ORIGINAL RESEARCH

Use of a simulated group visit to introduce advance care planning in the primary care setting

Julie C. Campbell*[1], Melanie Kroger-Jarvis[1], Sandra Selman[2]

[1] *College of Nursing, University of Cincinnati, Cincinnati, Ohio, United States*
[2] *Transitional Care, The Christ Hospital Health Network, Cincinnati, Ohio, United States*

Received: April 6, 2022 **Accepted:** April 17, 2022 **Online Published:** April 26, 2022
DOI: 10.5430/jnep.v12n9p1 **URL:** https://doi.org/10.5430/jnep.v12n9p1

ABSTRACT

Background and objective: When serious illness prevails or when faced with an end-of-life event, nurses should recognize symptoms and support patients with decision-making. By encouraging advance care planning (ACP) in the outpatient setting, patient involvement is enhanced. *Objective:* A performance improvement plan was used to increase nurse care manager confidence levels with hosting ACP conversations.
Methods: *Design:* Care managers attended a two-hour simulated session to observe how to educate and prepare patients to complete advance directives. The session included a video introduction with two different group activities that encouraged sharing experiences from the peer perspective. Options for care were explored, focusing on selecting a health care power of attorney and promoting an end-of-life values conversation. *Setting/Participants:* The group visit occurs in the outpatient setting in a small group with five nurse care managers in the first visit and nine nurses in the second visit. *Measures:* Using a Likert scale, a pre/post-visit survey was given with eight questions to measure confidence levels with ACP in the group visit setting. Follow-up interviews were voluntarily conducted to measure confidence in completing an ACP conversation with a friend or family member.
Results: Eight of the fourteen care managers participated in the post-visit interviews. 63% expressed themes of increased comfort in understanding and sharing ACP steps. The overall mean for pre/post survey confidence level increased from 3.77 to 4.33 (S.D. 0.25), with the most significant increase centered around confidence to lead a values conversation to select preferences for care.
Conclusions: This performance improvement plan to promote ACP in the outpatient setting aligns with past studies promoting a group visit to educate and prepare patients to complete advance directives. Although findings may have limited generalizability, due to their small sample size, future group visits should be considered as a possible solution to meet busy time constraints in the primary care office.

Key Words: Advance care planning, Advanced directives, Group visits, Care managers, Primary care nurses

1. INTRODUCTION

1.1 Nature and significance of the problem

Patients today expect to be full partners in their healthcare decisions. With the focus shifting from an authoritarian or even paternalistic view of their physician to the new patient-centered care, expectations are changing that support patient autonomy and involvement.[1] Synonymous to this change in decision-making is an improvement in medical technology. As a result, the patient is offered more choices than ever before. With more access to acute hospital interventions,

*Correspondence: Julie C. Campbell; Email: campbj7@ucmail.uc.edu; Address: College of Nursing, University of Cincinnati, Cincinnati, Ohio, United States.

life may be extended but not necessarily what the patient may feel is high-quality time.[2] The Institute of Medicine's report, Dying in America: Improving quality and honor- ing individual preferences near the end of life, encourages ongoing conversations between patients and their families, and patients and their medical team to assure care provided aligns with patient wishes.[3] A survey completed by the California Healthcare Foundation indicates that although patients express a desire to plan, 90% report no conversation being offered by their provider.[4] Nurses must recognize symptoms and support patients with decision-making when serious illness prevails or when faced with an end-of-life event. By encouraging advance care planning (ACP) in the outpatient setting, the patient can be more involved than they can during a crisis moment of acute hospitalization. The American Nurses Association emphasizes coordinating conversations that reflect patients' wishes and values.[2]

1.2 Available Knowledge

Despite the desire to begin these conversations, clinicians often face barriers such as the limited time during office visits and hesitation on the patient's side when approached during wellness visits. One proposed solution is a group session where 8-12 patients gather to introduce advance directives (AD) through a group ACP visit. A pilot program in Aurora, Colorado, reported increased patient participation, increased comfort to have a conversation with loved ones concerning their wishes, and a willingness to share and learn from peer perspectives.[5] Visits held at a San Francisco oncology center note participants sharing that the conversations increased their awareness of the power of attorney role and helped make AD more meaningful and personal.[6] Patients with heart failure who attended a group visit acknowledged appreciation for the space created to share and hear from others facing disease-specific complications and how their care values impact their AD decisions. The conversations were rich in content, increasing engagement for ACP.[7]

1.3 Problem Identified

When considering improving patient engagement for ACP conversations, a healthcare network chose their nurse care managers, based out of their primary care offices, to educate and support patients with this task. At first, three one-on-one visits were created to teach patients about AD and allow them to explore their values for end-of-life care. After initiating the new program in two offices and discovering that patients were reluctant to engage in ACP conversations after their yearly wellness visit, they became interested in finding a solution to help increase patient engagement for this topic. With the COVID-19 pandemic, direct patient care was limited, and the original program was delayed, reducing the care managers' confidence levels for these conversations. The design team chose a simulated group visit as a solution.

2. METHOD

2.1 Study design

To improve the confidence of the nurse care managers who wish to support patients in completing advance directives, a team comprised of the nursing Director for Care Management and Care Coordination, the Nurse Manager for Transitional Care, an Associate Nursing Professor, and the Doctor of Nursing student formed to design a group visit utilizing the Model for Improvement Method.[8] During the planning phase, a two-hour simulated visit was chosen to assist the care managers in re-educating themselves and observing firsthand how a patient group visit is organized and implemented. IRB exempt status was received for this performance improvement from the University of Cincinnati and The Christ Hospital Health Network. Two separate visits were offered to meet social distancing guidelines during the COVID-19 pandemic.

The session begins with an introduction, a review of studies or evidence for a group visit intervention, and a pre-visit survey to measure the confidence levels of the care managers before attending the session. The simulation then opens with a video to introduce the topic of advance care planning and its impact on a personal level. Next, the Institute for Healthcare Improvement: Conversation Project[9] materials and definitions are discussed, and two separate handouts are completed as group activities. The handouts promote discovering one's values for end-of-life care, identifying and initiating a healthcare power of attorney, and beginning a conversation with the healthcare team and the patient's leading support group. An important aspect to include is the sharing of peer perspectives during a value exercise in small groups. To conclude, a chaplain who executes advance directives daily with patients reviews Power of Attorney and Living Will paperwork and offers a time for questions or concerns. The cost associated with the Conversation Project material is minimal as handouts are free to reprint.

2.2 Sampling

The sample size was originally twenty care managers. With the impact of the pandemic on nursing positions and the loss of care managers, the actual number employed currently is fourteen nurses. These nurses work in primary care offices of an extensive healthcare system in the southwest Ohio region. While the group visit was part of their workday, participation in the surveys or interviews was voluntary. They were recruited to attend the visit and interviewed through email invitations and phone calls. Their primary role is to sup-

port patients after hospitalization and with chronic disease management through telephone conversations and follow-up resources. All fourteen did attend one of two group visits. No one was excluded. Ages range from 27- 57 years, with years of experience ranging from less than one month to 13 years. Participants were assured all results would remain anonymous.

2.3 Measures

This performance improvement plan improved the care manager's confidence to have a new ACP conversation with a friend or family member within 6-8 weeks after the initial group visit. To meet the aim, 75% of the care managers attended the group visit, and 100% completed the pre/post-visit survey. The survey measured the confidence of the care manager in the use of the group visit to educate future patients. Demographic questions were analyzed to determine if any factors impacted the outcome measures.[10] The central tendency was analyzed by measuring the mean from the pre/post survey results and the standard deviation to indicate any dispersion or variance.[11] Qualitative comments regarding subjective barriers or challenges were evaluated 10-12 weeks after the group visits to identify any common themes supporting future group visit design.

3. RESULTS

Out of fourteen care managers, 100% attended the simulated group visit and 100% completed the pre/post-survey. Eight of the survey questions measured confidence, with five focused on demographic characteristics as shown in Table 1. Demographics included care manager age, gender, years of experience, the highest level of education, and past training in advance directives or advanced care planning. Survey questions as shown in Table 2 measure first if the care manager recognized the importance of completing ACP in the outpatient setting. Then questions two and three measured their confidence in the group visit format, first to educate patients and second to increase patient engagement for achieving AD. Lastly, questions four through eight measured the separate steps involved in the ACP process.

In utilizing the five-point Likert scale to measure improved confidence in the care managers, the average mean for all eight questions increased from 3.77 to 4.33. The most significant increase noted was on question five- I feel confident in leading someone in a values conversation to help them select preferences for care. The slightest increase noted was for questions one and six. Question one-reviewing ACP in the outpatient setting is important, and question six- I feel confident to empower a patient to ask questions of their provider. Qualitative interviews were completed over one month by phone and email with six questions: (1) What are your general feelings 30-60 days post-visit concerning ACP? (2) Did you have a new conversation about ACP with friends or family? (3) Length of discussion and focus? (4) Barriers or challenges? (5) Any surprises in the conversation? (6) In considering a future visit for similar disease-focused patients, what is your primary concern we should address?

Table 1. Demographic information for care manager nurses

Demographics	n (%)
Years of Experience	
One year or less	n = 7 (54)
Two to three years	n = 3 (23)
Greater than five years	n = 3 (23)
Gender	
Female	n = 14 (100)
Male	n = 0 (0)
Age	
25-35 years	n = 5 (42)
36-45 years	n = 3 (25)
46-57 years	n = 4 (33)
Education	
Associate degree Nursing	n = 5 (42)
Bachelor's degree Nursing	n = 6 (50)
Greater Bachelor's degree	n = 1 (8)
Prior Advanced Care Planning and Advanced Directive Training	
Yes	n = 14 (100)
No	n = 0 (0)

With 8 of 13 care managers participating (one care manager resigned), patterns concerning their feelings for ACP after the group visit revealed an increase in comfort. Statements such as, "I feel more comfortable with the topic," "I feel more comfortable moving ahead with ACP now," "because it can be an awkward conversation, I feel like the visit helped; it was more of a discussion" were noted. The focus of their conversation included the following: relevant definitions, how to support a decision-maker after a traumatic event, end-of-life interventions that would not be acceptable and a discussion of who would be the decision-maker. Barriers to having the conversation included: "I didn't get to it because of personal health issues," another reported, "it just was not a top priority." Two of the care managers experienced similar reactions; their husbands or fathers had more difficulty with the conversation than the female members of their family.

Table 2. Pre/post survey statistical results for advance care planning simulated group visit Participants (n = 14)

Survey Statements	Pre-Group Visit Confidence	Post Group Visit Confidence
Advance care planning in outpatient setting is important		
Strongly disagree (1)	n = 0, (0)	n = 0, (0)
Disagree (2)	n = 0, (0)	n = 0, (0)
Neutral (3)	n = 0, (0)	n = 0, (0)
Agree (4)	n = 4, (29)	n = 3, (21)
Strongly Agree (5)	n = 10, (71)	n = 11, (79)
Mean	**4.70**	**4.80**
Group visit is effective way to familiarize patients with advance care planning		
Strongly disagree (1)	n = 0, (0)	n = 0, (0)
Disagree (2)	n = 0, (0)	n = 0, (0)
Neutral (3)	n = 5, (36)	n = 0, (0)
Agree (4)	n = 5, (36)	n = 7, (50)
Strongly Agree (5)	n = 4, (29)	n = 7, (50)
Mean	**3.90**	**4.50**
Group visit will help engage patients in completing advanced directives		
Strongly disagree (1)	n = 0, (0)	n = 0, (0)
Disagree (2)	n = 0, (0)	n = 0, (0)
Neutral (3)	n = 4, (29)	n = 1, (7)
Agree (4)	n = 7, (50)	n = 7, (50)
Strongly Agree (5)	n = 3, (21)	n = 6, (43)
Mean	**3.90**	**4.40**
Confident to complete steps for advanced directives		
Strongly disagree (1)	n = 1, (7)	n = 0, (0)
Disagree (2)	n = 0, (0)	n = 0, (0)
Neutral (3)	n = 7, (50)	n = 3, (21)
Agree (4)	n = 6, (43)	n = 6, (43)
Strongly Agree (5)	n = 0, (0)	n = 4, (29)
Mean	**3.30**	**4.00**
Confident to lead a values conversation for preferences for care		
Strongly disagree (1)	n = 0, (0)	n = 0, (0)
Disagree (2)	n = 3, (21)	n = 0, (0)
Neutral (3)	n = 6, (43)	n = 2, (14)
Agree (4)	n = 5, (36)	n = 9, (64)
Strongly Agree (5)	n = 0, (0)	n = 3, (21)
Mean	**3.10**	**4.10**
Confident to empower patient to ask question of their provider		
Strongly disagree (1)	n = 0, (0)	n = 0, (0)
Disagree (2)	n = 0, (0)	n = 0, (0)
Neutral (3)	n = 2, (14)	n = 0, (0)
Agree (4)	n = 8, (57)	n = 8, (57)
Strongly Agree (5)	n = 3, (21)	n = 6, (43)
Mean	**4.10**	**4.40**
Confident to help patient identify Healthcare Power of Attorney		
Strongly disagree (1)	n = 0, (0)	n = 0, (0)
Disagree (2)	n = 1, (7)	n = 0, (0)
Neutral (3)	n = 4, (29)	n = 1, (7)
Agree (4)	n = 8, (57)	n = 8, (57)
Strongly Agree (5)	n = 0, (0)	n = 5, (36)
Mean	**3.60**	**4.30**
Confident to equip patient for conversation with their decision maker		
Strongly disagree (1)	n = 0, (0)	n = 0, (0)
Disagree (2)	n = 1, (7)	n = 0, (0)
Neutral (3)	n = 4, (29)	n = 2, (14)
Agree (4)	n = 8, (57)	n = 7, (50)
Strongly Agree (5)	n = 0, (0)	n = 5, (36)
Mean	**3.40**	**4.20**
Mean for all eight questions	**3.80**	**4.30**

Notes. All means rounded to the nearest tenth. Numbers in parenthesis beside question options, such as “strongly agree” (5), represent points assigned for each response.

Another thought expressed was, "you have to be able to distinguish what you want from what they want and be able to verify you understand what they are telling you." Surprises with the conversation were that the men approached had a more challenging time discussing end-of-life wishes. One comment being, "I am still surprised how closed off my dad was, my husband was the same way when we first started" and that "it is harder to start the conversation with a younger person" it was harder to start the conversation with a younger person, like my fiancé". Lastly, when moving forward with future group visits the nurses stressed a need to talk to patients in person, not by telehealth when discussing ACP. Other concerns were to have providers prepared to discuss disease-based questions that may arise after the visit, share the benefits of ACP conversations, and know what wording to use to make the conversation more comfortable for the patient.

4. Discussion

When considering how to best support the care manager nurse to engage patients with ACP, the pre/post survey tool measured their confidence level before and after the group visit. A combined mean showed that confidence did improve overall with both understanding and applying the ACP steps. Five of the thirteen care managers confirmed this with qualitative statements regarding ACP during the interviews. The aim to improve engagement for ACP by promoting an ACP conversation with their family or friend by at least 75% was not met. Only 63% reported having a new discussion with barriers being personal medical issues, competing work responsibilities, and some stating, "It was more difficult to speak to younger people," referring to making that opening connection to start the conversation. Others noted a hesitancy when approaching males stating, "I am still surprised how closed off my dad was when talking with him about ACP. My husband was the same way, he did not want to talk about it", stating, "I don't want to think about something happening."

In considering questions 1 and 6 that focused on the importance of ACP in the outpatient setting and helping the patient ask medical questions to their provider, the mean average was higher pre-group visit, resulting in the least change in confidence. In review, replies may have been higher prior to the simulation due to the care manager's ongoing work role where they advocate and counsel patients routinely. Question 5 with the most significant change in confidence noted-helping the patient have a value conversation for preferences of care, interestingly correlated with the group visit design. Because sharing from the peer perspective was a priority, the design purposely had the most time set aside for this step.

When considering the demographic data from the nurse care managers, all 14 were female and had either an Associate or Bachelor of Science degree in nursing. Time as a nurse care manager ranged from one month to 13 years. They all had attended an ACP training one month prior to the simulated group visit to introduce the ACP process. There were no correlations for scores on the survey related to education or years in the position.

Limitations

Limitations for this performance improvement project included being unable to generalize or randomize due to the small convenience sample size. Another limitation was possible bias in the collection of qualitative responses by an unblinded DNP student. Researcher and participant bias was minimized by asking the questions in a nonjudgmental, open manner. All replies were written verbatim from the participant. The authors analyzed replies to assure the interpretation was factual. Another limitation was that all 14 care managers were female. This limited the ability to compare if the hesitancy some males had with ACP conversations would have been reduced if approached by a male. Lastly, while collecting the final qualitative data, the email systems between the hospital and the university may have been filtering the emails to the care managers into an "other" subset, delaying the messages from being seen. This could have resulted in fewer care managers responding to set up interviews.

5. Conclusion

Implications for Nursing

When considering the patient perspective with group visits, the literature reports that attending a group visit makes completing AD more meaningful and personal, increasing one's comfort in having a conversation with loved ones.[5][6] Interviews after attending this simulated visit found a similar theme, an increase in comfort with ACP with the perspective that the visit was "more like a discussion than an education session, it felt less awkward." This perspective should be considered by nurses who wish to engage patients to complete ACP. For future group visits, care manager nurses' recommendations were to keep ACP in-person, not a telehealth visit, where more personal sharing can be experienced. This correlated well with the patient perspective that an in-person time of sharing made the experience more meaningful and improved understanding of terms and responsibilities.[6]

A second consideration when planning the group visit is how to address the patient who expresses hesitancy to engage in end-of-life discussions. Several care managers mentioned that males were more reluctant in their qualitative responses. Successful care managers reported having a specific purpose-

an upcoming procedure, surgery, or a recent death as a catalyst to prompt conversations. It may be ideal when considering future group visits to pursue male patients by emphasizing the need to address ACP around life events-new relationships, marriage, the birth of a child, surgical procedures, or hospitalization. It might also be beneficial to have a male provider or nurse invite male patients to determine if this would improve engagement.

In conclusion, the data from the surveys and interviews were favorable for nurse care managers to consider instructing patients in a group setting. Educating the patient in this environment may lead to meaningful conversations where patients can pause and reflect on their values, supporting them in creating advance directives that reflect their wishes. The opportunity for improved communication enhances both patient autonomy and synergy within the healthcare system. In considering future quality improvement, care managers may want to pilot a project to study male versus female engagement for ACP conversations to determine if there are differences or specific barriers acknowledged.

CONFLICTS OF INTEREST DISCLOSURE

The authors have no conflict of interest to disclose.

REFERENCES

[1] Momeyer M, Mion LC. Crucial conversations: Discussing advance care planning with older adults and their families. Geriatric Nursing. 2019; 40(4): 437-440. PMid:31320128 https://doi.org/10.1016/j.gerinurse.2019.07.004

[2] American Nurses Association. Position statement: Nurses' roles and responsibilities in providing care and support at the end of life [Revised position statement]. 2016. Available from: https://www.nursingworld.org/~4af078/globalassets/docs/ana/ethics/endoflife-positionstatement.pdf

[3] Medicine IO. Committee on Approaching Death: Addressing Key End-of-Life Issues. Dying in America: Improving quality and honoring individual preferences near the end of life. 1st ed. National Academies Press. 2015.

[4] California Healthcare Foundation. Final chapter: Californians' attitudes and experiences with death and dying [PDF]. 2012. Available from: https://www.chcf.org/publication/final-chapter-californians-attitudes-and-experiences-with-death-and-dying

[5] Lum HD, Jones J, Matlock DD, et al. Advance care planning meets group medical visits: The feasibility of promoting conversations. The Annals of Family Medicine. 2016; 14(2): 125–132. PMid:26951587 https://doi.org/10.1370/afm.1906

[6] Rabow MW, McGowan M, Small R, et al. Advance care planning in community: An evaluation of a pilot 2-session, nurse-led workshop. American Journal of Hospice and Palliative Medicine®. 2018; 36(2): 143–146. PMid:30153741 https://doi.org/10.1177/1049909118797612

[7] Bandini JI, Kogan A, Olsen B, et al. Feasibility of group visits for advance care planning among patients with heart failure and their caregivers. The Journal of the American Board of Family Medicine. 2021; 34(1): 171–180. PMid:33452095 https://doi.org/10.3122/jabfm.2021.01.200184

[8] Associates in Process Improvement. Quality improvement 102: The Model for Improvement: Your engine for change summary sheet. IHI Open School for Health Professions. 2012. Available from: http://www.ihi.org/education/ihiopenschool/Courses/Documents/QI102-FinalOnePager.pdf

[9] Institute for Healthcare Improvement. (n.d.). The conversation project. Available from: https://theconversationproject.org/

[10] Trochim PWMK. Descriptive Statistics. Research Methods Knowledge Base. 2020. Available from: https://conjointly.com/kb/descriptive-statistics/

[11] Kaur P, Stoltzfus J, Yellapu V. Descriptive statistics. International Journal of Academic Medicine. 2018; 4(1): 60. https://doi.org/10.4103/IJAM.IJAM_7_18