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Impact of Group Visits for Older Patients with Heart Failure on Advance Care Planning Outcomes: Preliminary Data

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Abstract

Objective: Advance care planning (ACP) is critically important for heart failure patients, yet important challenges exist. Group visits can be a helpful way to engage patients and caregivers in identifying values and preferences for future care in a resource-efficient way. We sought to evaluate the impact of group visits for ACP among older adults with heart failure and their caregivers on ACP-related outcomes.

Methods: We conducted a mixed-methods pilot study evaluating the impact of an ACP group visit for older adults with heart failure and their caregivers on ACP-related outcomes including readiness and self-efficacy. The evidence-based PREPARE for Your Care video-based intervention was used to guide the group visits. Twenty patients and 10 caregivers attended one of five 90-minute group visits led by a trained facilitator. Group visit participants completed pre-, post-, and 1-month follow-up surveys using validated 5-point ACP readiness and self-efficacy scales. Qualitative feedback obtained within 3-days of a group visit were analyzed using a directed content analysis.

Results: Patient participants had a median age of 78. Approximately half were female while caregiver participants were mostly female. Participants were predominantly white. Patient

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readiness scores improved significantly pre-to-post (+0.53; p=0.002) but was not sustained at 1-month follow-up. Patient and caregiver self-efficacy showed some improvement pre-to-post but was also not sustained at follow-up. Interviews revealed positive impacts of group visits across 3 themes: encouraging reviewing or revisiting prior ACP activities, motivating patients to take direct steps towards ACP, and serving as a "wake-up" call to action.

Conclusions: Disease-focused group visits may have a short-term effect on ACP outcomes but ongoing touchpoints are likely necessary to sustain ACP over time. Results highlight a need for follow-up ACP conversations after a single group visit. Timing for follow-ups and the ideal person to follow-up ACP conversations needs to be explored.

Keywords

advance care planning; group medical visits; heart failure

Introduction

High-quality ACP is an iterative process aimed at achieving patient-centered and goal-concordant medical care[1,2] through regular discussions with loved ones and health care providers about one's healthcare values and preferences. It is particularly critical for older adults with heart failure, who often have multiple co-morbidities[3] and face an uncertain trajectory characterized by frequent decompensations and complex treatment choices.[4,5] However, there are various challenges[6–9] to effectively engaging patients and their caregivers in the ACP process, and ACP is often limited and initiated late in the trajectory of heart failure.

Group visits have the potential to overcome some of the structural and individual barriers to engaging in ACP. Group visits provide social support to encourage patients to engage in a typically difficult topic[10–12] and may motivate patients to take important steps in ACP through social persuasion and action cues.[12,13] Group visits also have potential to help caregivers develop an understanding of their loved one's values and goals for care and increase their confidence in surrogate decision-making. Group visit interventions can be a single event focused on a single central topic[14] or may be ongoing with multiple visits.[11,15]

While studies suggest that group visits for ACP among older adults are feasible,[16–18] and may improve ACP documentation[12] and some ACP engagement measures[19] little is known about the impact of a *disease-focused* group visit on ACP-related outcomes. ACP group visits for patients with the same primary condition may foster greater engagement in the ACP process through a shared disease experience and improved understanding of the relevance of ACP in the context of the disease trajectory. ACP group visits for patients with heart failure may be particularly effective at helping participants clarify their values and preferences for common and often intensive interventions within an uncertain and variable illness trajectory. Thus, the purpose of this study was to evaluate the preliminary impact of a single ACP group visit for heart failure patients and their caregivers on ACP-relevant process outcomes. Findings are intended to guide a future longitudinal trial of ACP group visits for older adults with heart failure.

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Methods

Overview

As part of a larger study of ACP group visits for patients with heart failure and their caregivers conducted at a large academic medical center in a major metropolitan area, we evaluated the preliminary impact of the group visits on ACP-relevant outcomes. Findings pertaining to the feasibility and acceptability of the group visit structure and curriculum are reported separately.[20]

We conducted five in-person group visits, each 1.5 hours long and led by a facilitator specifically trained in the group visit curriculum.[20] We used the evidence-based PREPARE for Your Care intervention (https://prepareforyourcare.org), an interactive tool using "how to" video stories to empower patients to identify their healthcare values and move them through the stages of ACP.[21] PREPARE has been shown to significantly increase engagement in ACP.[22,23] We provided participants with the PREPARE workbook to use during the group visit for exercises on values clarification and used disease-focused and culturally-relevant probing questions to encourage structured discussions. Participants were asked to consider and share their experiences with heart failure as they engaged with the discussions. The facilitator probed participants about heart failure-specific experiences raised in the group to foster discussion and consideration about care pathways, interventions, and care preferences related to the heart failure trajectory.

Recruitment and Eligibility

Patients were eligible to participate if they were 65 years or older with at least one heart failure hospitalization within the 12-months prior to the date of the data pull. We also encouraged direct patient referrals from providers in the Advanced Heart Failure Clinic and Departments of Family Medicine and Cardiology. Participants, including patients and their caregivers, who indicated interest were administered a short cognitive screener by phone[24] and, if appropriate, were scheduled for a group visit. Full recruitment procedures are described in detail elsewhere.[20] All study procedures were approved by the institutional review boards of the clinical site and the grantee institution.

Data Collection and Analysis

To evaluate the preliminary impact of the group visits on ACP-relevant outcomes among participants, we administered separate surveys to patients and caregivers at the start of the group visit (pre-survey), immediately following the group visit (post-survey), and one month after the group visit by telephone (follow-up 1 month survey); and conducted telephone interviews with all participants within 3 days of their group visit. The patient surveys used validated subscales of the ACP Engagement Survey[25] scored on a 1 (low) to 5 (high) point Likert scale to assess at pre-, post-, and one-month time points 1) *readiness* (10-items; e.g., "how ready are you to…formally ask someone to be your medical decision maker") and 2) *self-efficacy* (6-items; e.g., "how confident are you right now that you could ask someone to be your medical decision maker") to engage in ACP. The caregiver surveys assessed *surrogate decision-making self-efficacy* at pre-, post-, and one-month time points using a validated 9-item scale[26,27] (e.g., "I am confident that I will be able to make decisions

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about his/her healthcare") scored on a 1 (low) to 5 (high) point Likert scale. For all participants, we collected self-reported gender, race/ethnicity, financial status, religiosity, and acculturation. Survey data were descriptively analyzed. We calculated item-level means, overall scale means, and changes scores for readiness and efficacy scales. Mean readiness and efficacy scores were analyzed using a paired t-test, comparing pre-to-post, pre-to-1-month, and post-to-1-month. Statistical analysis was conducted using R version 3.6.1.

Follow-up interviews were conducted within 3-days of attending a group visit with 26 participants (17 patients, 9 caregivers) and ranged from 6–35 minutes. The remaining 4 individuals (3 patients, 1 caregiver) were unable to be reached for a follow-up interview. The interviewer took detailed notes during the interview which were analyzed using a directed content analysis.[28]

Results

Participant Characteristics

A total of 20 patients and 10 caregivers (N=30) attended one of the five group visits (Table 1). These 30 participants represented 21 unique patient/caregiver units; 12 patients attended alone, 1 caregiver attended alone (without the patient), and 8 patient-caregiver units (7 dyads, 1 triad) attended together. Group visits ranged from 3–10 participants.

Overall Changes in Readiness and Self-Efficacy

In general, readiness and self-efficacy improved immediately following the group visit but had dropped to almost or below pre-group visit levels by the 1-month follow-up survey (Figure 1). For example, patient readiness to engage in ACP improved significantly pre-to-post group visit (change score +0.53; p<.01) but dropped almost back to pre-group visit levels by the 1-month follow-up survey (change score −0.52; p<.01). Patient self-efficacy did not significantly change overall pre-to-post group visit (change score +0.29; p=0.11) and declined to below pre-group visit levels by the 1-month assessment (change score −0.40; p<0.05). Finally, overall caregiver self-efficacy showed some nonsignificant improvement pre-to-post group visit (change score +0.29; p=0.13) but dropped significantly from the post-group visit timepoint to the 1-month follow-up survey. Caregivers generally had a high baseline rating around their confidence level to make decisions for the patient.

Changes in Individual Readiness and Self-Efficacy Items

Eight out of the 10 items comprising the readiness scale significantly increased pre to post, but three of these items (pertaining to readiness to talk to one's doctor or medical decision maker about health situations that would make life not worth living, and readiness to sign official documentation) had dropped back to lower than pre-group visit levels by the time of the 1-month follow-up survey (Table 2). Among the patient self-efficacy items, two (confidence about asking someone to be a medical decision maker and confidence about talking with that individual regarding decision-making) did improve significantly from before to immediately after the group visit, but three items (confidence about talking with one's medical decision maker about decision-making as well as confidence about talking with one's doctor or one's medical decision maker about what would make life not worth

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living) dropped significantly between the post-group visit survey and the follow-up survey, to below pre-group visit levels.

Follow-Up Interviews

Overall, participants spoke positively about the group visit and described how the experience encouraged them to think about why ACP was relevant to their heart failure trajectory. They noted that the shared experiences around heart failure provided them with a common ground to discuss and consider ACP steps during the group visit. Participants spoke of three specific ways the group visit impacted their ACP engagement:

1. Encouraged them to review or revisit prior ACP documents by providing them with more knowledge about the topic and raising a wider range of healthcare decisions and options they may not have considered before.

2. Motivated them to take direct steps towards ACP immediately after, including having conversations with family members or health care providers about their preferences for care and continuing with the workbook exercises at home.

3. Served as a "wake-up" call to action by highlighting the significance and need to engage in ACP and serving as a reminder to start planning for the future.

Discussion

Overall, the group visit was found to increase patient readiness to engage in ACP immediately following the group visit but failed to sustain the improvement one-month after the group visit. In addition, the group visit had little demonstrable effect on either patient or caregiver self-efficacy or confidence to engage in ACP after the group visit, particularly over the longer-term. Importantly, the qualitative data underscored the value of the group visits to participants, particularly as a safe space to share healthcare experiences within the context of their heart failure trajectory, and as a prompt to engage in subsequent ACP activities such as talking to family members about specific treatment preferences. Together, our findings indicate there is some benefit to a disease-focused group visit intervention at encouraging patients to engage in ACP and facilitate ongoing consideration and communication of values and wishes.

Our findings suggest areas for further exploration. First, the absence of sustained improvements in ACP engagement among our participants suggest it may be necessary to include in the group visit an opportunity to undertake a concrete ACP step such as completing an advance directive. This may solidify gains made during the group visit and facilitate continued ACP engagement thereafter; indeed, other work has demonstrated an increase in ACP documentation following a group visit.[17] Second, future research might evaluate the utility of a follow-up ACP discussion with the patient's primary clinician to reinforce and extend any gains made. In addition, multiple group visits may be necessary to sustain longitudinal improvement in ACP outcomes, perhaps timed to sentinel events such as hospitalizations. Group visits in this context could serve as a "home base" to which patients regularly return to establish or revisit preferences, increase their readiness and confidence

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to engage in ACP, and undertake specific steps as relevant to their clinical and personal trajectory.

We found that improvements achieved during the group visit in patient readiness or confidence to talk with one's doctor or medical decision maker about what would make life not worth living were not maintained at the 1-month follow-up. Although we anticipated a group setting could help patients overcome emotional and cognitive barriers to visualizing difficult health scenarios and prepare them to talk with others about their preferences in those scenarios, the lack of sustained improvement in these items further underscore the importance of extending the ACP process beyond a single group visit.

This study was conducted at a single site in the Western region of the United States. Participants were mostly white, and caregivers were predominantly female. The small sample size limits statistical significance in the change from pre to post-group visit, and thus our findings suggest only trends in ACP-relevant outcomes. A planned future trial building on this pilot study will more robustly compare the impact of disease-focused group visits versus standard care on ACP outcomes over time.

This study demonstrates some benefit to an ACP group visit for older adults with heart failure in terms of their readiness to engage in ACP activities. Future research should assess the long-term effects of a disease-focused ACP group visits by implementing a series of group visits for continued engagement with ACP over time.

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Key Points

- ACP group visits for patients with heart failure improve readiness to engage in ACP but long-term impacts are uncertain.
- Ongoing touchpoints are likely necessary to sustain ACP gains over time.

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Why does this paper matter?

Advance care planning (ACP) remains limited for patients with heart failure. Disease-specific group visits can help to increase engagement with advance care planning, setting a foundation for values-based treatment decision making.

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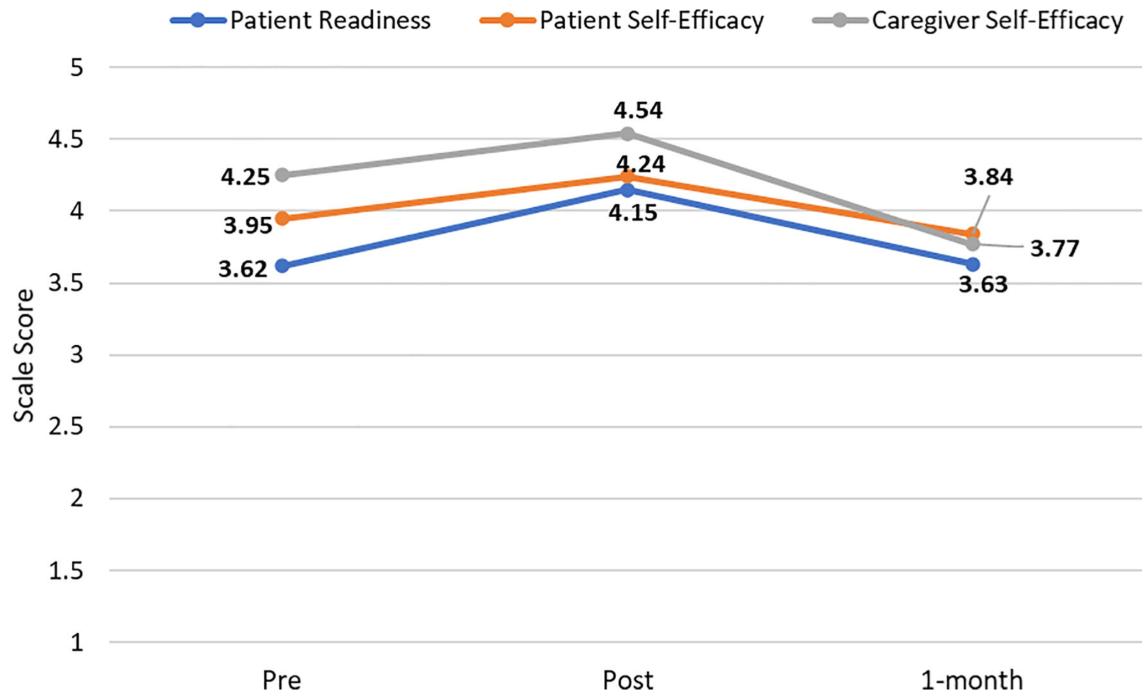

Figure 1:
Overall Change in Readiness and Self-Efficacy Scores at Pre-visit, Post-visit and 1-month timepoints

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Table 1:

Participant Demographics and Prior ACP Completion

		Patients (n=20)	Caregivers (n=10)	Total (n=30)
Age, median*		78	N/A	N/A
Female, n (%)		11 (55)	8 (80)	19 (63)
Race/Ethnicity, n (%)				
	White	15 (75)	6 (60)	21 (70)
	Black	2 (10)	0	2 (6)
	Latino/Hispanic	3 (15)	3 (30)	6 (20)
	Asian Pacific Islander	0	0	0
	Other/Multi-ethnic	0	1 (10)	1 (3)
Married		8 (40)	6 (60)	14 (46)
Completed AD†				
	Yes	11 (55)	-	11 (55)
	No	7 (35)	-	7 (35)
	Don't know	1(5)	-	1 (5)
Completed DPOA-HC‡,§				
	Yes	8 (40)	-	8 (40)
	No	10 (50)	-	10 (50)
	Don't know	1(5)	-	1 (5)
Completed POLST[4]				
	Yes	5 (25)	-	5 (25)
	No	13 (65)		13 (65)
	Don't know	1 (5)		1 (5)

*Median based on 17 patients (patient age missing for 3 patients)

†Data missing from 1 patient.

‡Durable Power of Attorney for Health Care

§Data missing from 1 patient.

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Table 2:

Patient Readiness and Self-Efficacy Overall and Item-level Scores

	Pre-Group Visit	Post-Group Visit	Follow-up 1-month †	Pre to Post Change	Post to Follow-up Change	Pre to Follow-up Change
	Mean (SD)			Change Score (p-value)		
Overall Readiness Scale Score (1-low to 5-high)	3.62 (1.17)	4.15 (0.67)	3.63 (0.55)	+0.53 (0.002) **	−0.52 (0.008) **	−0.01 (0.912)
How ready are you to formally ask someone to be your medical decision maker?	3.6 (1.24)	4.25 (0.79)	3.86 (0.64)	+0.65 (0.004) **	−0.39 (0.209)	+0.26 (0.448)
How ready are you to talk with your doctor about who you want your medical decision maker to be?	3.85 (1.31)	4.05 (0.89)	3.3 (1.18)	+0.2 (0.329)	−0.75 (0.66)	−0.55 (0.228)
How ready are you to sign official papers naming a person or group to make medical decisions for you?	3.6 (1.23)	4.10 (0.97)	3.6 (0.67)	+0.5 (.008) *	−0.5 (0.13)	0 (0.916)
How ready are you to talk to your medical decision maker about what health situations would make life not worth living?	3.5 (1.43)	4.10 (0.72)	3.15 (0.99)	+0.6 (0.042) **	−0.95 (0.007) **	−0.35 (0.417)
How ready are you to talk to your doctor about what health situations would make your life not worth living?	3.55 (1.39)	4.15 (0.75)	2.73 (1.22)	+0.6 (0.007) **	−1.42 (0.000) ***	−0.82 (0.075)
How ready are you to sign official papers about the kind of medical care you would want if you were seriously ill or dying?	3.75 (1.25)	4.20 (0.77)	3.35 (1.01)	+0.45 (0.016) *	−0.85 (0.809)	−0.4 (0.610)
How ready are you to talk to your medical decision maker about how much flexibility you want to give them?	3.5 (1.24)	4.25 (0.79)	3.46 (1.10)	+0.75 (.001) ***	−0.79 (0.358)	−0.04 (0.546)
How ready are you to talk to your doctor about how much flexibility you want to give your decision maker?	3.5 (1.24)	4.15 (0.88)	3.1 (1.22)	+0.65 (.005) **	−1.05 (0.18)	−0.4 (0.910)
How ready are you to sign official papers about how much flexibility to give your decision maker?	3.4 (1.27)	4.20 (0.83)	3.25 (0.97)	+0.8 (.0001) ***	−0.95 (0.010) **	−0.15 (0.709)
How ready are you to ask your doctor questions to help you make a good medical decision?	3.9 (1.25)	4.0 (0.79)	3.4 (1.11)	+0.1 (0.606)	−0.6 (0.059)	−0.5 (0.167)
	Pre-Group Visit ‡	Post-Group Visit ±	Follow-up 1-month §	Pre to Post Change	Post to Follow-up Change	Pre to Follow-up Change
	Mean (SD)			Change Score (p-value)		
Overall Self-Efficacy Scale Score (1-low to 5-high)	3.95 (0.83)	4.24 (0.63)	3.84 (0.53)	+0.29 (0.109)	−0.40 (0.026) *	−0.11 (0.667)
How confident are you right now that you could ask someone to be your medical decision maker?	3.9 (1.1)	4.3 (0.81)	3.9 (0.32)	+0.4 (0.046) *	−0.4 (0.062)	0 (0.968)
How confident are you right now that you could talk with your doctors about who you want your medical decision maker to be?	4 (1.1)	4.2 (0.70)	3.7 (0.99)	+0.2 (0.311)	−0.5 (0.129)	−0.3 (0.455)
How confident are you right now that you could talk with your decision maker about	4.2 (0.92)	4.5 (0.69)	3.5 (0.80)	+0.3 (0.083)	−1 (0.003) **	−0.7 (0.045) *

what would make your life not worth living?						
How confident are you right now that you could talk with your doctors about what would make your life not worth living?	4.1 (1.1)	4.2 (0.81)	3.3 (1.1)	+0.1 (0.547)	−0.9 (0.024) *	−0.8 (0.073)
How confident are you right now that you could talk with your decision maker about how much flexibility you want to give them to make decisions for you?	3.8 (1.0)	4.3 (0.80)	3.6 (0.74)	+0.5 (0.020) *	−0.7 (0.020) *	−0.2 (0.666)
How confident are you right now that you could ask the right questions of your doctors to help make good medical decisions?	3.8 (1.1)	4.1 (1.1)	3.5 (0.83)	+0.3 (0.288)	−0.6 (0.114)	−0.3 (0.379)

† n=16 patients

‡ n=18 patients

± n=20 patients

§ n=16 patients

* p<0.05

** p<0.01

*** p< 0.001

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