

Rural Promising Practice: Transforming Advance Care Planning into an Atmosphere of Support and Communication

This model of care shows promise to increase rural Veterans' access to care and services, and is recommended for replication at other facilities.

Medical Issue

Advance Care Planning (ACP) is the process in which individuals think about and plan for future care and treatment should they become unable to make or communicate health care decisions for themselves.¹ These preferences can be documented in a written legal statement, called an "advance directive."² Department of Veterans Affairs (VA) medical facilities offer information on ACP and advance directives. However, many Veterans have not yet considered ACP or completed/updated their advance directives.

Access Challenge

Veterans cite barriers to completing ACP, such as time constraints, lack of provider expertise, travel, and health illiteracy.^{3,4,5,6} Consequently, the care that Veterans receive in situations where they are unable to communicate directly, may be quite different from what they would have wished.^{7,8}

Solution

To proactively engage more Veterans in ACP, the Central Arkansas Veterans Healthcare System (CAVHS) established an interactive, group-based ACP program. At the core of this program are facilitated group meetings that promote and foster open discussions about care preferences, values, and beliefs. These meetings, often embedded into established group visits and shared medical appointments, provide an intimate, relevant, and supportive atmosphere for Veterans to participate in meaningful conversations with other Veterans, family members, and health care professionals with ACP expertise (e.g., a social

worker, nurse, psychologist, or chaplain). Specially trained health professionals lead the discussions and offer one-on-one assistance to help complete advance directives. These group leaders follow up with Veterans to assist with problem solving and/or setting next steps. To address travel barriers, the ACP program is available to rural Veterans through telehealth technology.

At CAVHS, the ACP program has provided services to more than 1,500 Veterans and their family members. In one review of the program, 70 percent (306/437) of Veterans chose to initiate or revisit a step of ACP after attending a group meeting.⁹

By enhancing communication and discussing ACP with family members, Veterans can reduce potential emotional distress and discord regarding health care decisions and increase their likelihood of completing advance directives.

To Learn More

The U.S. Department of Veterans Affairs' (VA) Office of Rural Health (ORH) implements a targeted, solution-driven approach to increase access to care for the 3 million Veterans living in rural communities who rely on VA for health care. As VA's lead advocate for rural Veterans, ORH works to see that America's Veterans thrive in rural communities. To accomplish this, ORH leverages its resources to study, innovate and spread enterprise-wide initiatives through partnerships.

To discuss implementing a Rural Promising Practice at your facility or to learn more, visit www.ruralhealth.va.gov or email rural.health.inquiry@va.gov.

¹ National Hospice and Palliative Care Organization. (2017). Advance care planning. Retrieved from <http://www.nhpco.org/advance-care-planning>

² National Institute on Aging Information Center. (2012). Advance care planning: Tips from the National Institute on Aging. Retrieved from <https://www.nia.nih.gov/health/publication/advance-care-planning>

³ Hawkins, N.A., Ditto, P.H., Danks, J.H., & Smucker, W.D. (2005). Micromanaging death: Process preferences, values, and goals in end-of-life medical decision making. *Gerontologist*, 45, 107-117.

⁴ Hickman, S.E., Hammes, B.J., Moss, A.H., & Tolle, S.W. (2005). Hope for the future: Achieving the original intent of advance directives. *Hastings Center Report*, S26-S30.

⁵ Singer, P.A., Martin, D.K., & Kelner, M. (1999). Quality end-of-life care: Patients' perspectives. *JAMA*, 281, 163-168.

⁶ Braun, U.K., & McCullough, L.B. (2011). Preventing life-sustaining treatment by default. *The Annals of Family Medicine*, 9, 250-256.

⁷ Silveira, M.J., Kim, S., & Langa, K. (2010). Advance directives and outcomes of surrogate decision making before death. *New England Journal of Medicine*, 362(13), 1211-1218. Retrieved from <http://www.nejm.org/doi/full/10.1056/NEJMsa0907901>

⁸ Benson, W.F., & Aldrich, N. (2012). Advance care planning: Ensuring your wishes are known and honored if you are unable to speak for yourself. *Critical Issue Brief*, Centers for Disease Control and Prevention. Retrieved from www.cdc.gov/aging

⁹ Garner, K.K., Dubbert, P., Lensing, S., & Sullivan, D.H. (2016). Concordance between Veterans' self-report and documentation of surrogate decision makers: implications for quality measurement. *Journal of Pain and Symptom Management*, 53(1), 1-4.

