Changing the Patient's Perception of Need to Complete an Advance Directive

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Disclosures:

- None

Objectives :

- Discuss "**patient perception"** of Advance Directives
- Review research regarding **barriers**
- Examine The Health Belief Model and Pender's Health Promotion Model
- Evaluate Group Medical Visits $
- Our journey: Respecting Choices as a model

Poll Question

one vote per practice please

Does your practice currently INITIATE AD'S?

A. YES

B. NO

Poll Question

one vote per practice please

How comfortable are you/your providers in INITIATING AD conversations?

A. Very Comfortable
B. Some What Comfortable
C. Uncomfortable
D. Very Uncomfortable

The WHY:

- AD's improve the dying experience for nursing home residents and decreases the cost of end-of-life care while honoring residents' expressed wishes about health care (Galambos, 2017).
- The Centers for Medicare and Medicaid (CMS) reported that from 2002-2010 *medical spending for patients 65 to 84 years old grew 36%* and for those older than 85 years, old grew by 38% (Morrison, 2015).

Current State

- At present, there are **47.6 million** Americans over the age of 65 years, a number predicted to increase to *72.8 million by the year 2030* (Stevens, Flanagan, & Pedroff, 2017).
- 2012 study by the California Healthcare Foundation found that 82% of those surveyed believe it is important to have end-of-life wishes in writing yet only 23% had done so.*
- 2013 study conducted by *The Conversation Project*, 90% of people believe they should talk with their loved ones about end of life wishes, yet only 27% had actually done so.*

Barriers

- Lack of exposure to the subject
- Minority, race*
- Brown et al:
  - Young age, lower level of education,
  - disease-related interference with daily activities, and a higher level of death anxiety (Brown et al., 2016).
- Religious beliefs

Barriers

- Ingrained lack of urgency or need
- PCP discomfort with the subject “Overall, 97.5% of physician’s expressed comfort in discussing ACP yet reported discussing advance directives with only 43% of appropriate patients” (Snyder, Hazelett, Allen, & Radwany, 2013)

How to Change Perception?

KEEP TELLING YOURSELF THAT IT’S JUST A DOLPHIN….

How the Health Belief Model was Developed

- The model was developed in response to the failure of a free tuberculosis (TB) health screening program.
- When few adults came out for the free services, program organizers began investigating why more adults did not come out.
- Hochbaum, however, began to study what motivated the few who did come out. He quickly learned that their perceived risk of disease and perceived benefits of action were crucial factors in their motivation.

How the Health Belief Model was Developed

- The model was first presented with only four key concepts:
  - Perceived Susceptibility,
  - Perceived Severity,
  - Perceived Benefits, and
  - Perceived Barriers.
  - The concept of Cues for Action was added later to "stimulate behavior."
- Finally, in 1988, the concept of Self-Efficacy was added to address the challenges of habitual unhealthy behaviors such as smoking and overeating.

How to change perception?

- Can we modify “change perception” to provide Health Promotion?

How to change perception?

- Provide INFLUENCE—*Change PERCEPTION*,
- Example: conversation with someone of influence
  - Family
  - PCP
  - Clergy
  - Advertising/ incentives
- Call to Action: new health diagnosis

Pender's Health Promotion Model

- Dr. Nola Pender's model focuses on three areas:
  - individual characteristics and experiences;
  - behavior-specific cognitions and affect;
  - behavioral outcomes.

The Health Promotion Model makes four assumptions:

- **Individuals seek** to actively regulate his/her own behavior.
- Individuals, in all their biopsychosocial complexity, **interact with the environment,** progressively transforming the environment as well as being transformed over time.
- **Health professionals, such as nurses, constitute a part of the interpersonal environment, which exerts influence on people through their life span.**
- Self-initiated reconfiguration of the person-environment interactive patterns is essential to changing behavior

Other Options…

- Computer technology and software availability were evaluated. Easy-to-use, patient-facing advance care planning tools, without clinician-and/or system-level interventions, can increase planning documentation 25% to 35% (Sudore, Boscardin, Feuz, McMahan, & Barnes, 2017).
- The use of interactive computer programs can help African Americans engage in effective advance care planning, including creating an accurate advance directive document that will be shared with loved ones (Markham, Levi, Green, & Schubart, 2015).

Group Medical Visits:

- WHY? *PCP has the greatest influence on the patient motivation*
- May include additional family members
- Allows more time for discussion
- Billable (commercial= 99411)
- Office visit Advance Care Planning= 99497

Our Journey:

Community Health Network Indianapolis

- My DNP Project, asked “what are we doing?”
- Found very disparate work mainly in Palliative care
- Formed Workgroup, Selected RESPECTING CHOICES “first steps” as our model, sought funding,

Our Journey:

Community Health Network Indianapolis

- Phase One Goal: provide incentive to all 15,000 employees to attend ACP session
- Phase Two Goal: connect with area “community” religious and social groups to provide outreach

Summary

Questions/ Feedback

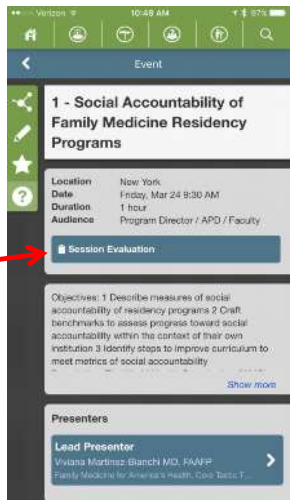
Poll Question:

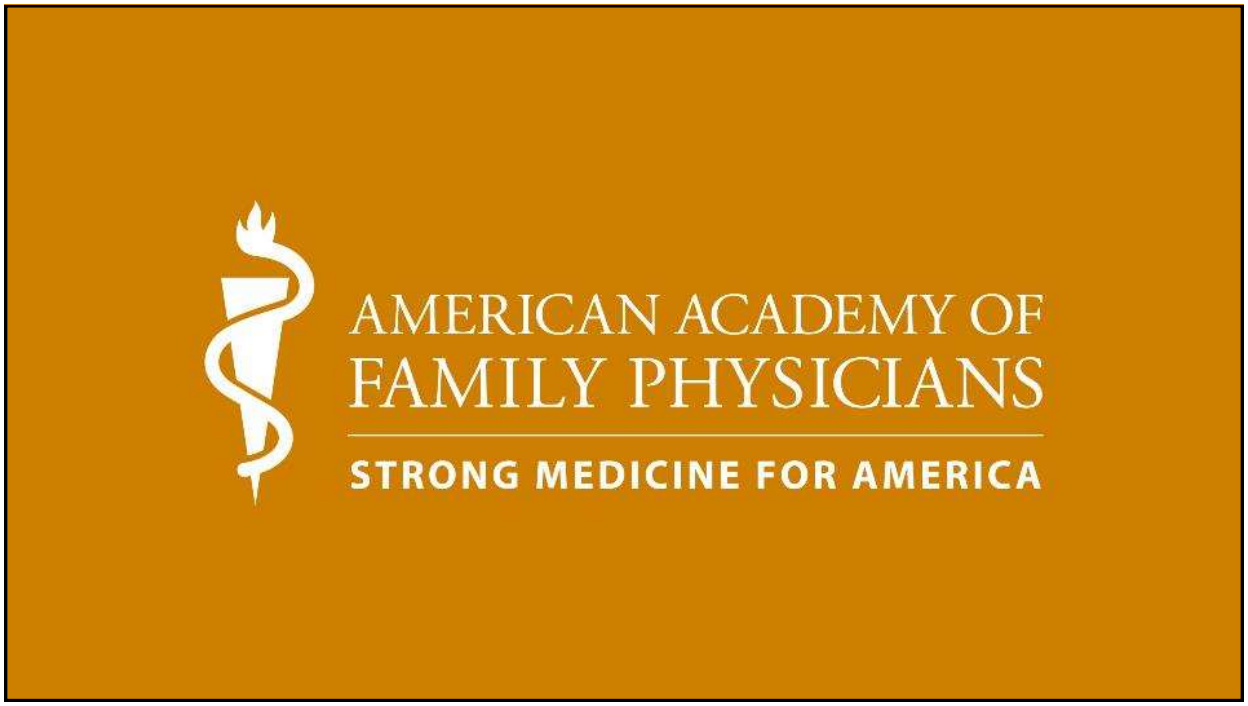
Enter your email address to be included in any follow-up communication from the presenter(s).

Please…

Complete the session evaluation.

Thank you.

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