals and wishes related to future medical care.

The Present Study

The purpose of this study is to explore the perceptions and experiences of healthcare professionals regarding ACP outcomes and barriers. The purpose of this study is to explore the perceptions and experiences of healthcare professionals regarding ACP outcomes and barriers. The researcher attempted to answer the following questions:

- RQ1: What are the differences in outcomes for allied healthcare professionals versus physicians?

- RQ2: What are the barriers to ACP outcomes for allied healthcare professionals versus physicians?
- RQ3: What are the effects of barriers on ACP outcomes?
- RQ4: How much is interdisciplinary communication needed in ACP discussions?

While physicians are the main source of ACP conversations, other healthcare workers can offer support in continuing the conversation of ACP. A survey was sent to healthcare professionals within a not-for-profit, faith-based medical center in Texas that deals with direct patient care to explore which areas of ACP outcomes need the most focus to improve EOL care decisions for patients and families.

Limitations

This study has many limitations. First, the direct implications for social work practice might be vague. The roles of social work are unique but differ depending on the setting of social work one practices in. For example, the case manager role might be used greatly in an acute care setting to assist with the patient's plan of care. If a social worker is limited to a case manager role, ACP might get overlooked due to not being able to take the role of an educator, researcher, or counselor. Second, confidence in having ACP conversations does not accurately reflect the quality of the conversation. Many professionals have been through different trainings for ACP or have received no training. So, to hear that a physician has confidence in ACP conversations with patients does not mean they are having quality conversations. Third, the negative value of external validity is an issue in being able to generalize the findings from the convenience sample of this study. The population being surveyed cannot accurately reflect all healthcare fields'

confidence in their knowledge of ACP and barriers. Each specialty in the medical setting has different needs they are assessing for patients. For example, a cardiothoracic surgeon, whose goal is to treat the patient through surgery of the heart, lungs, and chest, might not find it necessary to discuss ACP needs due to the nature of their practice being to help prolong life. The nature of each specialty might reflect differently at each hospital due to relationships between healthcare workers and other hospital teams such as palliative care or hospice teams. If there are positive existing relationships, this could reflect different attitudes of ACP from healthcare workers. Even with these limitations, this study can still contribute to the ACP confidence and barriers from multiple disciplines in healthcare.

Understanding of confidence, willingness, participation, and barriers of healthcare workers in ACP is critical for social workers to provide quality EOL services. As a social worker valuing patient self-determination (NASW, 2017), ACP is important in enhancing each patient's capacity of information pertaining to their treatment decisions regarding EOL. Once patients comprehend, medically, what their treatment options are, social workers can empower the patient to make a plan that fits their values and wishes. In settings where EOL conversations are frequent, social workers need to be sure that patients and families can make informed decisions while still addressing their emotional and spiritual needs. Understanding each patient from a person-in-environment framework is needed in helping address how the patient functions day-to-day and how this can affect their decision making. This can include understanding family dynamics, financial limitations, and socioeconomic needs, and recognizing how these all could influence EOL care (CAPC, 2021).

Key Terms

Healthcare Professional

A healthcare professional refers to a qualified practitioner that uses evidence-based practice to provide care to a patient (WHO, 2021). A healthcare professional can include a doctor, nurse practitioner, physician's assistant, nurse, social worker, etc. In this study, a healthcare professional will also be defined by currently working in direct patient care.

Patient Autonomy

Patient autonomy is the idea of patients having control over their medical decisions while being influenced by their physicians rather than being told their decision (Bernstein, 2018). Patient autonomy encourages the patient to be the decision maker in their care. Physicians and other healthcare professionals must strive to educate and support patients through the decision-making process to give full autonomy to their care.

CHAPTER II

LITERATURE REVIEW

Advance care planning (ACP) is a process influencing end-of-life (EOL) care through knowing and recognizing a person's personal values, life goals, preferences, and wishes regarding future medical care (Leung et al., 2018). ACP is important in understanding a patient as a whole person in terms of their attitude and willingness in EOL decisions. Making the decisions regarding EOL care is a complex process, often happening in times of unexpected crisis and poor understanding while working with a variability of preferences (Rath et al., 2022). In moments like these, helpful tools known as advance directives (AD) can aid in preparing for EOL decisions to ensure that a patient's rights and wishes are upheld in the event of a medical emergency or crisis (Friend & Alden, 2021). Conversations on ACP, after filling out ADs, are done the most when a diagnosis like cancer is present (McDonald et al., 2017). If the point of ACP is to plan in advance for worst-case scenarios, how are healthcare professionals able to have effective conversations regarding EOL to ensure plans are made in advance?

The purpose of this literature review is to explore the purpose and policies behind ACP in order to understand how ACP has been used in integrated healthcare teams, and the effect of ACP on outcomes of EOL. This review will also discuss the attitudes and willingness of advance care planning for individuals in a socio-cultural context to explore the benefit of ACP and understand how the process looks in practice. This review will further explore the roles of healthcare professionals in implementing and continuing ACP

conversations with patients and families, and the barriers related to having these conversations.

Method of Literature Review: Search Strategies

The ACU Library database was used with keywords including, “advance care planning,” “end-of-life care,” “advance directives,” “healthcare professionals AND advance care planning” to find accurate peer-reviewed articles pertaining to end-of-life care and advance care planning. CAPC and Respecting Choices were also used as a means of obtaining information on palliative care and interventions on ACP. Most articles are published in the last 10-15 years. Articles related to policies or legislation exceed that time frame to be able to understand the history related to ACP and initial development of ADs.

Policies of Advance Directives

Policies and Legislation

The Patient Self-Determination Act (PSDA) of 1990 was passed to inform patients of their rights regarding accepting or refusing medical care. This act provided laws and regulations in recognizing patients’ wants and wishes through advance directives (Parkman, 1997). This act served as guidance on EOL decision making for patients, families, and healthcare workers (Hinderer & Lee, 2013). The PSDA has reported positive outcomes and improvement in quality of life for many patients and their families due to the nature of honoring the patient’s rights and wishes (Bradley & Rizzo, 1999).

The PSDA was a starting point for states to establish and define legislation pertaining to advance directives (Parkman, 1997). For this review, the Texas Advance

Directives Act (TADA) will be used as a reference for advance directives and advance care planning. TADA was established in 1999 to help address patients' rights regarding their medical issues and later revised in 2017 (TADA, 2017). TADA attempts to offer guidance on medical futility disputes and identify patient autonomy in a healthcare setting. Patient autonomy works with patient-centered care and involves the patient in a collaborative environment for their care (Coleman, 2012). This era of patient autonomy is new for physicians to grasp and offers challenges in ACP and EOL conversations (Sutherland, 2019). The patient-doctor relationship has evolved from physicians making all the decisions for patients, to patients being educated by their physician and making informed decisions regarding their own medical care (Bernstein, 2018). TADA offers appropriate legislations and rules to recognize patient's wants and wishes for EOL decision making and start the appropriate conversations for them (Pope, 2016).

The Meaning and Importance of Advance Directives

An AD is "a legal document that explains how you want medical decisions about you to be made if you cannot make the decisions yourself" (American Cancer Society, 2019). These documents, such as medical powers of attorney, living wills, and out-of hospital do-not-resuscitate orders, offer instruction and provision in medical and healthcare related wants and needs (TADA, 2017). ADs are used to explore ACP conversations and have, in writing, wishes and wants to be able to communicate to medical teams (Rath et al., 2022). These documents are important to promoting ACP and starting conversations with families and loved ones.

Medical powers of attorney (MPOA) are used to name decision makers when the patient becomes incompetent to make their own medical decisions. Without a MPOA,

legal surrogates are named according to priority of relationship to the patient. This varies state to state, but typically, legal surrogates include spouses, court-appointed guardians, and nearest living relatives (Hendrick Health, 2018). According to the Texas Health and Safety Code 166.039, the legal decision maker to an incompetent adult without an advance directive follows this hierarchy: (1) the patient's spouse, (2) the patient's reasonably available adult children, (3) the patient's parents, and (4) the patient's nearest living relative (2015). Within hospital systems in Texas, legal surrogacy can be narrowed down further, adding people like the patient's siblings or a clergy member (Hendrick Health, 2018). MPOAs become important to patients and their families so that the patient can name the exact people they want as their medical decision maker. If an incompetent patient has no medical power of attorney named or no legal surrogate available, the patient's care is then subject to two physicians to make treatment decisions regarding EOL (TADA, 2017).

After starting those conversations and electing a decision maker, patients can fill out a living will, or directive to physicians, to offer more guidance on specific of EOL decisions. The purpose of a living will is to identify use of artificial methods once a person is in a terminal or irreversible condition (TADA, 2017). This AD gives the patient the ability to share specifics on using/not using artificial methods as well as being able to identify things like duration and instructions on treatments (Hendrick Health, 2018). It is important to note that, in a living will, refusing all medical care is different than not choosing aggressive care. If a living will is not issued before a patient is unable to communicate, decisions are made by either the patient's MPOA (if applicable) or next of legal kin. Lastly, the state of Texas requires an out-of-hospital do-not-resuscitate (OOH-

DNR) for patients who do not wish to receive resuscitation in the event of cardiac arrest. In the state of Texas, if an ambulance is called for a person experiencing cardiac arrest, legally the ambulance is required to perform CPR unless there is an OOH-DNR presented to the EMT workers (Hendrick Health, 2018).

Integrated Healthcare Teams and ACP

Advance Directives Working in the Perfect World

If ADs worked perfectly in ACP, they would facilitate EOL decision making and "reduce the decision-making burden on family members and healthcare professionals" (Toro-Flores et al., 2017, p. 27). They would also promote ongoing conversations through healthcare professionals to prevent unwanted treatments (Friend & Alden, 2021) specific to a patients' values and wishes. ADs can be a useful tool for ACP but cannot be the end of ACP.

ADs can guide the conversations of ACP for patients, but there are still other things to consider for patients participating in ACP (Friend & Alden, 2021). An important part of this process is the patient being open to having difficult conversations about EOL with their loved ones. Forms like MPOAs and living wills can be useful, but without the direct communication between families, loved ones, and even healthcare professionals, a patient's true wishes still might not be upheld (Downey et al., 2013). Other challenges can be present in an EOL situation such as time-sensitive decisions, complexity of medical treatment, vagueness of living wills or wishes, and lack of understanding of patient's wishes, all of which should be avoided to truly respect the patient's autonomy (Rath et al., 2022). Although there was a high hope for ADs success in ACP, there are still many limitations to them. Many AD completions do not clarify

goals and wishes of patients accurately, but rather give too vague or too specific direction (Hickman et al., 2005). The completion of ADs is usually considered finished plans for EOL conversations, but all adults should periodically engage in EOL conversations to prepare for an unexpected injury, illness, or incapacitation (Moorman et al., 2021). While giving the patient complete autonomy to decide if they want medical treatments is good, ADs must seek an "individualized plan through a process of interaction with the patient" and healthcare professional that addresses the patient's bio-psycho-social needs (Hickman et al., 2005, p. 28). If these conversations that begin too vague or too specific are not continued through a person's life, then how can treatment be guided in an unplanned medical situation?

It is well researched that ADs are favored by many patients and their families with many different healthcare needs (Detering et al., 2010), yet there is still a lack of completion. With the lack of completion of advance directives, one can only assume advance care planning and EOL conversations are not being addressed appropriately or effectively with patients and their families. Decision making can be a complex process, so healthcare teams need to prepare patients and families for decision-making through ACP.

Doctors and Their Role

Patient-centered care is focused on knowing and recognizing the patient's values while caring for them. Patient-centered care is what physicians strive for to give control to the patient in their care, and striving for patient-centered care can be achieved through the conversations of ACP (Mapes et al., 2019). Most patients are open to the discussion on ACP (Alshanberi et al., 2018), but the education of physicians on EOL conversations

can cause a lack in completion of ADs (Fulmer et al., 2018). Physicians play an important role in ACP planning, being able to help clarify a patient's understanding of illness and treatment options and help encourage caregivers in understanding the patient's preferences (Martins et al., 2022). Physicians can start the conversations of ACP and EOL, and with that responsibility comes a need to understand how a patient might confidentially be given the information and resources to participate in these discussions. In a recent study, 99% of physicians coming from a variety of backgrounds agreed on the importance of EOL decisions, but only 29% of them had some kind of formal training on these conversations (Fulmer et al., 2018). Physicians need to be educated and trained on EOL conversations to be better prepared to initiate ACP.

Due to the nature of ACP being an ongoing conversation (Friend & Alden, 2021), other healthcare professionals play just as important role as physicians in EOL conversations. ACP programs and interventions use other healthcare workers, such as nurses, social workers, and health care coaches to continue to the conversation with patients and their families (Berglund et al., 2020; Leung et al., 2018; Patel et al., 2021).

Roles of Other Healthcare Professionals

Due to the complexity of EOL decisions, the attitude towards ADs and ACP with physicians reveals adherence to participating in ACP with patients (Coleman, 2012). While completed documentation of ADs is helpful, ACP is most effective with a facilitated, ongoing conversation (Dixon et al, 2018; Downey et al., 2013). The role of other healthcare professionals like nurses, social workers, healthcare coaches, and more can provide continued education and support through the ACP conversations (Kastbom et al., 2019; Patel et al., 2021), showing a need for interdisciplinary teams to collaborate on

ACP with patients (Kwak et al., 2022). Physicians can agree that other healthcare groups, like nurse practitioners, nurses, social workers, etc., are capable of engaging in ACP conversations with patients (You, 2015), but the exact roles and responsibilities can be unclear for these healthcare professionals (Kwak et al., 2022).

Nurses play a unique role in the care of a patient because of the closeness and frequency of care given, compared to a physician or other healthcare worker. Due to representing the largest group in healthcare, their wide medical knowledge, and the frequency of seeing their patients, nurses are equipped to offer guidance and support on ACP conversations (Leung et al., 2018). Nurses are valuable in ACP because they are connected uniquely and intimately to healthcare organizations and patients (Izumi, 2017).

Nurses assuming these unique roles also face many challenges including time constraints and perceptions of nurses needing to do everything, but also avoid discussing EOL planning (Jeong et al., 2011). With the correct training, nurses could be in a good position to participate in ACP conversations due to working closely with patients and being able to observe changes in their health, yet they often lack the support from other clinicians (Izumi, 2017).

Social workers in the medical setting can face a lot of vagueness in their roles, especially on an interdisciplinary team. Just like nurses, there is a confusion of role in ACP conversations. In an acute setting, social workers are seen mainly for their case manager role, specifically discharge planning, which means a lot of connecting with outside resources and are often being blamed for problems outside their control (McLaughlin, 2015). While the case manager role is important in an acute care setting, social workers have the skills to play roles such as educator, facilitator, counselor, or

advocate. Many times, medical social workers cannot fill these roles because of the emphasis on discharge planning from the hospital system (McLaughlin, 2015).

Although the role of social work can be misrepresented in the medical setting, social workers are trained in unique interventions and skills. Social workers are skilled to act as a patient advocate, helping other team members remember and understand a patient's wishes and values (ACP Decisions, 2020). Reaching the bio-psycho-social needs of a patient helps others in a multidisciplinary team understand a patient. One of the other unique skills, defined by Silverman, is *organizational empathy* (2018). This term refers to the social worker embracing the environment they are practicing in, which is a transitional period for any social worker. This skill reflects the adaptability of a social worker to take on greater tasks in an interdisciplinary team.

Social workers' values align directly with themes of ACP competencies, including working collaboratively (which include effective communication) and facilitating conversations affectively to patients and families (Kwak et al., 2022). Social workers' ethics and values align in the collaborative and facilitation environments, making social workers effective practitioners to continue ACP conversations.

Continuing a conversation related to EOL presents its own challenges to healthcare professionals. Supportive care intervention designs can assist patients on education about the disease and guidance with prognosis (McDonald et al., 2017), assisting patients in making informed, educated decisions on their goals of care (Park et al., 2020). Effective support for EOL conversations happens through recognizing the patient's psychosocial, physical, and financial concerns (CAPC, 2020). As a healthcare worker, starting and continuing ACP conversations in a sensitive and realistic light

advocates for patient autonomy. Programs like palliative care help patients identify the goals of their care and match that to their treatment choices (CAPC, 2022). A study done in 2020 shows the importance of early-on ACP conversations with a social work-led palliative program. This program improved conversations on goals of care with patients to plan ahead for their future medical care, increasing patient-directed care and the hospice referral rate (Berglund et al., 2020). Consulting a palliative care team on appropriate cases can step in to address goals of a patient, managing physical symptoms, understand family dynamics, assist in completing ADs, or offer emotional and spiritual support to the patient and/or their family (Rath et al., 2022). Interdisciplinary palliative care teams are made up of physicians, nurses, social workers, chaplains, and other allied healthcare workers, all which are trained to assist in ACP for patients (CAPC, 2022).

Factors of ACP

There are many factors that influence ACP conversations. Kwak et al. (2022) found three main competency themes of ACP: (1) professional commitment to advocating for patients' values and self-determination, (2) professional responsibility to facilitate ACP, and (3) specific tasks in ACP. Each competency can be represented by different members of an interdisciplinary team working with a patient and their families. To be committed to advocating for a patient's values and self-determination, practitioners must be competent in understanding a patient in their environment. This means culturally, economically, ethnically, and financially (CAPC, 2022). Defining factors like independence and interdependence can guide conversations of ACP to be effective in the practice setting (Friend & Alden, 2021). This could even include understanding a

patient's attitude toward death so that the practitioner's intervention for ACP will be most effective for the patient.

Facilitating the ACP conversations must involve clear communication between healthcare professionals, patients, and families. Facilitation includes orchestrating and coordinating meetings to discuss aspects of ACP from a medical lens, education of ACP in everyday practice, and aligning values of the patient with the proposed treatment plan (Kwak et al., 2022). During the facilitation of the ACP conversations, there are specific roles each member of the interdisciplinary team is assigned to orchestrate. These could include determining capacity of the patient, filling out ADs such as naming a decision maker and defining the patient's values related to their care, or continuing education as a practitioner to optimize how to help patients through ACP (Kwak, et al., 2022). Howard et al. explored four concepts of ACP as healthcare professionals: willingness, participation, confidence, and barriers (2020). Each of these concepts were measured to see varied perceptions by different healthcare professionals, rather than just one profession (e.g., physicians). Non-physician involvement in ACP is low due to the lack of knowledge and clarity in performing ACP conversations (Howard et al., 2018). Understanding each of these concepts from different professions will help expand ACP conversations to more professions and clarify the process of ACP on interdisciplinary teams.

Conclusion: Implications of Literature Review for New Research

This literature review attempted to explore the importance of ACP conversations and understand how integrated healthcare teams use ACP in direct-patient care settings. ACP becomes important in exploring EOL decisions by addressing patients' values and

preferences to align those to the care they are receiving. ACP is done in many different capacities with patients and families through different specialties, interventions, or organization. ACP conversations are important to start with patients, but also just as important to continue the conversation depending on preferences and stage of illness of patients. Due to the importance of keeping the ACP conversation ongoing, interdisciplinary teams can carry different responsibilities related to ACP. Responsibilities of ACP for healthcare professionals have been tested in different settings, but further research needs to be done on all healthcare professionals' outcomes and barriers of ACP in their setting or professional career. Howard and colleagues (2020) created a survey to measure the willingness, confidence, participation, and barriers of healthcare professionals in doing ACP. This survey addresses the engagement of other healthcare professionals, like nurses and social workers, instead of just physicians. Further research needs to be done to compare the views of various healthcare professionals working together to engage and implement ACP conversations with patients and families. Increasing the capacity of non-physician healthcare workers to participate in ACP should grow in order to give equal access and appropriate services to patients who might need it most. Therefore, this study suggests describing healthcare professionals' outcomes and barriers in implementing ACP conversations with their patients will guide the process of ACP through different healthcare professionals. Overall, addressing barriers of engaging in ACP conversations and exploring the outcomes of participation as different healthcare professionals will guide the process of ACP through different healthcare professions.

CHAPTER III

METHODOLOGY

Advance care planning (ACP) is used to influence end-of-life (EOL) care decisions and to plan ahead for future medical decisions. The purpose of this study is to explore the perceptions and experiences of healthcare professionals regarding ACP outcomes and barriers. The sample population involves healthcare professionals working in direct patient care. This does not only include healthcare professionals working with EOL care, but rather all healthcare professionals in direct patient care. The researcher attempted to answer the following questions:

- RQ1: What are the differences in ACP outcomes for allied healthcare professionals versus physicians?
- RQ2: What are the barriers to ACP outcomes for allied healthcare professionals versus physicians?
- RQ3: What are the effects of barriers on ACP outcomes?
- RQ4: How much is interdisciplinary communication needed in ACP discussions?

Based on the review of the literature, the ACP process has been explored through different interventions with different professionals to understand the best process of EOL conversations with families and patients. By exploring the outcomes and barriers of healthcare professionals engaging in ACP, potential areas of improvement can be identified in the ACP process.

Research Design

This study uses an observational, cross-sectional survey design due to being collected at one point in time and with a representative group of people. This design is expected to suffer from weak internal validity because the cross-sectional data do not imply causality (Sekaran & Bougie, 2016).

Sampling

The study population is healthcare workers operating in direct patient care, including physicians, nurses, and social workers. A desirable sampling frame for this study would have a list of all healthcare professionals in Texas in a faith-based healthcare system. Since that is not possible to obtain such a list, the sample of this study will include the survey respondents out of all healthcare professionals in one single faith-based, non-profit hospital system in West Texas. Given that information, this study will use a non-probability sampling method; more specifically, convenience sampling will be utilized to collect the data. This limits the external validity of the study (Yegidis et al., 2018).

Instruments

To measure the variables for this study, this study used two different surveys – one for physicians and one for allied healthcare professionals. Each survey is identical in its question on outcomes of ACP but are different within the section on barriers. The DECIDE Allied Health Questionnaire for Primary Care that has been developed by a group of researchers (Howard et al., 2020) and is used for this study with their permission (Appendix B). This survey includes four key elements regarding APC: willingness, confidence, participation, and barriers. Each element is measured using a seven-point

scale from 0–6. Each element will be shown through means and standard deviations. The questions in the survey were based on a previous survey which explored barriers and enablers of goals of care conversations sent out to physicians and nurses in a hospital setting (You et al., 2015). Those questions were then presented to two focus groups of primary care physicians and palliative-trained clinicians to construct the validity of the content and wording of questions. Once questions were created, they were proposed to two more focus groups with nurse practitioners, nurses, and social workers (Howard et al., 2020). This process insured content validity of the questions. The original authors of the survey did not report on internal reliability of the questionnaire, but there was a high response rate in the previous survey done, helping prove reliability of the survey.

The mean score for each construct was used to explore ACP outcomes and barriers. The means and standard deviations through percentages and continuous variables were used to average the data and show the variability in the data (Yegidis et al., 2018). Cronbach's alpha was used to measure variability in the results.

ACP Outcomes

ACP outcomes are measured by the same set of questions both for allied health care providers and physicians. Although this measure may be valid for such construct, the subjective nature of measurements suggests limitations in its validity of measuring their actual ACP willingness, confidence, and participation. The ACP outcomes include three sub-constructs: (1) the willingness of healthcare professionals having ACP conversations with patients and families, (2) their confidence in performing those conversations, and (3) their frequency in participating in ACP (Howard et al., 2020). Each of these sub-

constructs (i.e., willingness, confidence, and participation) were measured in the following six aspects of ACP.

1. Initiate discussions about ACP with patients.
2. Exchange information (e.g., explain ACP, reasons why it is important, and related health care laws) with patients.
3. Be a decision coach (clarifying values, assisting with weighing options for care, etc.) for patients who are trying to engage in ACP.
4. Participate in finalization of the ACP plan (preferences of care, values statements, designation of substitute decision maker) with patients and their families.
5. Help patients communicate their ACP with their families.
6. Help patients communicate their ACP with other health care professionals.

Willingness

The willingness of healthcare professionals to have ACP conversations was measured through a series of statements related to their comfort level and likelihood of initiating ACP conversations with patients. Physicians and allied health professionals were asked to rate their level of willingness on a seven-point scale from not at all willing to extremely willing based on a series of statements: 0=not at all willing, 1=not willing, 2=somewhat not willing, 3=neither unwilling or willing, 4=somewhat willing, 5=willing, 6=extremely willing.

Confidence

The confidence of healthcare professionals in ACP conversations was measured through a series of statements on a seven-point scale from not at all confident to extremely confident. Physicians and allied healthcare professionals were given the same

series of statements to measure their confidence in ACP conversations: 0=not at all confident, 1=not confident, 2=somewhat not confident, 3=neither unconfident or confident, 4=somewhat confident, 5= confident, 6=extremely confident.

Participation

The participation of healthcare professionals having ACP conversations were measured through the series of statements on a seven-point scale. Physicians and allied healthcare professionals were given the same series of statements to measure their participation: 0=never, 1=rarely, 2=once a month, 3=once a week, 4=2-3 times a week, 5=4-6 times a week, 6=daily.

Barriers

The barriers of healthcare professionals in having ACP conversations were measured through a series of statements on a seven-point scale (0=not at all, 1=very little, 2=a little, 3=a moderate amount, 4=a lot, 5=a great deal, 6=an extreme amount). Unlike the ACP outcomes, the questions for allied healthcare professionals and physicians are different. The series of statements for each question is presented in Table 1. Physicians were asked to rate barriers related to three different categories: (1) barriers related their role as physicians, (2) barriers related to characteristics of the patient, and (3) barriers to the healthcare system or external factors. Statements physicians were asked to rate as barriers are listed in Table 1.

Other allied healthcare professionals were asked to rate barriers related to four different categories: (1) barriers related to their role in ACP, (2) barriers related to physician involvement, (3) barriers related to characteristics of the patients, (4) barriers related to the healthcare system or external factors. A few questions regarding external

factors were excluded due to the wording of questions being aimed towards primary care providers to fit an acute care setting rather than primary care. Allied healthcare professionals were given a series of statements under each category and asked to rate how that item is a barrier to them, which are presented in Table 1. Allied healthcare professionals were asked one more category than physicians and that section was "barriers related to physician involvement" which is listed in Table 1.

Table 1

Questions Related to Barriers for Allied Healthcare Professionals and Physicians

	Allied Healthcare Professionals	Physicians
Barriers to My Role	• My role in doing ACP is not clearly defined in our practice is a barrier. • My lack of knowledge about ACP and its relationship to advance directives and goals of care discussions is a barrier. • My lack of knowledge about the legal status of ACP documents in the state is a barrier. • My difficulties in dealing with uncertainty of prognosis for patients with chronic illness is a barrier. • My difficulties with defining the right moment to engage patients in ACP is a barrier. • My having to deal with the emotional impact of ACP conversations in patients is a barrier. • My belief that physicians are better positioned to initiate ACP is a barrier. • My belief that advance care plans are too simplified for complicated medical scenarios is a barrier. • My fear that these conversations will diminish hope in patients with serious illness is a barrier. • My fear that ACP will negatively impact my relationship with patients is a barrier.	• My lack of knowledge about ACP and its relationship to advance directives and goals of care discussions is a barrier. • My lack of knowledge about the legal status of ACP documents in this state is a barrier. • My difficulties in dealing with uncertainty of prognosis for patients with chronic illness is a barrier. • My difficulties with defining the right moment to engage patients in ACP is a barrier. • My having to deal with the emotional impact of ACP conversations in patients is a barrier. • My belief that it is my job to cure people is a barrier. • My belief that other healthcare professionals are better positioned to initiate ACP is a barrier. • My belief that patients should initiate this type of discussion is a barrier. • My belief that advance care plans are too simplified for complicated medical scenarios is a barrier. • My fear that these conversations will diminish hope in patients with serious illness is a barrier. • My fear that ACP will negatively impact my relationship with my patients is a barrier.
Barriers to Characteristic of the Patient	• Patients' difficulty accepting their poor prognosis is a barrier. • Patients' difficulty understanding the limitations and complications of life sustaining therapies (mechanical	• Patients' difficulty accepting their poor prognosis is a barrier. • Patients' difficulty understanding the limitations and complications of life sustaining therapies (mechanical

	ventilation, CPR, vasopressors, etc.) at the end of life is a barrier. • Patients' fear of upsetting their families by discussing the topic is a barrier. • The patient's strong religious convictions is a barrier.	ventilation, CPR, vasopressors, etc.) at the end of life is a barrier. • Patients not understanding or misinterpreting my reasons for bringing up the topic is a barrier. • Patients' lack of understanding about how treatment decisions are made at the end of life is a barrier. • Patients' fear of upsetting their families by discussing the topic is a barrier. • The patient's strong religious convictions is a barrier. • Incapacity of patient because of diminished consciousness or dementia or other cognitive disability is a barrier. • Family unwillingness to support me in engaging the patient in ACP discussions is a barrier.
Barriers to Characteristic of the External System	• Insufficient access to or availability of other health care professionals (social works, nurses or others) to help with ACP • Lack of ready access to forms and resources for patients • Inability to electronically transfer patient's advance care plan (other hospital stays, other departments, etc.)	• Insufficient time during hospital visit to deal with this topic is a barrier. • Patients getting different messages from other specialists involved in patient's care is a barrier. • Lack of financial remuneration for ACP is a barrier. • Insufficient access to or availability of other health care professionals (social works, nurses or others) to help with ACP is a barrier. • Lack of ready access to forms and resources for patients is a barrier. • Inability to electronically transfer patient's advance care plan (other hospital stays, other departments, etc.) is a barrier.
Barriers to Physician Involvement	• Physician not in agreement with me about when to initiate ACP is a barrier. • Physicians' lack of time to have conversations with patients/family is a barrier. • Physicians' lack of communications skills is a barrier.	

Perceptions on Need for Interdisciplinary Communication

This study assessed the need for interdisciplinary communication between healthcare professionals based on their ratings on how acceptable they would find for specific healthcare professionals to participate in ACP conversations with patients. The healthcare professionals listed included physicians, nurse practitioners, physician assistant, nurses, and social workers. Two categories of questions regarding the type of participation were asked: 1) Exchanging information about ACP (e.g., explain ACP, reasons why it is important, related health care laws, etc.), and 2) Assisting the patient in communicating the ACP plan to their family members and other healthcare teams. The rating was measured on a seven-point scale from extremely unacceptable to extremely acceptable.

Demographics and Professionals' Information

Questions regarding participants' professional degree (i.e., physician, nurse practitioner, PA, nurse, social worker) and number of years in practice were used to compare how professionals differ in knowledge, participation, and willingness in having ACP conversations. Two questions regarding palliative care interest and certification were added, those included "Have you undertaken extra training or certification in palliative care?" and "Do you have a special interest in palliative care in your practice?" These questions were used to look at if interest in palliative affects outcomes of ACP. Other questions include "What area of medicine do you practice or what department do you work in (if applicable)?", "Do you believe IPE training is important for healthcare professionals to participate in?", and "Have you received Interprofessional Education (IPE) training during your educational training or professional career?" Participants are

asked some other basic demographic questions as well, including their gender, age, and race.

Suggestions to Improvement for ACP

Participants were asked one open-ended question regarding their suggestions to improvement for ACP. Participants were asked to reflect on their most important variables and give suggestions they might have to overcome their biggest barrier in ACP for themselves and other healthcare professionals.

Ethical Considerations

Privacy and Confidentiality

The survey is anonymous because no identifying information was recorded. Participation is completely voluntary, and each participant can withdraw from the study at any time. Each response is kept confidential. Identifiable information is not kept with a surveyor's response and full confidentiality is assured with the published results since they will be used for statistical purposes only.

HIPAA Considerations

HIPAA considerations were made in this study. No medical information was collected about the participants of this study, so there are minimal risks of violating HIPAA rules or regulations. The only personal information that the researcher used was the professional role of the participants.

IRB Application

This research was reviewed and approved by ACU's Institutional Review Board (IRB) (See Appendix A for the approval letter). The IRB application included the agency's permission of this study (See Appendix C).

Data Collection

Once IRB approval was obtained, the researcher created a survey in Qualtrics and sent a representative of the research department of the hospital an invitation letter (Appendix D) that includes two links to two different Qualtrics surveys: allied healthcare professional or physician. The representative then emailed the invitation letter to healthcare professionals in the hospital. By clicking the appropriate link, participants were instructed to read and sign the informed consent form before taking the survey and give their consent by clicking "I consent."

No identifying information is recorded to protect participant confidentiality. The information gathered is recorded through Qualtrics into an excel sheet which was then transferred to a SPSS file. Once it was transferred from Excel to SPSS, the spreadsheet was deleted. The statistical analysis was then deleted after the analysis was completed.

Analysis Plan

Statistical Package for the Social Sciences (SPSS) will be used for the data analyses. Descriptive statistics will be used to describe the sample characteristics and the respondent's ratings of each question about their confidence, willingness, and participation. Each proposed research question will be examined in these ways:

RQ1: To examine the current status of ACP outcomes, descriptive analyses were conducted on each factor. Mean and standard deviations were described through percentages and continuous variables. Independent samples t-tests were conducted to compare the ACP willingness, confidence, and participation between allied health professionals and physicians.

RQ2: To examine the current status of ACP barriers to outcomes, descriptive analyses were conducted on each factor. Mean and standard deviations were described through percentages and continuous variables. *T*-tests were not conducted for this question because the measurements were different for the two groups.

RQ3: To examine the factors of ACP outcomes, linear regression analyses were conducted by using various types of barriers as independent variable and ACP outcomes as dependent variable.

RQ4: To examine the receptiveness of healthcare professionals, descriptive analyses were conducted for the allied healthcare professionals. Means and standard deviations were described through percentages and continuous variables.

Per the original author, "Categorical variables are described as counts. Percentages and continuous variables are described as means and standard deviations. Multiple linear regression analyses will be used to explore the factors of ACP related outcomes" (Howard et al., 2020, p. 221).

CHAPTER IV

FINDINGS

The current study measures the advance care planning (ACP) outcomes and barriers of healthcare professionals working in direct patient care. The following four research questions were used to measure the perceived perceptions and experience of healthcare professionals regarding ACP:

- RQ1: What are the differences in ACP outcomes for allied healthcare professionals versus physicians?
- RQ2: What are the barriers to ACP outcomes for allied healthcare professionals versus physicians?
- RQ3: What are the effects of barriers on ACP outcomes?
- RQ4: How much is interdisciplinary communication needed in ACP discussions?

Participants

The survey had a total of 22 responses. The survey was sent out on March 15, 2023, and data were collected through March 22, 2023. Out of the 200 participants contacted, 18 allied healthcare professionals and 4 physicians completed the survey, yielding a response rate of 22%. Although not all participants answered every question, every case was included in the analysis because of the small sample size. Table 2 presents descriptive statistics regarding survey participants demographic and professional information. Most participants of the allied healthcare survey were female (61.1%) from

the allied healthcare professionals. Physician participants were majority male (75%). The largest group of allied healthcare professionals with recorded responses were nurses (38.9%) or the response was not recorded (33.3%). Of the practice years recorded, there was a wide range of years from the allied healthcare professionals, anywhere from less than three years of practice experience to over 30 years. Of the allied healthcare professionals, 22.2% reported previous palliative care training or certification and 44.4% showed an interest in palliative care as a specialty.

Table 2

*Demographic and Professional Information of Sample (*N = *18,* N = *4)*

		Allied Healthcare Professionals *N = 18*		*Physicians* *N = 4*	
Variable	Category	*n*	*%*	*n*	*%*
Sex	Male	1	5.6	3	75.0
	Female	11	61.1		
	No answer	6	33.3	1	25.0
Age	25-34 years old	4	22.2	2	50.0
	35-44 years old	3	16.7	1	25.0
	45-54 years old	2	11.1		
	Over 54 years old	3	16.7		
	No answer	6	33.3	1	25.0
Position	Physician			3	75.0
	Nurse Practitioner	3	16.7		
	Nurse	7	38.9		
	Social Work	2	11.1		
	No answer	6	33.3	1	25.0
Palliative Care Training	Yes	4	22.2	2	50.0
	No	8	44.4	1	25.0
	No answer	6	33.3	1	25.0
IPE Training	In my educational training	1	5.6	1	25.0
	In my professional career	1	5.6		
	BOTH	7	38.9	2	50.0
	I have not participated	3	16.7		
	No answer	6	33.3	1	25.0
IPE Importance	Yes	10	55.6	3	75.0
	No answer	8	44.4	1	25.0
	No answer	1	5.6	1	25.0

Findings on APC Outcomes and Barriers

To answer RQ1 and RQ2, descriptive analyses were conducted for each outcome and barrier. This study used existing scales to measure ACP outcomes and barriers: willingness, confidence, and participation. Howard and colleagues suggest finding composite variables of ACP outcomes and variables through sum or mean scores (2020). Composite variables combine correlated variables to create meaningful information that

is more comprehensible to research (Song et al., 2013). The answers from each series of questions for the outcomes and barriers are combined to make meaning of their presence in ACP conversations. Means and standard deviations were used to average the data and composite variables and show how much variability there is in the results (Yegidis et al., 2018). These two measures account for all values from the participant's responses.

Cronbach's alpha is a range used to assess internal consistency of a scale. Cronbach's alpha was used as a tool to find the reliability and consistency of ACP outcomes and barriers survey questions. Acceptable values of Cronbach's alpha range from .70 to .97, but even some low alpha values have been argued to be useful in a few circumstances (Taber, 2017).

The outcome measures for Cronbach's alpha ranged from .821 to .974 besides one construct in the allied healthcare professionals survey (i.e., Barrier regarding physicians: alpha=0.499). By eliminating one item, "Physician not in agreement with me about when to initiate ACP," the alpha was increased to .652. Although this alpha is slightly lower than the cut-off point, two items were used to calculate the construct: "Physicians' lack of time to have conversations with patients/family" and "Physicians' lack of communication skills." For other constructs, all items for each construct were used to calculate the mean score that measure each composite variable.

Tables 3 and 4 present data related to the outcomes and barriers of ACP reported from the survey. The data are presented in means and standard deviations for allied healthcare professionals and physicians. Among allied healthcare professionals, the average willingness to engage in ACP was a mean score of 5.11 out of a maximum of 6, while physicians showed a greater variability (1.50) and lower mean (4.38) for

willingness of ACP engagement. The confidence in having ACP conversations showed a greater mean for physicians (5.08) than allied healthcare professionals (4.67) while also having less variability (1.06 vs. 0.48). The frequency of ACP conversations was comparable among physicians and allied healthcare professionals with means of 3.67 and 3.32, meaning participating in ACP was frequent no matter one's profession. The participants seemed to have similar thoughts toward barriers related to their role with low means of 1.68 and 1.53 with standard deviations of 1.04 and 0.85. Allied healthcare professionals relayed a higher mean (4.10) for barriers related to patients for participating in ACP than physicians (3.08).

Independent samples *t*-tests were conducted to compare the ACP willingness, confidence, and participation between allied health professionals and physicians, reported in Table 3. None of the mean differences were statistically significant. T test for barriers were not conducted because the measurements were different for the two groups.

Table 3

Descriptive Statistics of ACP Outcomes and Tests of the Mean Difference

	Allied Healthcare Professionals ($N = 18$)				Physicians ($N = 4$)				Mean Difference	
	Min	Max	*M*	*SD*	Min	Max	*M*	*SD*	*t*	*p*
Willingness	3.7	6.0	5.11	0.75	2.2	5.5	4.38	1.5	-1.48	0.16
Confidence	2.7	6.0	4.67	1.06	4.5	5.7	5.08	0.48	0.76	0.46
Participation	0.0	6.0	3.32	1.69	1.0	5.7	3.67	1.95	0.35	0.73

Table 4

Descriptive Statistics of Barriers to ACP

	Allied Healthcare Professionals $N = 18$				Physicians $N = 4$			
	Min	Max	*M*	*SD*	Min	Max	*M*	*SD*
Barrier to My Role	0.20	3.80	1.68	1.04	0.80	2.60	1.53	0.85
Barriers to Physicians	1.00	6.00	3.00	1.22				
Barriers to Patients	2.00	6.25	4.10	1.09	2.50	3.75	3.08	0.63
Barriers to System	0.00	6.00	2.48	1.68	0.33	2.00	1.00	0.88

Note. Scale:0=not at all, 1=very little, 2=A little, 3=neutral, 4=a lot, 5=a great deal, 6=an extreme amount

Exploring the Association Between Barriers and ACP Outcomes

To answer RQ3, this study explored the association between barriers to ACP (i.e., factors) and each ACP outcome variable (i.e., outcome). A multiple regression analysis was performed to test the following a hypothesis for each ACP outcome:

- Outcome 1: Barriers of allied healthcare professionals' roles in ACP will have a negative effect on willingness to engage in ACP conversations.
- Outcome 2: Barriers of allied healthcare professionals' roles in ACP will have a negative effect on the confidence to engaging in ACP conversations.
- Outcome 3: Barriers to the patients will have a negative effect on the frequency of participation for ACP conversations from allied healthcare professionals.

The multiple linear regression was only performed for the allied healthcare professionals due to the small sample size of the physician survey. Field's recommendations for assumptions testing a regression model were considered before testing the hypotheses (2013). Multicollinearity problems, high correlation between factors, were examined with the tolerance value for predictors (less than 0.2) or variance inflation factor (VIF) (10 or above). One of the barrier factors (i.e., barriers on system)

had a small tolerance value (close to 0.2) and a high correlation with other barrier factors. Therefore, this factor was excluded in multiple regression models. A set of non-barrier factors (e.g., palliative training and IPE experience, years in practice) were included in the models but excluded in the final models given the small correlations with the outcome variables.

Table 5 presents the results of the regression analyses. The results indicate that the overall regression model for willingness of ACP engagement (R^2 = 0.311, F = 2.659, p = .120) and frequency of participation (R^2 = 0.286, F = 1.070, p = .0415) was not statistically significant. The results do indicate the overall regression model for confidence of ACP conversations was statistically significant (R^2 = 0.706, F = 6.404, p = 0.016). These results show that barriers in allied healthcare professionals' roles was statistically significant on their confidence in ACP, t = -3.992 and p = 0.004.

This shows that outcome 2 was supported, showing allied healthcare professionals reported more barriers to their roles and had lower confidence in ACP. Outcomes 1 and 3 were not supported. Outcome 1 does show a trend with a p-value of .052 but did not reach statistical significance.

Table 5

*Factors of ACP Outcomes: Allied Healthcare Professionals (*N = *12)*

	Willingness		Confidence		Frequency	
Factor	*t*	*p*	*t*	*p*	*T*	*p*
Barriers to My Role	-2.282	0.052	-3.992	0.004	-1.161	0.279
Barriers to Physicians	-0.788	0.454	-0.366	0.724	-0.482	0.643
Barriers to Patients	0.946	0.372	1.625	0.143	-0.294	0.777
F	2.659	0.120	6.404	0.016	1.070	0.415
R square	0.311		0.706		0.286	

Perceptions on the Need for Interdisciplinary Communication

RQ4 was answered through descriptive analysis. The need for interdisciplinary communication in ACP was explored through mean scores of each profession acceptability from others. Table 6 shows level of acceptance of professions to engage in ACP. All mean scores of acceptability were greater than 4. Physicians and nurse practitioners have the highest mean scores (6.17 and 6.25), but with high standard deviation (1.02 and 1.14). Nurses and social workers also have high mean scores of 6.08 and 6.17, but with lower standard deviations of 0.76 and 0.69.

Table 6 also includes the level of acceptance for others' participation in ACP from physicians. Of the four physicians, each profession had a mean score of 7, showing great acceptance for each profession (nursing and social work) to engage in ACP discussions with patients.

Table 6

Perceptions on Need for Interdisciplinary Communication to Patients

	Exchange Information about ACP				Assisting Patient in Communication with Others			
		Allied		Physician		Allied		Physician
	n	*M*	*n*	*M*	*n*	*M*	*n*	*M*
Physicians	12	5.17	3	6.00	12	5.33	3	5.67
Nurse Practitioners	12	5.25	2	6.00	12	5.33	2	6.00
Physician Assistants	12	5.17	2	6.00	12	5.17	2	6.00
Nurses	12	5.08	2	6.00	12	5.33	1	6.00
Social Workers	12	5.17	2	6.00	12	5.25	2	5.00
Other	3	6.00	0		2	4.50	0	

Note. Exchanging Information about ACP (e.g., explain ACP, reasons why it is important, related health care laws, etc.). Assisting the patient in communicating the ACP plan to their family members and other healthcare teams.

Scale: 0=extremely unacceptable, 1=very unacceptable, 2=somewhat unacceptable, 3=neutral, 4=somewhat acceptable, 5=very acceptable, 6=extremely acceptable

Suggestions to Improvement for ACP

Participants were asked to reflect on their most important variables and give suggestions they might have to overcome their biggest barrier in ACP for themselves and other healthcare professionals. Out of the 22 survey responses, 10 participants provided a response to suggestions to improve ACP: 8 allied healthcare professionals and 2 physicians. Due to the limited number of responses and nature of the quantitative study, a full thematic content analysis was not done. Rather, one theme was chosen that was shown in three of the responses. The overall greatest theme from the eight responses of the allied healthcare professional was the need for better communication between medical teams and staff. Responses from allied healthcare professionals include "Better communication between all providers on care team (physicians, nurses, social workers, palliative care, etc.)," "More training and education about ACP for healthcare professionals," and "To have more cooperation with physicians to discuss need for ACP."

CHAPTER V

DISCUSSION

Advance care planning (ACP) plays an important step in understanding a patient's values, preferences, and future wishes regarding medical care, giving the patient control over future medical decisions. Patients' and families' appreciation and participation in ACP is well researched, but there is a gap in knowing and understanding healthcare workers' outcomes and barriers related to initiating and participating in ACP conversations with patients and their loved ones. The purpose of this study was to explore the perceptions and experiences of healthcare professionals regarding ACP outcomes and barriers. The research questions explored include:

- RQ1: What are the differences in ACP outcomes for allied healthcare professionals versus physician?
- RQ2: What are the barriers to ACP outcomes for allied healthcare professionals versus physicians?
- RQ3: What are the effects of barriers on ACP outcomes?
- RQ4: How much is interdisciplinary communication needed in ACP discussions?

Without understanding the factors of participating in ACP and the barriers for healthcare professionals, ACP is at risk of never reaching patients in order to give full patient autonomy in their future medical care.

Discussion of Major Findings

This study explored ACP factors from healthcare professionals in rural West Texas at a faith-based medical institution. The study participants mostly consisted of in-patient nurse practitioners, nurses, social workers, and other direct-care providers who participate in ACP with patients. The allied healthcare professionals worked in different specialties and departments including critical care, case management, and medical surgical floor. Reliability tests were used on each scale to test the accuracy of the survey questions, resulting in one item from the allied healthcare professionals survey (i.e., "barriers to external system") being eliminated to ensure greater reliability.

In exploring the relationship of the current study findings to analyzed literature and RQ1, the three outcomes of ACP show moderate-to-high mean ratings for physicians and allied healthcare professionals. In the original study, Howard et al. found high mean ratings for all three outcomes for physicians, revealing higher levels of willingness, confidence, and participation which physicians had when engaging in ACP (2020). The results from the current study differed in showing a higher mean for allied healthcare professionals' willingness to engage in ACP with patients versus physicians' mean willingness. The other two outcomes of confidence and participation showed lower means for allied healthcare professionals compared to physicians' means. This conveys that allied healthcare professionals lacked confidence and participation in ACP discussions with patients but were very willing to engage in such conversations. These findings match with the findings of Howard et al. (2020) concerning allied healthcare professionals being less confident and less engaged in ACP discussions (2020).

The current study results show low confidence and participation means for allied healthcare professionals compared to physicians. This suggests the need to improve confidence in allied healthcare professionals such as nurses and social workers to increase engagement and participation of ACP with patients. Previous studies related to ACP suggest role clarity, education, and skill-building to address these outcomes in allied healthcare professionals (Howard et al., 2020; Wang et al., 2017). Roles for allied healthcare professionals differ across settings. Many programs have tested interventions for nurse-led ACP in community settings and have shown great improvement to quality conversations on ACP (Hinderer & Lee, 2013; Leung et al., 2018). But many settings have vague interdisciplinary team guidelines to ACP (Kwak et al., 2022), causing lower confidence and participation from healthcare professionals in different fields. The findings from the analyzed literature are supported through the current study due to the healthcare professional's confidence being affected by their perceived barriers to their roles in ACP.

Addressing the biggest barriers to allied healthcare professionals could also serve to improve the ACP process (You et al., 2015). In the present study, allied healthcare professionals presented higher means in barriers to ACP than physicians reported. Allied healthcare professionals reported barriers to patients as "a lot" compared to physicians reporting a moderate amount. This section answers RQ2 to address barriers to outcomes for ACP for allied healthcare professionals versus physicians.

Through the regression analysis, the current study found for allied healthcare professionals, the higher barriers perceived in their role, the lower confidence they had in engaging in APC conversations. The perceived barriers within their roles were highest in

"my lack of knowledge about ACP and its relationship to advance directives and goals of care discussions is a barrier," "my belief that physicians are better positioned to initiate ACP," and "my lack of knowledge about the legal status of ACP document in the state." This suggests that confidence can be improved for allied healthcare professionals through more knowledge and skills related to ACP in their specialties. A study done in 2008 reported social workers reported their learned knowledge and skills for ACP is not addressed appropriately in their training and education, causing social workers to feel less prepared in working with end-of-life conversations (Christ & Sormanti, 2000). Knowledge and education of ACP for nurses have limited literature and a lack of understanding overall (Miller, 2018).

Lastly, allied healthcare professionals' reception of other healthcare professionals participating in ACP shows high means in the present study. This shows allied healthcare professionals show great acceptance for physicians and nurse practitioners to engage in ACP, but responses had a great variability in how accepting they were toward physicians and nurse practitioners. This means the responses of nurses and social workers were more clustered around the mean and their level of acceptance from other allied healthcare professionals to engage in ACP was high. Subsequently to Howard et al., social workers, nurses, and nurse practitioners were perceived to be acceptable to engage in ACP with patients and families (2020). It is important to note in the current study the reported importance of Interprofessional Experience (IPE) from the participants. Over half of the participant's agreed IPE is important in education and professional career. With a high rate of IPE experience from participants, high acceptability for other professionals participating in ACP makes sense.

Limitations of This Study

This study presents many limitations. The sample of healthcare workers participating is voluntary so participants could have differing views from those who do not participate. The survey was also only sent out to 200 participants through an email, many of which nurses and physicians are not routinely checking. This could give reason to the small sample size.

With the small sample size, the study is going to be limited to generalizing the findings to a whole population of healthcare workers. Third, when measuring confidence and willingness it does not necessarily reflect satisfaction or quality of a conversation. Training in ACP differs between profession and even specialty, so a professional could be confident in their speaking but not be accurate in the actual discussion.

Lastly, since a palliative program was present where the study was done. A setting where a palliative program is established could affect any outcome of ACP from healthcare professionals. If a hospital has an established relationship and built trust with a team of professionals whose job is to aid in ACP, outcomes of ACP from individuals could be affected. If there is an established relationship, healthcare professionals might be comfortable passing those conversations to a palliative team and disregard their own capacity to aid in such EOL conversations. It is important to note that this study was done at one hospital system in West Texas. This system has three hospital locations in the surrounding area. The survey was sent within the hospital system, meaning any healthcare professionals from any of the locations could have participated in the study. The palliative program is not present at all three locations. This could influence the outcomes from healthcare professionals.

Implications of Findings

Implications for Practice

This study explored ACP factors of healthcare professionals engaging and participating in ACP with patients. The findings show that allied healthcare professionals have acceptance for other professionals participating in ACP (both physicians and allied healthcare professionals). And since the findings of this study reported confidence being affected by barriers to healthcare professionals' roles, defining responsibilities and roles of each profession might be explored (Howard et al., 2020). Exploring roles of professionals could be achieved by having organized and facilitated approaches to expand ACP conversations in health care (Dixon et al., 2018). Howard et al. did also conclude that clinical support from clinicians would be needed for some roles in interdisciplinary teams, such as social work (2020). Knowledge and role defining for allied healthcare professionals is needed to improve outcomes of ACP. Exploring education for professionals like social work and nursing for ACP could result in better patient outcomes (Wang et al., 2018). Education of ACP in allied healthcare professionals could expand the knowledge in professionals to improve confidence in such conversations. With increased clinician support, role clarity, and proper education on ACP, confidence could be improved for allied healthcare professionals' participation in ACP.

Implications for Research

The current study found great receptiveness from all healthcare professionals to participate in ACP with patients (Table 6), revealing a need to expand interprofessional communication (Kwak et al., 2022). Future studies testing specific interdisciplinary ACP

interventions and IPE need to be done to expand improvement in interprofessional ACP with patients and families. An emerging idea in these recent years in healthcare is the transdisciplinary team model. This model suggests interprofessional collaboration that extends to integrating methods outside one's field of practice. This approach works to meet the bio-psycho-social needs of a patient within a team setting (Daly & Matzel, 2013). Integrating this model could encourage interprofessional collaboration to achieve the best patient outcomes and aid in the confidence needed for allied healthcare professionals engaging in ACP.

Implications to Policy

The Patient Self-Determination Act (PSDA, 1990) and Texas Health and Safety Code 166 provide the basis to advance care planning in hospitals in Texas. Through these the PSDA, patients are required to receive information on decision making regarding their medical care decisions and opportunity to engage in ACP through advance directives paperwork (Bradley et al., 1999). Hospital policies follow Texas Health and Safety Code Chapter 166 when advance directives are not present (TADA, 2017), but these practices can vary from hospital to hospital. The PSDA requires healthcare professionals to educate patients on their rights related to the healthcare they are receiving (Teoli et al., 2022), and this requires healthcare professionals to be informed on this topic themselves. For the specific agency where this survey was conducted, education or training for ACP to healthcare professionals is not specified. For the PSDA to be followed, healthcare professionals must be properly informed to be able to educate patients on their rights regarding their medical care decisions. From the current study, confidence of healthcare professionals performing ACP is low, so creating a policy in the

agency to require education for healthcare professionals could appropriately implement the PSDA in hospital systems and improve confidence in ACP conversations with patients and families.

Conclusion

End-of-life care is a topic that is avoided by patients and families until it is too late to engage appropriately in a person's medical care. The ACP process attempts to understand a person's values and preferences to align those to their future medical care, especially regarding end-of-life decisions. Healthcare professionals, such as physicians, nurses, or social workers, carry the responsibility to engage patients into such conversations.

These findings suggest healthcare professionals' confidence can be improved through addressing barriers to their roles. Having opportunities to expand their knowledge on ACP is needed to promote better patient outcomes in end-of-life care. Regarding research, exploring interdisciplinary approaches to ACP, specifically through the lens of a transdisciplinary model, could be useful in practicing the best approaches for ACP with patients and families. Policy within agencies need to be re-evaluated to be able to reflect proper education to healthcare professionals on ACP law and regulations regarding patients' rights to medical decision making. Requiring education on laws and regulations related to ACP will appropriately implement the PSDA in hospital systems and can improve confidence in healthcare professionals performing ACP conversations.

This research study attempted to explore the perceptions and experiences of healthcare professionals in an acute care setting regarding ACP outcomes and barriers. Because of the small sample size of allied healthcare professionals and physicians, the

results show to be insignificant to generalize to all healthcare workers. But with the limitations mentioned previously, these findings can be used with caution. From the current study and analyzed literature, there is a need to improve the confidence and participation of all healthcare workers in ACP conversations.

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APPENDIX A

Institutional Review Board Approval Letter

Date: January 26, 2023

PI: Faith Parsons

Department: RES-Residential Student, 20531-Masters in Social Work

Re: Initial - IRB-2022-119

IRB application

The Abilene Christian University Institutional Review Board has rendered the decision below for *IRB application*.
The administrative check-in date is --.

Decision: Exempt

Category:

Research Notes:

Additional Approvals/Instructions:

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable. All approval letters and study documents are located within the Study Details in Cayuse IRB.

The following are all responsibilities of the Primary Investigator (PI). Violation of these responsibilities may result in suspension or termination of research by the Institutional Review Board. If the Primary Investigator is a student and fails to fulfil any of these responsibilities, the Faculty Advisor then becomes responsible for completing or upholding any and all of the following:

• When the research is completed, inform the Office of Research and Sponsored Programs. If your study is Exempt, Non-Research, or Non-Human Research, email orsp@acu.edu to indicate that the research has finished.
• According to ACU policy, research data must be stored on ACU campus (or electronically) for 3 years from inactivation of the study, in a manner that is secure but accessible should the IRB request access.
• It is the Investigator's responsibility to maintain a general environment of safety for all research participants and all members of the research team. All risks to physical, mental, and emotional well-being as well as any risks to confidentiality should be minimized.

For additional information on the policies and procedures above, please visit the IRB website
http://www.acu.edu/community/offices/academic/orsp...
or email orsp@acu.edu with your questions.

APPENDIX B

Questionnaire Permission from Authors (Howard et al., 2020)

myACU powered by Google

Faith Parsons <fmp17b@acu.edu>

ACP Questionnaire Permission

Howard, Michelle <mhoward@mcmaster.ca> Thu, Nov 24, 2022 at 8:19 AM
To: Faith Parsons <fmp17b@acu.edu>

Hi Faith,

Thanks for reaching out. Yes please feel free to use the questionnaire. Attached are the versions for physicians and other clinicians in primary care.

Best of luck with your project, please do let me know how it goes and if you have any feedback on the questionnaires from your respondents.

Regards,

Michelle Howard MSc, PhD

Associate Professor, Department of Family Medicine

Pronouns: She/Her

McMaster University

David Braley Health Sciences Centre

100 Main Street West, 5th floor

Hamilton, ON L8P 1H6

Phone: (905) 525-9140 x 28502 mhoward@mcmaster.ca @mhoward101 MacExperts

McMaster University recognizes and acknowledges that it is located on the traditional territories of the Mississauga and Haudenosaunee nations, and within the lands protected by the "Dish with One Spoon" wampum agreement. To learn more about the land we are on, visit www.native-land.ca

[Quoted text hidden]

2 attachments

DECIDE Allied Health Questionnaire Primary Care 28Jul2014.doc
270K

DECIDE Physician Questionnaire Primary Care 28Jul2014.doc
257K

APPENDIX C

Agency Approval Letter

HENDRICK HEALTH

Acknowledgement of Hendrick Health IRB Agreement to Cede IRB Review and Abilene Christian University IRB to Provide Oversight

This form documents that:

1) Abilene Christian University will serve as the Reviewing IRB for Hendrick Health for the study noted below;

   and

2) Hendrick Health has agreed to cede IRB review to Abilene Christian University for the study noted below.

Study Title:	*Advanced Care Planning Survey to Healthcare Professionals*
Principal Investigator:	Faith Parsons

IRB review will be ceded under the Hendrick Institutional Review Board Authorization Agreement.

Questions about the IRB review process under this agreement or study status should be directed to Abilene Christian University Institutional Review Board.

Sincerely,

Danielle Goss

Danielle Goss, MHA, MPH, CHRC, HEC-C
IRB Co-Chair
325-670-2918
dgoss@hendrickhealth.org

APPENDIX D

Survey Invitation Letter

Dear Prospective Participant,

My name is Faith Parsons and I am a student from the ACU Master's School of Social Work. As a thesis project, I am conducting a survey study (IRB number: 119) regarding advance care planning (ACP) and healthcare professionals' engagement to explore their willingness, confidence, and participation in having ACP conversations, and assess the barriers related to each profession.

To participate, you must be a healthcare professional working in direct patient care. The surveys are divided in two ways: Physicians and allied healthcare professionals. If you have any questions what category you might fall into, please reach out to me.

The survey will take approximately 10-15 minutes. The survey is voluntary and confidential. Please answer the questions to your comfort level. The results will be reported for the group of respondents as a whole.

Please click the appropriate survey link to give electronic consent and to participate in the survey:

- Physicians: https://abilenechristian.qualtrics.com/jfe/form/SV_79QaqO2Y7mamxrU
- Allied Healthcare Professionals: https://abilenechristian.qualtrics.com/jfe/form/SV_bpv6XihseUZShGC

If you have any questions or concerns, please feel free to contact me at fmparsons@hendrickhealth.org or at 325-670-7692. Thank you for your consideration, and I look forward to your participation.

Sincerely,

Faith Parsons, LBSW