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Advance Care Planning: Understanding Clinical Routines and Experiences of Interprofessional Team Members in Diverse Health Care Settings

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Abstract

Background—Interprofessional health care team members consider advance care planning (ACP) to be important, yet gaps remain in systematic clinical routines to support ACP. A clearer understanding of the interprofessional team members' perspectives on ACP clinical routines in diverse settings is needed.

Methods—One hundred eighteen health care team members from community-based clinics, long-term care facilities, academic clinics, federally qualified health centers, and hospitals participated in a 35-question, cross-sectional online survey to assess clinical routines, workflow processes, and policies relating to ACP.

Results—Respondents were 53% physicians, 18% advanced practice nurses, 11% nurses, and 18% other interprofessional team members including administrators, chaplains, social workers, and others. Regarding clinical routines, respondents reported that several interprofessional team members play a role in facilitating ACP (ie, physician, social worker, nurse, others). Most (62%)

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settings did not have, or did not know of, policies related to ACP documentation. Only 14% of settings had a patient education program. Two-thirds of the respondents said that addressing ACP is a high priority and 85% felt that nonphysicians could have ACP conversations with appropriate training. The clinical resources needed to improve clinical routines included training for providers and staff, dedicated staff to facilitate ACP, and availability of patient/family educational materials.

Conclusion—Although interprofessional health care team members consider ACP a priority and several team members may be involved, clinical settings lack systematic clinical routines to support ACP. Patient educational materials, interprofessional team training, and policies to support ACP clinical workflows that do not rely solely on physicians could improve ACP across diverse clinical settings.

Keywords

advance care planning; primary care; long-term care; survey; health care team; interprofessional

Introduction

Systematic, team-based approaches to advance care planning (ACP) can result in the vast majority of adults receiving treatment consistent with their advance care plans.¹ The Institute of Medicine (IOM) Dying in America report called for incentives, quality standards, and system support to promote high-quality clinician–patient conversations related to ACP.² Advance care planning is a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. Advance care planning discussions may include choosing and preparing a surrogate decision maker, preparing for medical decision-making, documenting medical wishes in an advance directive, or translating values into medical treatment plans and orders.³ The IOM report recognized gaps in integrated clinical routines, system-based workflow processes, and policies and guidelines for ACP across practice settings.

Even though physicians may express comfort with having ACP discussions, studies have shown that these conversations still do not occur regularly.^{4,5} Common barriers to ACP discussions noted by physicians were lack of time, limited training, and lack of system-based support for ACP.⁶ A recent study of Canadian inpatient physicians and nurses identified potential targets for improving clinical workflows related to communication and decision-making about goals of care, including patient/family factors, communication between health care providers and patients, interprofessional collaboration, education, and resources.⁷ Taken together, these studies allude to widespread need for systematic clinical routines to facilitate ACP in clinical settings and that physicians may not be the most appropriate interprofessional team member to be responsible for all ACP-related activities given time constraints and workforce shortages.

No research studies focus on current ACP clinical routines from the perspectives of US interprofessional team members in different health care settings. The term interprofessional refers to providers from different disciplines who make up the greater care team, and interprofessional teams are common in the delivery of palliative care. Previous research surveys on ACP have focused on a single setting (eg, inpatient hospital or primary care),^{6,7} a

single group of health care providers (eg, only physicians or only palliative care providers),^{5,8} specific diseases such as cancer or heart failure,⁹ or were conducted outside the United States.^{7,10}

This study explores perspectives and experiences of interprofessional team members related to ACP clinical routines in different health care settings. We conducted a state-wide survey of interprofessional health care team members in Colorado, including rural settings, ambulatory care, and long-term care facilities. This study provides a state-based perspective and complements surveys of US physicians and hospice and palliative care social workers regarding ACP conversations.^{11,12} The purpose of the study is to better understand current clinical routines, system-based workflow processes, and policies relating to ACP to help inform opportunities to improve ACP in diverse clinical settings.

Methods

Study Design and Participants

We conducted a state-wide online survey of interprofessional health care team members to understand current system supports for ACP, including clinical routines, workflow processes, and policies relating to ACP in Colorado clinical settings. We aimed to include individuals from diverse health care settings across Colorado, especially primary care practitioners who work in rural, safety net, and long-term care settings. We developed a convenience sample based on the authors' outreach to administrative contacts of state-wide professional organizations and Colorado health care system networks. The professional organizations included Colorado Medical Directors' Association, Colorado Academy of Family Physicians, Colorado Society of Advanced Practices Nurses, and Colorado Chapter of the American College of Physicians. The health care system networks included Colorado Community Health Network (federally qualified health centers), Colorado Rural Health Center (rural clinics), ClinicNET (safety net clinics), and HealthONE system (community hospitals). Each organization or network agreed for health care team members within their organizations to be contacted. Recipients were invited to share the online survey link with other team members (ie, snowballing). To reduce burden on participating organizations/networks, we did not require a list of members and thus are unable to determine a survey response rate. The study was conducted between April and June 2015. The Colorado multiple institutional review board (IRB) approved this study (#15-0745).

Survey

The survey was created by 4 authors who collectively have expertise in primary care (internal medicine, family medicine, geriatric medicine), palliative care, and ACP with clinical experience in outpatient clinic, long-term care, and inpatient palliative care consultation. The team developed a 35-question survey that included multiple choice and open-ended questions (Appendix A). The survey provided a brief description of ACP as a process. Recognizing that some survey respondents may work in multiple health care settings, survey respondents were asked to respond based on their self-identified primary clinical practice setting.

The survey focused on the following domains: (1) role on the health care team (ie, physician, advanced practice nurse, nurse, administrator/manager, chaplain, social worker, pharmacist, physician assistant, or other), clinical specialty, clinical setting, and geographic location, (2) description of clinical routines, workflow processes, and policies related to ACP, and (3) health care team members' perspectives and experiences related to ACP in their clinical practice (ie, "How much do you agree or disagree that nonphysicians can have ACP discussions with patients/families with appropriate training?"). Survey respondents were asked about clinical routines (eg, ability to store ACP documents in the medical record), workflow processes (eg, ability to transfer ACP documents), and policies (eg, use of guidelines to trigger review of ACP documents). The survey was conducted in April to June 2015, prior to the Centers for Medicare and Medicaid Services (CMS) initiation of ACP reimbursement on January 1, 2016,¹³ and explored billing practices to identify if, and how, clinicians were seeking reimbursement for ACP.

Survey respondents could provide free text answers for 3 questions: (1) "What is currently working well in your practice to promote ACP with patients and their families?"; (2) "What would make patient or family engagement in ACP easier?"; and (3) "Does your clinical practice setting provide community outreach or education programs or services to improve patient or family engagement in ACP? If yes, please briefly describe the program." The survey was designed to be completed in approximately 15 minutes.

The survey was piloted by a group of university-based interprofessional clinicians and health services researchers, with subsequent revision of questions for clarity and missing content. The revised survey was reviewed by 3 experts with backgrounds in primary care, palliative care, and community health. The experts provided feedback to refine the final version of the survey. Potential respondents were sent a single invitation e-mail to participate in the study with a link to complete the survey online via Research Electronic Data Capture (REDCap).¹⁴ Participation was anonymous and, per approval from the IRB, informed consent was implied by voluntary participation in the survey.

Data Analysis

Quantitative survey responses are described using number of respondents and percentages of the total sample. The categorization of counties into urban, rural, and highly rural was determined using the 2013 National Center for Health Statistics' Urban–Rural Classification Scheme for Counties.¹⁵ We excluded 8 respondents who identified as administrator/manager to focus on direct patient care experiences. Proportions were compared using χ^2 test. Statistical analyses were conducted using SAS version 9.3 (SAS Institute Inc, Cary, North Carolina). For the open-ended questions, 2 authors (KA and HDL) systematically organized the data, using a mixed inductive and deductive approach, to identify consistent themes.¹⁶ The study team discussed the coded data and reached consensus on identified themes and meanings.¹⁷

Results

Interprofessional Team Members and Practice Characteristics

A total of 118 health care team members responded to the survey, including physicians (53%), advanced practice nurses (18%), nurses (11%), and other interprofessional team members including administrators, chaplains, social workers, and others (18%). Table 1 describes the survey respondents. As expected, several clinical specialties were represented, including family medicine (46%), geriatric medicine (21%), and internal medicine (14%). Respondents were from community-based outpatient clinics, long-term care facilities, academic institution-based clinics, federally qualified health centers, and hospitals. Nearly 40% of respondents were from rural or highly rural locations.

Clinical Routines, Workflow Processes, and Policies Related to ACP

As shown in Figure 1, several interprofessional team members were reported as involved in clinic-based ACP workflow processes, either by directly meeting with patients for ACP discussions or indirectly assisting with clinic workflows. While physicians (80%) were the most commonly reported team member to directly meet with patients or family members, social workers (48%) and advanced practice nurses (43%) were also frequently involved in direct ACP counseling in clinical practice. Survey respondents described workflow processes and policies in their clinical settings (Table 2). About two-thirds (64%) of practices were able to electronically store patients' ACP documents. Only 46% reported that ACP documents from their practice setting could be systematically available/transferred to another health care setting such as the emergency department, hospital, or subacute rehabilitation facility, though the details of how transfer of documents occurred were not asked. Most respondents (62%) did not have, or did not know if they had, guidelines or policies about when to review ACP documentation with patients. Very few practices (14%) had a community outreach or education program to improve patient and family engagement in ACP.

Interprofessional Team Member Perspectives Related to ACP

Two-thirds of the survey respondents agreed that systematically addressing ACP is a high priority in their practice setting (Figure 2). While 71% of respondents strongly or somewhat agreed that it is the responsibility of the physician to have ACP discussions with patients or family members, a larger number of respondents (85%) responded that they strongly or somewhat agree that nonphysician health care team members can have ACP conversations with appropriate training. Notably, 13% of respondents felt that their skills for having ACP discussions need significant improvement or that they have no skill at all.

The interprofessional team members' experiences related to ACP practices are shown in Table 3. The frequency of ACP discussions varied widely. Nearly half (49%) of the survey respondents reported having discussed ACP with less than 25% of their patient panel, whereas one-quarter (24%) had discussed ACP with more than 75% of their patient panel. There was also a wide range in the estimated amount of time that interprofessional team members reported spending on ACP discussions. Those in family medicine clinical specialties tended to have shorter conversations than those in geriatrics or internal medicine

specialties (Figure 3A; $P = .056$). Advanced practice nurses tended to have longer ACP conversations (Figure 3B; $P = .068$). The differences in conversation lengths based on specialty or interprofessional team member role were not statistically significant. Experiences related to billing for ACP discussions also varied. Interprofessional team members reported that ACP discussions were not billed (37%), were billed based on time (34%), or they were uncertain how ACP discussions were billed (23%). When ACP was not billed for, some respondents described that they considered the ACP counseling to be part of the office visit charge, an annual wellness visit, or “routine care.”

Using open-ended questions to explore what was working well to promote ACP, a common theme was having workflow processes in place to require ACP to be reviewed on admission to long-term care facilities. The Colorado Medial Orders for Scope of Treatment (MOST; Colorado's Physician Orders for Life-Sustaining Treatment Paradigm program¹⁸) was frequently mentioned as a tool utilized by providers. One provider described their facility's policy: “All admits to our facility sign a MOST form. They are then reviewed quarterly for long-term residents.” Aligned with the survey results in Figure 1, another theme described by survey respondents was the involvement of different interprofessional team members in facilitating ACP in the clinical setting. Examples include descriptive statements regarding team-based care (“Having both staff and providers asking families/patients about ACP”) and specifically mentioning which team members were promoting ACP (“Medical assistants flag physicians when documentation is not present”).

Interprofessional Team Member Needs Related to ACP

When asked about resources needed to systematically incorporate ACP into practice, common needs were training for providers and staff (30%), dedicated staff to facilitate ACP processes (26%), and patient educational materials (18%; Figure 4). Regarding patient and family education, several respondents suggested that written materials or videos for families to watch would be helpful. Three respondents suggested public relations campaigns or public service announcements to promote ACP in the community. One respondent suggested: “Print and television and Internet information similar to the direct-to-consumer advertisement pharmaceutical companies are currently using. Get the message to the public so they'll take the time to discuss with providers.”

Discussion

Although many clinical settings could electronically store ACP documents, most settings lacked systematic clinical routines to support ACP discussions involving the interprofessional team and lacked policies for reviewing or transferring ACP documents to other health care settings. Two-thirds of the respondents said that addressing ACP was a high priority, though there were few patient education programs or training for interprofessional team members to promote ACP, a known barrier to implementation on ACP clinical routines.¹⁹ This survey of interprofessional team members, including physicians, advanced practice nurses, and other health care professionals, found that some interprofessional team members reported spending a considerable amount of time discussing ACP (more than 20 minutes), but most were not billing for ACP.

With a national shortage of primary care providers and more individuals living with serious chronic conditions, systematic ACP will not be possible without a team-based approach. While physicians were reported to be the predominant interprofessional team member directly involved in discussing ACP with patients, 85% of the respondents also felt that nonphysicians can have ACP discussions with appropriate training. We and others have described how ACP can be a care team responsibility, where interprofessional team members contribute to different aspects of ACP.^{1,3,7,20} Similar to how management of hypertension involves several disciplines to assess, diagnose, treat, and monitor blood pressure, our findings suggest opportunities to review ACP clinical workflows and identify appropriate responsibilities for each team member to optimize patient engagement in ACP.

The interprofessional team is already an essential component of long-term care, and team-based ACP interventions in nursing homes have been successful in improving care for adults with serious illnesses.^{21,22} Ambulatory care settings are increasingly adapting team-based models, such as the patient-centered medical home model and group medical visits, to assist with care coordination and chronic care disease management.^{23,24} Team-based ACP processes, including ACP group visit models, can be integrated into primary care and long-term care settings.^{25,26} Social workers, nurses, advanced practice providers, or trained ACP facilitators can directly meet with patients for early and ongoing ACP discussions that are designed to identify each patient's understanding of and readiness to engage in ACP.^{1,3} Clinical settings that involve non-physician team members may be able to effectively integrate ACP into routine care.

The importance of team-based coordination of ACP cannot be overstated given the increased focus on ACP (the broader process that includes advance directives) as a measure of patient-directed care, patient safety, and quality care. In primary care settings, the National Committee for Quality Assurance's Patient-Centered Medical Home 2014 standards includes a metric related to advance directives.²⁷ Within hospitals, The Joint Commission 2009 requirements emphasize providing information and supporting discussions related to advance directives so that patients understand their options for decision-making.²⁸ Starting on January 1, 2016, the CMS began reimbursement to health care providers for ACP counseling.²⁹

This study describes common system gaps and clinical resource needs for ACP across diverse health care settings in Colorado. The results extend prior research by showing that clinical settings do not conduct ACP in a structured way³⁰ and emphasize that providing educational materials for patients and families, prioritizing training for health care providers and staff, and dedicating staff to facilitate ACP could support systematic integration of ACP into clinical routines. There are several initiatives to improve ACP involving interprofessional team members, including facilitator-based models for multiple ACP conversations, communication guides and skills training related to discussing serious illness and end-of-life care, and tools that provide print, video, or web-based patient-oriented tools for ACP or decision aids for serious illness.^{1,31-34} There are also public awareness campaigns to increase patient engagement in ACP.^{2,35} Colorado does not have a state-wide registry for ACP documents; such a registry could improve the ability for health care settings to access an individual's ACP documents regardless of their location, though further testing

is needed. Studies of ACP registries in Oregon (Physician Orders for Scope of Treatment [POLST] form) and West Virginia (advance directive and/or Physician Orders for Scope of Treatment [POST] forms) suggest that end-of-life preferences, as documented in POLST/POST orders, are honored.^{36,37}

Given that new ACP billing codes for Medicare beneficiaries are time-based codes, the 17% of the survey respondents who reported spending at least 20 minutes when discussing ACP are able to bill for this clinical activity. The long-term impact of the ability to bill for time spent discussing ACP remains to be seen, including whether ACP discussions occur more frequently and/or longer. This survey serves as an initial description of Colorado health care providers' billing practices before the implementation of Medicare reimbursement for ACP. Future research should also investigate whether the quality of ACP conversations improves as providers are able to bill for ACP. If the number of nonphysician, interprofessional team members who are involved in ACP counseling grows, each discipline's training should ensure that adequate training and competency is achieved.

This study has several limitations, including the lack of generalizability to other US states. As a convenience sample, sampling bias is present and the results are not representative of all health care providers and settings in Colorado, including medical and surgical specialty care, private practices, Veterans Administration, Colorado's Program for All-inclusive Care of the Elderly, and long-term acute care settings. While responses were received from 24 of 62 counties, the respondents were primarily from physicians, advanced practice nurses, and urban counties around the Denver metro area. Other members of the interprofessional team, including social workers, physician's assistants, chaplains, psychologists, medical assistants, and other care coordinators, are only present in very small numbers, and thus, their perspectives on ACP are underrepresented. Further work should include each county, health care setting, and interprofessional team member, including urban, suburban, and rural settings, to accurately reflect the ACP routines of the state as a whole. Although the survey was distributed to a large number of potential participants in different clinical settings through a single e-mail, the response rate is likely low. Finally, there may be selection bias in that respondents who consider ACP to be a high priority were more likely to respond.

In conclusion, while several interprofessional team members consider ACP a priority, it is not being performed in Colorado in a systematic fashion with clinical practices and policies in place that would facilitate ACP in the clinical setting or permit availability outside the setting in which it was completed. Better incorporation of nonphysicians with appropriate training to provide team-based care, clinic-specific policies to support best practices, and patient education and outreach to increase patient readiness are opportunities for improving ACP in diverse clinical settings. As ACP practices evolve and become more prevalent with the advent of billing codes for ACP and increasing emphasis on providing medical care that is aligned with patient preferences, future studies will be needed to assess these changes.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Figure 1.

Multiple interprofessional team members participate in advance care planning. Survey respondents (N = 118) who reported whether an interprofessional team member directly met with patients or family members (orange bars) or assisted with any aspect of the ACP process (blue bars) in the clinical setting.

Figure 2.
Interprofessional team member perspectives related to advance care planning.

Figure 3.
Time spent in advance care planning discussions. A, By clinical specialty. B, By discipline.

Figure 4.
Interprofessional team member needs related to advance care planning.

Table 1Interprofessional Team Member and Practice Characteristics Description.^a

Respondent Demographics	n (%)
Role on health care team	
Physician	62 (53)
Advanced practice nurse	21 (18)
Nurse	13 (11)
Administrator/manager	8 (6.8)
Chaplain	4 (3.4)
Social worker	3 (2.5)
Pharmacist	1 (0.8)
Physician assistant	1 (0.8)
Other ^b	5 (4.2)
Practice characteristics	
Clinical specialty	
Family medicine	54 (46)
Geriatrics	25 (21)
Internal medicine	17 (14)
Subspecialty practice ^c	9 (7.6)
Palliative care or hospice	7 (5.9)
Other ^d	6 (5.1)
Clinical setting	
Community-based clinic	55 (47)
Long-term care facility ^e	23 (20)
Academic institution-based clinic	17 (14)
Federally qualified health center	13 (11)
Hospital	8 (6.8)
Location by county ^f	
Urban	69 (62)
Rural	22 (20)
Highly rural	20 (18)
Number of patients seen annually by respondent	
<500	51 (44)
500-1000	28 (24)
1001-2000	19 (16)
>2000	18 (16)

^aN = 118.^bOther interprofessional team members included a patient navigator, dental hygienist, state long-term care ombudsman, psychologist, and hospital-based quality manager.^cOther subspecialties included orthopedic pain management, perioperative care, medical oncology, stroke, hospitalist, and trauma.

^d Other clinical specialty types included pediatrics, behavioral health, dentistry, and quality management.

^e Including skilled nursing care, assisted living facilities, Program for All-Inclusive Care of the Elderly.

^f Counties included in “urban” category, including suburban areas are Adams, Arapahoe, Broomfield, Denver, Douglas, and Jefferson. Counties included in “rural” category are Larimer, Mesa, and Weld. Counties included in “highly rural” category are Archuleta, Chaffee, Delta, Eagle, Garfield, Huerfano, Las Animas, Logan, Montezuma, Morgan, Pitkin, Prowers, Summit, and Yuma.

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Table 2Clinical Routines, System Processes, and Policies Related to ACP.^{a,b}

Question About ACP System Support	n (%)
Are ACP documents electronically stored?	
Yes	76 (64)
No	21 (18)
Unknown	21 (18)
Are ACP documents systematically available to another health care setting?	
Yes	53 (45)
No	35 (30)
Unknown	27 (23)
Does practice setting have guidelines or policies about when to review ACP documentation?	
Yes	44 (37)
No	50 (42)
Unknown	23 (19)
Are community outreach or education programs offered by practice setting to improve engagement in ACP?	
Yes	16 (14)
No	95 (81)

Abbreviation: ACP, advance care planning.

^aN = 118.^bMissing values were <6%.

Table 3**Interprofessional Team Member Experiences Related to ACP Practices,^{a,b}**

Survey Question	n (%)
With what proportion of your patient panel have you ever discussed ACP?	
<25%	53 (49)
26%-50%	16 (15)
51%-75%	13 (12)
>75%	26 (24)
When you have ACP discussions, what is a typical amount of time you spend on these discussions?	
<5 minutes	15 (14)
5-10 minutes	26 (24)
11-15 minutes	28 (26)
16-20 minutes	15 (14)
>20 minutes	19 (17)
When you have ACP discussions, how often does the patient or a family member initiate the discussion?	
Always	1 (0.9)
Often	10 (9.1)
Sometimes	73 (66)
Never/unknown	20 (18)
How does your practice bill for the ACP discussions? ^a	
Not billed for	41 (37)
Time based	37 (34)
ICD-9 code	15 (14)
I am not sure	25 (23)
Overall, how would you rate your skill level for having ACP discussions with patients and families?	
I have no skill	4 (3.7)
Needs significant improvement	10 (9.2)
Needs some improvement	17 (16)
Somewhat good	32 (29)
Very good	27 (25)
Excellent	19 (17)

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Abbreviations: ACP, advance care planning; ICD-9, *International Classification of Diseases, Ninth Revision*.

^a n = 110, excludes administrators.

^b More than 1 response allowed.