American Journal of Hospice
& Palliative Medicine®
2022, Vol. 39(6) 737–744
© The Author(s) 2021
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/10499091211038503
journals.sagepub.com/home/ajh
SAGE

A National Survey of Social Workers Focusing on Attitudes, Knowledge, and Practice Behaviors for Educating Patients About Advance Directives: Implication During COVID19

Frances R. Nedjat-Haiem, PhD, LCSW[1], Tamara J. Cadet, PhD, LICSW, MPH[2], Humberto Parada Jr, MPH, PhD[3], Shiraz I. Mishra, MBBS, PhD[4], and Karen Bullock, PhD, LCSW[5]

Abstract

Social workers have a critical role on medical teams for facilitating effective conversations about advance care planning (ACP) in palliative and end-of-life care. Engaging patients in such conversations may be influenced by clinicians' attitudes. During the COVID19 pandemic, the need to examine barriers to serious illness care across healthcare settings and areas of specialty practice became abundantly clear. This study examines: (1) social workers' attitudes about ACP and (2) factors that influence the completion of advance directives (ADs). Using a cross-sectional study design, we surveyed 142 social workers on their knowledge, attitudes, and behaviors related to ADs. Using exploratory factor analyses, we identified 2 provider practice attitudes factors, 3 perceived barriers factors, and 2 perceived importance of AD factors. We then used logistic regression to estimate odds ratios (ORs) and 95% confidence intervals (CIs) for each of the factors in association with the frequency social workers reported educating patients about ADs. While various positive and negative attitudes and barriers toward educating patients are important factors to consider, social workers' perceptions of the importance of engaging patients in ACP education was the most important factor that influenced their behaviors. The odds of always/often (vs. sometimes/rarely/never) educating patients about ADs in their practice were greater for those social workers who reported they see the importance of AD decision-making (OR = 3.21, 95%CI = 1.83-5.62) and confirming goals-of-care (OR = 1.76, 95%CI = 1.03-3.01). Social worker's ACP knowledge and skills for educating patients are important in initiating conversations prior to a health crisis, especially important for developing a comprehensive care plan.

Keywords
advance care planning, advance directives, social workers

Background

The lack of understanding about the factors that influence advance care planning (ACP) and the completion of advance directives (ADs) were brought to the forefront for many social workers during the COVID19 pandemic, even for those who were not trained in palliative care. Being thrust into critical care settings where all patients were experiencing serious illness, initiated or complicated by the incurable coronavirus, has compelled social workers to reimagine and rethink the integration of ACP in primary care settings.[1]

ACP is a process that guides individuals and their families toward discussions to document an AD indicating their preferences for healthcare decision-making for end-of-life care. In healthcare decision-making, individuals have a right to engage in communication that helps them understand their decisions, to make informed choices about their healthcare; and they have the right to refuse life-sustaining medical treatments, which can be indicated on an AD document.[2] Provider efforts to educate patients and promote the completion of an AD assumes that a patient will be responsible to document it and bring it back to

---

[1] School of Social Work, San Diego State University, San Diego, CA, USA
[2] School of Social Work, Simmons University, Boston, MA, USA
[3] School of Public Health, San Diego State University, San Diego, CA, USA
[4] University of New Mexico Health Sciences Center, Albuquerque, NM, USA
[5] School of Social Work, North Carolina State University, Raleigh, NC, USA

Corresponding Author:
Frances R. Nedjat-Haiem, PhD, LCSW, School of Social Work, San Diego State University, 5500 Campanile Drive, San Diego, CA 92182, USA.
Email: fnedjathaiem@sdsu.edu; nedjatha@gmail.com

the provider to be placed in their medical chart. Despite this recognition of patients' rights to self-determination, many people who become critically ill have not followed through to make such plans. They have not documented an AD, nor have they discussed their wishes for life-sustaining treatments with anyone.[3]

Social workers who work in the medical field play a critical role for helping individuals and their families with ACP, which includes documenting an AD. Social workers are often tasked with addressing the health and behavioral healthcare needs of seriously ill patients, providing education and counseling about the right to refuse life-sustaining medical treatments.[4] Since ACP does not readily occur in medical settings, Nedjat-Haiem and colleagues (2018) developed and tested an ACP intervention model led by social workers and guided by motivational interviewing counseling to support documenting an AD and encourage talking with a provider and family member about EOL wishes.[5] Additionally, Morrison and colleagues (2005) developed and tested a multi-component ACP intervention designed for nursing home social workers,[6] which highlights social work roles for ACP education to help patients identify and document their treatment preferences for end-of-life care. These social work interventions demonstrate effective outcomes which can improve patients' documentation of life-sustaining treatments and increase the likelihood of concordant medical decision-making with patients' wishes. In spite of the evidence, some research suggests that social workers may have difficulty fulfilling this role because they lack skills, ability or knowledge for engaging in such practice.[7] However, as master's level training providers, medical social workers (aka healthcare social workers) are uniquely qualified for educating patients and families about ACP.

Although social workers have a responsibility to engage patients in ACP conversations to address end-of-life care before a crisis arises, their attitudes about ACP can influence this from happening. While positive attitudes about ACP can influence this process, social workers may not feel qualified or have experience with educating patients. This can make them feel uncomfortable toward initiating ACP conversations to prepare them for EOL care.[8,9] Some research suggests that experiencing death anxiety among social workers can negatively impact their ability to facilitate ACP conversations with patients.[10] Conversely, empathetic or positive attitudes toward ACP may facilitate open communication.[11]

Additionally, healthcare providers face challenges in delivering ACP information that hinders ACP education.[12] Some providers think that engaging patients in ACP conversations is too difficult; and it takes up too much of their time.[13] Knowledge gaps about ACP also influences providers to feel uncertain about the process; and organizational barriers, such as lack of a policy or procedures, can impede the delivery of information to support the documentation of patients' wishes for life-sustaining treatments. Thus, the primary aims of this study is to examine social workers' attitudes about educating patients about documenting an AD.

Methods

We used a cross-sectional design to recruit social workers (n = 142) through social media to broadly reach individuals working in the medical field for this study. A survey link was sent out through social media targeting listservs frequented by social workers who were asked to participate and also promote the survey through Facebook, Twitter, and Linkedin. Additionally, various organizations emailed a survey link to their members. Social workers were asked to complete a one-time online survey. They were not provided incentives for participation. This study was approved by the Institutional Review Board.

Survey Instrument

We developed a questionnaire by reviewing the literature on ADs and by involving 3 healthcare providers (a nurse, physician, and social worker) to evaluate the accuracy of the questions.[14] Some items were adapted from a survey that providers completed on their attitudes using ACP in palliative care units.[11] In addition, the survey was pilot tested with 2 providers who reviewed the questions for readability and clarity. The questions assessed social workers' (n = 142) knowledge and attitudes about educating seriously ill patients about ADs. At the beginning of the survey, social workers were given a brief definition on ADs as legal documents used in patient care to document patients' wishes for medical treatment and to appoint a durable power of attorney for healthcare decision-making. Completing the survey took approximately 20 to 25 minutes.

Key Variables

The following variables were assessed in the study: Perceived knowledge, attitudes about ADs, importance of ADs, and barriers to educating patients on ADs. Perceived knowledge about ADs was assessed by asking social workers, "How knowledgeable are you with educating patients about ADs?" This item was measured using a 2-point scale with either "very knowledgeable" or "somewhat knowledgeable." Ten items were used to assess social workers' attitudes about AD's asking, "How much do you agree with the following questions," which were related to the purpose of using ADs in patient care.

Attitudes were measured using a 4-point scale indicating whether social workers "strongly agree" to "strongly disagree" with the questions. Social workers were asked how strongly do you agree with the following: Educating patients about ADs helps to improve patient-provider communication; Educating patients about ADs reduces their emotional distress; Completing an AD is an effective way for patients to influence their medical treatment options; Educating patients about ADs reduces family discord about medical treatment options; I have difficulty asking terminally ill patients about their treatment preferences for an AD; I am concerned that talking with patients about ADs will upset or overwhelm them; Patients' cultural values and beliefs make it difficult to educate them about ADs; and Patients will worry less about unwanted treatment after documenting an AD. We also asked social workers if they experienced benefits to educating patients about ADs, measured yes/no.

Social workers were also asked about the importance of educating patients on ADs which was measured using 10 items scored on a 4-point scale from 1 "not at all important" to 4 "extremely important." Behaviors for engaging in patient education for ADs was measured by 2 questions: (1) Do you personally educate patients about ADs in your practice? (yes/no) and (2) In your practice, how frequently do you educate patients about ADs (Always/Often or Sometimes/Rarely/Never).

Barriers influence educating patients about ADs were measured using 15 items scored on a 5-point Likert scale from 1 "not at all a barrier" to 5 "extremely a barrier" with higher scores indicating greater barrier to educating patients. Questions about barriers included such items as: Providers have uncertainty about how to educate patients about ADs; Lack of competency/skills to educate patients about ADs; Provider feel uncomfortable discussing ADs; Patients are resistant to being educated about ADs; Patients become emotionally upset when being educated about ADs; It is the responsibility of providers; Providers are not in control of when patients complete ADs; ADs are not useful in patient care; Patients change their minds on medical treatment options; and Patients cultural values and beliefs influence educating patients on ADs.

Demographics (gender, age, race) were measured by single items in the questionnaire. Information about work environment was collected indicating degree, primary work setting, and years of practice.

Statistical Analysis

Univariate analyses were used for describing participant characteristics, demographics, level of knowledge, attitudes, and practice behaviors related to AD education with patients. In preparation for conducting a logistic regression analysis to examine predictors on frequency of educating patients practice, we conducted 3 exploratory factor analyses[15] (FA): (a) on the 10 items related to attitudes for educating patients about ADs; (b) on the 15 items related to the barriers; and (c) on the 10 items which indicated the importance of educating patients on ADs. Factors were identified by examining factor loading coefficients. Factor loadings ≥ 0.5 on only one factor and <0.5 on the other factors were used to generate factor scores to create subscales for subsequent analyses, these were the regression scores that were saved from the exploratory factor analysis. For each subscale, we computed Cronbach's alphas to assess internal reliability of the items in each factor. We used logistic regression to estimate odds ratios (ORs) and 95% confidence intervals (CIs) for each of the identified factors in association with the frequency with which social workers reported educating patients about ADs in their practice (yes/no). We considered a number of potential confounding variables, but selected the most parsimonious model given the small sample size.[16] Analyses were conducted using IBM SPSS Statistics Version 25.0 (IBM Corp., Armonk, NY).[17]

Table 1. Demographic Characteristics of the Sample (N = 142).

Variable	Category	Frequency	%
Gender	Male	14	9.9
	Female	120	84.5
	Missing	8	
Age	20 to 39	35	24.6
	40 to 59	61	43.0
	60 to 89	37	26.1
	Missing	9	
Race	Non-Hispanic white	123	86.6
	Asian or Pacific Islander	2	1.4
	Hispanic/Latino	7	4.9
	Black or African American	2	1.4
	More than one race/ethnicity	1	.7
	Missing	7	
Degree	Bachelors	3	2.1
	Masters	134	94.4
	PhD	5	3.5
Primary Work Setting	Hospital—Inpatient	82	57.7
	Ambulatory Care—Outpatient	48	33.8
	Hospice	6	4.2
	Skilled nursing	2	1.4
	Long-term care	2	1.4
	Home health care	2	1.4
Years worked	1 to 10	43	30.3
	11 to 20	38	26.8
	21 to 30	36	25.4
	>31	25	17.6

Results

The social workers who participated in this study ($n = 142$) reported working in various in-patient hospital and out-patient medical settings. A response rate was not obtained due to multiple recruitment methods including snowball sampling. As shown in Table 1, most participants were female (84.5%), non-Hispanic White (86.6%) and had a broad range of experience working as healthcare provider, mostly in hospital, in-patient settings (57.7%).

Knowledge, Attitudes, and Behavior Toward Advance Directive Education

Table 2 describes knowledge, attitudes, and behaviors toward educating patients about ADs. For knowledge, most social workers (85.9%) indicated they were very knowledgeable about educating patients about ADs. For attitudes, most (94.4%) said that they experienced benefits toward educating patients about ADs. A series of questions about the importance of educating patients indicated that social workers viewed ADs as very or extremely important to ask patients about their durable power of attorney for healthcare decision-making (95.8%) and to ask about decisions to use life-sustaining treatments (85.2%). Regarding behaviors, the majority of social workers

Table 2. Descriptive Analysis on Knowledge, Attitude, and Behavior.

Characteristics	Statement	Categories	N	%	Mean (SD)
Knowledge	1. How knowledgeable are you with educating patients about advance directives?	Very knowledgeable	122	85.9	1.14 (.349)
		Somewhat knowledgeable	20	14.1	
Attitude	1. Have you experienced benefits to educating patients about advance directives?	Yes	134	94.4	n/a
		No	7	4.9	
	2. How important is it for you to educate patients about advance directives?	Not very important	1	.7	4.59 (.621)
		Moderately important	7	4.9	
		Very much important	41	28.9	
		Extremely important	93	65.5	
	3. How important is it for you to ask the patient to designate a durable power of attorney for healthcare decision making?	Not very important	3	2.1	3.61 (.640)
		Moderately important	3	2.1	
		Very much important	40	28.2	
		Extremely important	96	67.6	
	4. How important is it for you to ask the patient about their decisions to use life-sustaining treatments?	Not very important	4	2.8	3.35 (.80)
		Moderately important	17	12.0	
		Very much important	47	33.1	
		Extremely important	74	52.1	
Behaviors	1. Do you personally educate patients about advance directives in your practice?	Yes	136	95.8	1.04 (.202)
		No	6	4.2	
	2. In your practice, how frequently do you educate patients about advance directives	Always/Often	119	83.8	1.16 (.370)
		Sometimes/Rarely/Never	23	16.2	

Table 3. Factor Analysis on Provider Practice Attitudes.

	Item statement	Item#	Factor loadings[a]		Mean (SD)	α
			1	2		
Positive attitudes, benefits	Educating patients about advance directives helps to improve patient-provider communication.	2	.902		4.40 (.760)	.712
	Completing an advance directive is an effective way for patients to influence their medical treatment options.	1	.832		4.33 (.849)	
	Educating patients about advance directives reduces family discord about medical treatment options.	3	.682		4.18 (.856)	
Negative attitudes, concerns	I have difficulty asking terminally ill patients about their treatment preferences for an advance directive	8		.755	1.47 (.906)	.478
	I am concerned that talking with patients about advance directives will upset or overwhelm them	4		.701	1.75 (.829)	
	Patients' cultural values and beliefs make it difficult to educate them about advance directives	10		.635	2.22 (.861)	
	Eigenvalues		1.99	1.475		
	Percent variance		33.318	24.581		
	Number of items		3	3		

[a] Extraction method: Principal Axis Factoring; Rotation method: Varimax; Factor scores were saved with regression method.

indicated that they educate patients on ADs (95.8%) and many (83.4%) said they always/often educate patients.

Attitude Scale

An exploratory FA on 10 items related to social workers' attitudes generated 2 factors with 3 items. Those items that did not fall on either factors were dropped. The 6 items remaining related to social workers' attitudes and represented positive benefits and negative concerns about educating patients on ADs. These factors were retained using a cutoff eigenvalue score greater than 1.0 and accounted for 57.9% of the common variance. Notably, there is often a low to moderate shared variance found in social science research.[18] The Kaiser-Meyer-Olkin (KMO) was .578 adequate for FA and Bartlett's test of sphericity was 144.65 (df 15, $p = .001$) indicating the suitability to support a FA. Table 3 shows a theoretically relevant scale of attitudes on educating patients. The first scale was defined as positive benefits (Cronbach's alpha = [.712]); and a second scale showed negative concerns (Cronbach's alpha = [.478]). Mean scores for the most prevalent positive benefit items

Table 4. Factor Analysis of Barriers.

	Item statement	Item#	Factor loadings 1	2	3	Mean (SD)	α
Provider barriers	Providers have uncertainty about how to educate patients about advance directives.	2	.880			3.32 (.994)	.859
	Providers feel uncomfortable discussing advance directives with patients.	4	.868			3.44 (1.180)	
	Lack of competency/skills to educate patients about advance directives.	3	.857			3.04 (1.135)	
Patient barriers	Patients become emotionally upset when being educated about advance directives	6		.880		2.62 (1.024)	.791
	Patients are resistant to being educated about advance directives	5		.863		2.96 (1.028)	
	Patients' cultural values and beliefs influence educating them about advance directives	15		.660		2.65 (1.109)	
Organizational system	Advance directives are not useful for patient care.	13			.818	1.65 (1.096)	.669
	Providers are not in control of when patients complete an advance directive.	10			.689	2.63 (1.217)	
	Patients change their mind on medical treatment options.	14			.694	2.14 (.937)	
	Eigenvalues		3.617	1.822	1.073		
	Percent variance		40.184	20.242	11.924		
	Number of items		3	3	3		

suggested "Educating patients about ADs helps to improve patient-provider communication" (mean [SD] = 4.40[.760]), "Completing an AD is an effective way for patients to influence their medical treatment options" (mean [SD] = 4.33(.849), and "Educating patients about ADs reduces family discord about medical treatment options" (mean [SD] = 4.18[.856]). In terms of attitudes reflecting negative concerns on educating patients about ADs, mean scores for the most prevalent attitudes suggest that "I have difficulty asking terminally ill patients about their treatment preferences for an AD" (mean [SD] = 1.47[.906]), "I am concerned that talking with patients about ADs will upset or overwhelm them" (mean [SD] = 1.75[.829]), and "Patients' cultural values and beliefs make it difficult to educate them about ADs" (mean [SD] = 2.22[.861]).

Barrier Scale

An exploratory FA was conducted on 14 items associated with barriers toward educating patients about ADs which generated 3 factors indicating perceived barriers each with 3 items. These 3 factors were retained using a cutoff value greater than 1.0, accounting for 72.35% of the common variance. The Kaiser-Meyer-Olkin (KMO) .754 was adequate for conducting a FA with this data. The Bartlett's test of sphericity was 518.780 (df 36, p = .001) indicating the suitability to support a FA. Three theoretically relevant scales represent barriers that social workers indicated were problems toward educating patients about ADs. The first relevant scale (Table 4) represented provider barriers (Cronbach's alpha = .859). Another scale indicated patient barriers (Cronbach's alpha = .791), while a third was shown and identified organizational barriers (Cronbach's alpha = .669). See mean scores for each item in the 3 scales. The most prevalent indicator of provider barriers was that "Providers have uncertainty about how to educate patients about ADs" (mean [SD] = 3.32[.994]). In terms of patient barriers hindering AD education, mean scores suggested "Patients become emotionally upset when being educated about ADs" (mean [SD] = 2.62[1.024]). Finally, the most prevalent organizational barrier toward education showed by mean scores suggested "ADs are not useful for patient care" (mean [SD] = 1.65[1.096]).

Importance of Advance Directives

An exploratory FA was conducted on 10 items associated with perceived importance of educating patients about ADs which generated 2 factors. These factors were retained using a cutoff value greater than 1.0, accounting for 72.62% of the common variance. The Kaiser-Meyer-Olkin (KMO) .891 was adequate for conducting a FA with this data. The Bartlett's test of sphericity was 839.86 (df 36, p = .001) indicating the suitability to support a FA. The 2 theoretically relevant scales represent the importance of AD documentation in decision-making as well as the importance of ADs to confirm the goals of care. The first relevant scale (Table 5) consisted of 5 items (Cronbach's alpha = .897). The most prevalent indicator of AD documentation in decision-making was "Ask the patient whether they have completed an AD" (mean [SD] = 4.57[.614]). In terms of the other relevant scale which consisted of 3 items (Cronbach's

Table 5. Factor Analysis of Perceived Importance of Advance Directives.

	Item statement	Item#	Factor loadings[a] 1	Factor loadings[a] 2	Mean (SD)	α
Advance directive documentation in decision making	Importance—ask the patient whether they have completed an advance directive?	5	.896		4.57 (.614)	.897
	Importance—obtain a copy of the patient's advance directive to insert into the medical chart?	6	.785		4.52 (.793)	
	Importance—recommend that patients complete an advance directive if they do not have one?	7	.731		4.53 (.641)	
	Importance—ask the patient if they would like to make changes to their existing advance directive?	8	.728		4.19 (.848)	
	Importance—educate patients about advance directives?	1	.704		4.58 (.624)	
	Importance—ask the patient to designate a durable power of attorney for healthcare decision making?	9	.678		4.60 (.644)	
Advance directive in confirming goals of care	Importance—confirm to goals of care with the patient?	2		.892	4.58 (.624)	.885
	Importance—confirm the goals of care with the family?	3		.867	4.45 (.844)	
	Importance—ask the patient about their decisions to use life-sustaining treatments (Resuscitation and intubation)	10		.771	4.33 (.829)	
	Eigenvalues		5.52	1.02		
	Percent variance		61.38	11.24		
	Number of items		6	3		

[a] Extraction method: Principal Axis Factoring; Rotation method: Varimax; Factor scores were saved with regression method.

Table 6. Multivariable Logistic Regression Odds Ratios (ORs) and 95% Confidence Intervals (CIs) on Educating Patients About Advance Directives (ADs).

		Educating patients about ADs	
Constructs/variables		OR (95% CI)	*P*
Number of years worked		0.96 (0.91-1.01)	0.12
Positive attitudes/benefits		1.51 (0.85-2.67)	0.15
Negative attitudes/concerns		0.79 (0.44-1.42)	0.43
Provider barriers		0.87 (0.49-1.56)	0.64
Patient barriers		0.85 (0.56-1.56)	0.60
Organizational system barriers		0.83 (0.45-1.53)	0.83
Importance of advance directive documentation in decision making		3.21 (1.83-5.62)	<0.01
Importance of advance directive in confirming goals of care		1.76 (1.03-3.01)	0.04
Model	Constant	18.33	
Summary	*N* included in Analysis	142	
Hosmer and Lemeshow test	X2, df	6.163, 8	0.63
	Pseudo R^2	.362	
	−2 log likelihood	87.237	

alpha = .885), the most prevalent indicator of AD in confirming the goals of care was "Confirm the goals of care with the patient" (mean [SD] = 4.58[.624]).

Logistic Regression Analysis

We used logistic regression to examine factors associated with the frequency for which social workers reported educating patients about ADs, while controlling for demographic factors (Table 6). The most parsimonious logistic regression model included number of years worked, Positive Attitudes/Benefits, Negative Attitudes/Concerns, Provider Barriers, Patient Barriers, Organizational System Barriers, Importance of Advance Directive Documentation in Decision-Making, and Importance of Advance Directive in Confirming Goals of Care. Odds of always/often (vs. sometimes/rarely/never) educating patients about ADs were 221% (OR = 3.21, 95% CI = 1.83-5.62) and 76% (OR = 1.76, 95% CI = 1.03-3.01) higher for each one-point increase in importance toward AD documentation in decision-making and in confirming the goals of care with patients, respectively. It is important to note that social workers reporting negative attitudes, and barriers of any kind were associated with lower odds of educating patients about ADs, though not statistically significant.

Discussion

As healthcare providers, medical or clinical social workers have received education and are trained to engage patients in ACP discussions about ADs. However, barriers exist toward engaging patients in such conversations, which limit patients understanding of the meaning of documenting an AD. This study examined social workers' attitudes and knowledge about ACP and ADs as factors that may influence their educating patients in ACP discussions. While various positive and negative attitudes and barriers toward educating patients are important factors to consider, social workers' perceptions of the importance of engaging patients in ACP education was the most important factor that influenced their behaviors to educate patients about ADs. The odds for (always/often vs sometimes/rarely/never) educating patients about ADs in their practice increased with increasing social workers' perceptions of the importance of AD decision-making and confirming goals-of-care. Interestingly, the trend that different types of barriers stemming from provider uncertainty or feelings of discomfort and fear that patients might get upset or resist engaging in ACP were associated with lower odds of educating patients about ADs; however, since underpowered in this data set it is not clear whether this would have been statistically significant to impact the frequency of educating patients. More research is needed in this area.

Similar to another study,[19] social workers in this study indicated they were knowledgeable about ACP and experienced benefits to educating patients. However, missed opportunities for engaging in ACP conversations continue to persist.[20] These gaps are in part due to the lack of skills for beginning or initiating complex conversations involving multiple methods for talking about the possibility of dying while documenting an individual medical plan of care for future death. The complexity of ACP conversations also involve an understanding of how and when to engage patients and their families, which is more difficult when patients are in pain or may not feel well, experiencing mental distress.[21] Notably, social workers were overwhelmingly positive toward educating patients about ADs, while also embracing barriers like having concerns when educating patients. It is important to note that the 3 questions scaled for negative barriers had low internal consistency indicating that it may not be a reliable measure for experiencing negative barriers. However, research suggests these types of barriers are important factors for understanding provider engagement in ACP EOL care conversations.[19,22] Perhaps social work providers who participated in the study held a particular interest in this topic or had extensive experience educating patients about ADs, particularly because they self-selected to participate in this study. While there was a range of experience indicated across the sample of social work participants, number of years worked was not a significant predictor of frequently (always/often) educating patients about ADs. Also, of interest was the fact that this was a highly educated sample suggesting that they should have received education in this area in school. However, there may be a disconnect about learning about having discussions about ADS and actually doing them. Increasingly social worker trainees are participating in simulated experiences alone or with other professional disciplines to help decrease the disconnect between learning and experiencing.[23] There may be an opportunity to create simulated experiences for social work trainees in engaging and talking with patients about AD particularly because there is a process for engaging patients in this area.

Knowledge about this topic is often learned through provider training involving a process for engaging patients in asking certain types of questions for EOL care planning. First, providers need to ask their patient whether or not they have completed an AD. This question should indicate a baseline understanding from the patient's view about ADs. If they say they have completed one, then it would be important to obtain a copy of the AD document for their medical chart. However, medical charts may have inconsistent information about a patient's AD because after completing an AD the patients must return to their provider and give them a copy to be placed in their medical chart, which may not always happen. Therefore, it is important for providers to ask about obtaining a copy for the medical chart. Social workers are often advocating for patients' rights which involves getting updated information to support quality patient care. Additionally, providers need to ascertain whether a patient might want to change their mind about their AD. Thus, social workers are involved in asking patients about the possibility of making changes to their existing AD to gather a clear understanding about a patient's EOL care wishes which can change over time.[24] Another part of the ACP process involves helping patients with designating a durable power of attorney for healthcare decision-making and confirming the goals of care with patients and families. The goals of care include developing an understanding of patients' decisions about the use of life-sustaining treatment in the event they are needed in EOL care. More provider education is needed, especially among clinical social workers, to support engaging in AD education with patients.

Limitations

There are several limitations to this study worth noting. First is the sampling method. A snowball approach was utilized to recruit participants. These participants self-selected to participate in the survey which potentially suggest bias. This is one possible reason that 84% that they had educated patients in their practice. Therefore, these findings may not be generalizable to all social workers. Second, because of the cross-sectional design, there was not a comparison group to better understand the responses and results. Finally, the sample largely represented social workers who worked in-patient hospitals. There are social workers in other settings with adults who may need ADs that may have differing perspectives on educating patients about ADs.

Conclusions

Despite the limitations, this study contributes to a growing literature addressing the role of social workers on hospice and palliative care teams. As the U.S. populations continue to grow older and manage multiple chronic illnesses, the need for patients to be engaged and educated on the purpose and benefits of AD is critical. Having these discussions among an interdisciplinary team of clinicians with patients and family members may decrease the likelihood that difficult conversations will emerge for other members of the healthcare team and create opportunities for social workers to take the lead in these discussions, which can lead to improved patient outcomes and provider satisfaction.

Author's Note

Tamara J. Cadet is now affiliated with School of Social Policy & Practice at the University of Pennsylvania, PA, USA.

Declaration of Conflicting Interests

The authors declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: HP was supported by the National Cancer Institute (K01 CA234317), the SDSU/UCSD Cancer Center Comprehensive Partnership (U54 CA132384 & U54 CA132379), and the Alzheimer's Disease Resource Center for Advancing Minority Aging Research at the University of California San Diego (P30 AG059299).

ORCID iD

Frances R. Nedjat-Haiem https://orcid.org/0000-0001-5501-3157

References

1. Sevier CH, Fischer J, Bullock K. Leaning in to serious illness care through stories and science. *N C Med J*. 2020;81(4):237-241.
2. National Institute of Aging. Advance care planning: healthcare directives. Published 2018. Accessed July 29, 2020. https://www.nia.nih.gov/health/advance-care-planning-healthcare-directives
3. Yadav KN, Gabler NB, Cooney E, et al. Approximately one in three US adults completes any type of advance directive for end-of-life care. *J Health Aff*. 2017;36(7):1244-1251.
4. Otis-Green S, Thomas J, Duncan L, et al. Advance care planning: opportunities for clinical social work leadership. *J Clin Soc Work J*. 2019;47(3):1-12.
5. Nedjat-Haiem F. R., Cadet T. J., Amatya A., Thompson B., & Mishra S. I. (2019). Efficacy of motivational interviewing to enhance advance directive completion in Latinos with chronic illness: a randomized controlled trial. *Am J Hosp Palliat Med®*. 36(11), 980-992.
6. Morrison RS, Chichin E, Carter J, Burack O, Lantz M, Meier DE. The effect of a social work intervention to enhance advance care planning documentation in the nursing home. *J Am Geriatr Soc*. 2005;53(2):290-294.
7. Munn JC, Adorno G. By invitation only: social work involvement at the end of life in long-term care. *J Soc Work End-of-Life Palliat Care*. 2008;4(4):333-357.
8. Wang CW, Chan CL, Chow AY. Social workers' involvement in advance care planning: a systematic narrative review. *J BMC Palliat Care*. 2018;17(1):5.
9. Nedjat-Haiem FR, Carrion IV, Gonzalez K, Ell K, Thompson B, Mishra SI. Exploring health care providers' views about initiating end-of-life care communication. *Am J Hosp Palliat Med*. 2017; 34(4):308-317.
10. Peck MR. Personal death anxiety and communication about advance directives among oncology social workers. *J Soc Work End-of-Life Palliat Care*. 2009;5(1-2):49-60.
11. Munuera Gómez P. Advanced care planning: a bibliographic review from the perspective of social work in health care. *J Ann Bioethics Clin Appl*. 2020;3(2):1-9.
12. Bergman-Evans B, Kuhnel L, McNitt D, Myers S. Uncovering beliefs and barriers: staff attitudes related to advance directives. *Am J Hosp Palliat Med*. 2008;25(5):347-353.
13. Boddy J, Chenoweth L, McLennan V, Daly M. It's just too hard! Australian health care practitioner perspectives on barriers to advance care planning. *Aust J Prim Health*. 2013;19(1):38-45.
14. Nedjat-Haiem FR, Cadet TJ, Amatya A, Mishra SI. Healthcare providers' attitudes, knowledge, and practice behaviors for educating patients about advance directives: a national survey. *Am J Hosp Palliat Med®*. 2019;36(5):387-395.
15. DiStefano C, Zhu M, Mindrila D.Understanding and using factor scores: considerations for the applied researcher. *J Pract Assess Res Eval*. 2009;14(20):1-11.
16. Bursac Z, Gauss CH, Williams DK, Hosmer DW. Purposeful selection of variables in logistic regression. *J Source Code Biol Med*. 2008;3(1):17.
17. Wagner WE III. *Using IBM® SPSS® Statistics for Research Methods and Social Science Statistics*. Sage Publications; 2019.
18. Wagner WE III. *Using IBM® SPSS® Statistics for Research Methods and Social Science Statistics*. Sage Publications; 2016.
19. Wang CW, Chan CL, Chow AY. Social workers' involvement in advance care planning: a systematic narrative review. *BMC Palliat Care*. 2018;17(1):5.
20. Shah K, Swinton M, You JJ. Barriers and facilitators for goals of care discussions between residents and hospitalised patients. *J Postgrad Med J*. 2017;93(1097):127-132.
21. Hussain FA. Using a frame of reference for talking to patients about death and dying. *J Br J Nurs*. 2019;28(16):1069-1075.
22. Heyman JC, Gutheil IA. Social work involvement in end of life planning. *J Gerontol Soc Work*. 2006;47(3-4):47-61.
23. Putney JM, Levine AA, Collin CR, O'Brien KH, Mountain-Ray S, Cadet T. Teaching note—implementation of online client simulation to train and assess screening and brief intervention skills. *J Soc Work Educ*. 2019;55(1):194-201.
24. Sudore RL, Stewart AL, Knight SJ, et al. Development and validation of a questionnaire to detect behavior change in multiple advance care planning behaviors. *PLoS One*. 2013;8(9):e72465.