Implementation of Advance Directives Among Community-Dwelling Veterans

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Prevention of disability at the end of life, and maintenance of independence, self-determination, respect, and dignity are common themes in the literature on aging. Older adults report that independence and quality of life are the most important issues in old age (National Advisory Council on Aging, 1992). The importance of empowering older adults to gain greater control over their health and personal care, strengthening their role in decision making, and allowing them to make informed choices is being increasingly recognized. However, many older adults who become disabled are unable to make health or personal care decisions and must rely on others to decide for them.

Allowing older adults to retain control of the level of care they receive is important, because advances in medical technology have increased the capacity to sustain life despite debilitating illness. In acute, life-threatening illnesses, physicians often provide aggressive treatment to terminally ill patients who are unable to make their wishes known (Alemayehu et al., 1991; Tomlinson, Howe, Notman, & Rossmiller, 1990; Zweibel & Cassel, 1989). In many instances, people prefer less aggressive care for terminal conditions should a time come when they are unable to make their wishes known (Diamond, Jernigan, Mosesley, Messina, & McKeown, 1989; Molloy, Guyatt, Alemayehu, & McIlroy, 1991).

Until now, there have been few effective ways to allow older adults to control the level of care they receive, in the event of incompetence and when they are unable to make their wishes known. One mechanism that may ensure that the level of care received is consistent with the person’s wishes is the implementation of advance directives. Advance directives are frequently offered to residents on admission to many long-term care institutions in Canada. Seniors living in the community may also benefit from directive education prior to a medical crisis or placement in an institution. Unfortunately, few community agencies offer advance directives to their clients, and few individuals complete advance directives prior to medical events (Cugliari, Miller, & Sobal, 1995; Reilly et al., 1995; Terry & Zweig, 1994).

Ideally, directives should be considered and completed in informal settings before institutionalization or acute hospitalization. Layson and colleagues (1994) reviewed the literature regarding patient-physician practices and attitudes toward discussions about the use of life-support treatment and found many discrepancies between desired frequency of discussions and actual frequency. Inconsistencies
were also found as to when these discussions should occur. Elderly patients want these discussions when they are healthy; before they become ill; and before, rather than at the time of, hospitalization (Capron, 1990; Haisfield et al., 1994; LaPuma, Orentlicher, & Moss, 1991; Shore et al., 1993; White & Fletcher, 1991). These discussions can take place in informal settings with trained facilitators who educate patients and discuss their health care choices and treatment wishes. Ideally, patients, family members, powers of attorney (POA), and family physicians should be involved in the discussions.

Few data are available about the feasibility of systematically implementing directives in community-based settings. In a recent study in which visiting community nurses systematically implemented an advance directive program, 70% of chronically ill older people who were offered directives completed them (Patterson et al., 1997). This study also showed that nurses strongly supported patient autonomy (Molloy et al., 1997). Implementing directives in the community is possible and more information is desirable about the feasibility of different approaches.

In the present study, we collaborated with Veterans Affairs Canada (VAC) to examine the effectiveness of systematically implementing a directive program in the veteran community by educating VAC counselors to introduce the program to veterans. We noted the proportion of veterans completing directives after the implementation of the program and gathered feedback from veterans.

**Method**

**The Directive**

The “Let Me Decide” (LMD) advance directive (Molloy & Mepham, 1996) has an instructional component and allows for the nomination of a proxy. The directive is arranged in five sections: introduction, personal statement, health care chart, definition, and signature. In the introduction of the LMD, individuals state why they want to nominate their POA and express their wishes regarding levels of medical and personal care. The health care chart (Figure 1) provides explicit choices for treatment of life-threatening illness, cardiac arrest, and artificial feeding. Different treatment choices are made depending on whether people are in a reversible–acceptable or an irreversible–intolerable condition. The personal statement allows individuals to state what they would consider to be an intolerable or unacceptable condition. The definition section defines the terms used in the health care chart. The signature section contains the signature of the individual completing the directive, two witnesses, the family physician, and POA.

**Veterans Affairs Canada**

The pilot intervention was introduced by three VAC counselors working in separate geographic field areas (Fields 1, 2, and 3) in south central Ontario, Canada. VAC counselors act as home care case managers in the delivery of the Veterans Independence Program (VIP). The VIP offers veterans without substantial income assistance in personal care, meal preparation, housekeeping, ground maintenance, home adaptation, and transportation to day care facilities over and above that provided by publicly funded programs. Services are provided in response to clients' needs, as identified by multidisciplinary assessments, and delivered by service delivery teams including counselors or case managers, client support assistants, nurses, and physicians.

**Educational Training: Veterans Affairs Counselors**

Counselors attended a 2-day workshop and received extensive training using manuals and video- and audiotapes on the LMD program. They were also trained to assess capacity to complete advance directives. Role-playing allowed counselors to participate in and practice the LMD education process. Counselors were also informed about the study protocol.

After counselors educated a few veterans in the community, a clinical nurse specialist observed them in a typical LMD interview with a veteran and provided feedback. The nurse evaluated the counselors' skills and ability to facilitate the educational process. Counselors had regular contact with the study coordinators and attended regular focus group meetings in which they received ongoing education and an opportunity to discuss issues of concern. These meetings also allowed study coordinators to provide updates and discuss the progress in each field.

**Client Recruitment and Randomization**

Before we selected individuals to participate in the study, we screened veterans to exclude those who had moved to long-term care facilities or to adult residential care facilities, had demonstrated aggression toward VAC staff in the past, or were deemed ineligible for the VIP program on the basis of their personal income. In each field, 50 community-dwelling veterans receiving VIP benefits were then selected at random. Each veteran was exposed to the specific ad-
vance directive implementation strategy piloted in his or her field area.

Implementation Process

All veterans received a mailing of the LMD booklet and a letter of introduction explaining the purpose of the study. Before mailing the letter of introduction and booklet, counselors in Fields 2 and 3 called the study participants. They explained the purpose of the program and study and asked if the veterans were interested in receiving the mailing.

Two weeks after the mailing, all counselors followed up with phone calls to determine if veterans were interested in having a home visit to discuss the program and study in more detail. If a veteran in Field 1 agreed to a home visit, the counselor informed the veteran that a referral was going to be made to another counselor, “the directive expert,” who would then contact him or her to schedule a home visit. In Fields 2 and 3, the veteran’s counselor provided the education. The counselors encouraged the veterans to review the booklet before the scheduled visit and recommended that the veterans invite their POA to attend the education session. Counselors also invited the veteran’s spouse to complete directives if they were interested.

At the introductory visit, counselors provided detailed information about the program and study. If the veteran consented to participate in the study, veterans and families nominated proxies. Counselors then initiated the LMD education process and assessed the veteran’s capacity to complete an advance directive using a two-stage process. First, veterans completed the Standardized Mini-Mental State Examination (SMMSE; Molloy, Alemayehu, & Roberts, 1991). Those who scored 16 or more were deemed competent to be educated. Veterans who scored 15 or less were deemed incompetent to complete advance directives and were not educated. Second, after the education of veterans, counselors assessed veterans’ capacity to understand and appreciate the consequences of their health care decisions with the Screening Instrument to Assess Capacity to Complete an Advance Directive (SIACAD) (Molloy et al., 1996). This instrument is specific to the LMD directive and contains 24 questions with “yes,” “no,” or “don’t know” choices. Veterans who scored more than 15 on the SIACAD proceeded with the educational–directive completion process.

At the 6-month follow-up, we contacted veterans who were educated about directives to determine the status of the directive completion process and to obtain information regarding their attitudes about the use of advance health care directives.

Statistical Analysis

The number of completed directives and feedback from veterans obtained through follow-up calls are presented. We used descriptive statistics to present data and Pearson chi-square tests to compare proportions. Statistical significance was set at $p < .05$.

### Table 1. Participants’ Demographic Data

<table>
<thead>
<tr>
<th>Variable</th>
<th>$X$ or %</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>77.39</td>
<td>76.70–78.07</td>
</tr>
<tr>
<td>Male gender</td>
<td>96.67%</td>
<td>86.37–100.00</td>
</tr>
<tr>
<td>Married</td>
<td>69.33%</td>
<td>61.87–76.80</td>
</tr>
<tr>
<td>Income eligibility</td>
<td>53.33%</td>
<td>45.26–61.41</td>
</tr>
<tr>
<td>Low risk level</td>
<td>60.67%</td>
<td>52.76–68.57</td>
</tr>
<tr>
<td>Resides in a house</td>
<td>66.67%</td>
<td>59.04–74.30</td>
</tr>
<tr>
<td>Resides with someone else</td>
<td>74.67%</td>
<td>67.63–81.71</td>
</tr>
</tbody>
</table>

$^a$ Mean for continuous data, percentage for categorical data.

$^b$ 95% confidence interval around the mean or percentage.

### Results

Veterans’ demographic characteristics are shown in Table 1. Because we found no differences across areas, participants from all three areas are combined into one table. All veterans contacted before the mailing (Fields 2 and 3) wished to receive the mailing. Of the 150 veterans contacted, 34 reported having a POA in place. These veterans did not see the value of completing the LMD and were removed from the analysis.

Of the remaining 116 veterans contacted, 82 (71%) expressed interest in meeting counselors to receive more information. Sixty-seven of these 82 (82%) veterans were educated. The remaining 15 (18%) had not made a decision by the end of the waiting period. All veterans educated were competent to complete advance directives. Figure 2 outlines study implementation results.

Of 49 veterans who refused to be educated, 19 (39%) cited personal reasons for refusal to be educated, 14 (29%) cited personal or family illness, and 2 (4%) felt uncomfortable discussing the topic. Seven (14%) veterans said their family would make these decisions for them, 4 (8%) wanted to discuss the di-

![Figure 2. Systematic implementation of the Let Me Decide directive program.](image-url)
rective with their lawyers first, 1 (2%) wanted to discuss with his or her doctor first, 1 (2%) family member said no, and 1 (2%) veteran moved out of district.

Forty-one (35%) of 116 veterans completed directives with a counselor and 1 (1%) completed a directive by him or herself. In total, 42 (36%) completed a directive.

We found different rates of directive completion across the fields of the 116 veterans who did not have a preexisting POA. In Field 1, 10 (26%) of the 39 veterans completed a directive; in Field 2, 6 (17%) of the 35 veterans completed a directive; whereas in Field 3, 26 (62%) of the 42 veterans completed a directive, $\chi^2(2, n = 116) = 19.40, p < .001$. The Field 3 counselor appeared to be more effective than Field 1 and 2 counselors. Seventy-four (64%) of the 116 veterans offered an opportunity to complete an advance directive failed to do so.

We also examined differences in total directive completion (new plus existing POAs), because the proportion of veterans with existing directives may have affected the directive completion rate across fields. At the end of the study, the number of veterans with directives in Fields 1, 2, and 3 (50 veterans in each field) were, respectively, 21 (42%), 21 (42%), and 34 (68%). This difference reached statistical significance, $\chi^2(2, n = 150) = 9.01, p = .011$.

Counselors made follow-up calls to the 67 veterans who were educated, and 38 (57%) responded. Of the 38 who responded, 20 (53%) had initiated a directive and 18 (47%) had not completed a directive. Of the 20 who initiated directives, 10 (50%) had discussed it with their physicians and 15 (75%) had discussed it with their families. All 20 (100%) who initiated a directive reported that the education they received regarding directives was beneficial, and similarly, all 20 (100%) reported that VAC should introduce this program to other veterans. Among the 18 respondents who did not complete a directive, 17 (94%) had discussed it with their physicians and 17 (94%) had discussed it with their families.

**Discussion**

This study has shown that veterans are interested in learning about advance directives. Every veteran contacted wanted to receive the mailing, and more than half of the participants wanted more information after receiving the mailing. Of those who received more information, 80% were educated about directives. Eventually, 42 new directives were completed, in addition to the 34 preexisting POAs, ensuring that more than half of all veterans had directives in place at follow-up.

Veterans exhibited a variety of responses to the program despite the initial interest. Some welcomed the opportunity to complete the directive, whereas others received the education but did not complete the directive. Others simply refused the education. Several reasons were identified to explain this response pattern. Some veterans already had a POA in place and may have believed that they were inter-changeable and LMD was not necessary. Education may have dispelled this misconception. Many veterans had already gone to a lawyer and believed they had what they needed. They did not want to go through the process again. Others believed that their family or others should make these decisions for them. And many others simply stated personal reasons.

In the extant literature, several variables associated with directive completion have been identified. Directive completion is more likely in younger individuals (Patterson et al., 1997). Thus, higher or lower rates of completion could have been achieved at different times in these veterans' lives. In addition, gender, education, and ethnicity are related to willingness to complete directives (Eleazer et al., 1996; High, 1993; Luptak & Boul, 1994; Rubin, Strull, Falkow, Weiss, & Lo, 1994). Furthermore, many older adults have difficulty thinking about end-of-life issues. Some individuals think that negative thoughts can create negative outcomes (Carrese & Rhodes, 1995) and that truth telling is not always desirable (Frank et al., 1998).

We also found considerable variation in directive completion rates across counselors. The characteristics of the veterans serviced by these counselors were fairly similar and are not likely to explain these differences. Also, the differences in implementation protocols are unlikely to explain the outcome differences. Individual variability in practice style, comfort with the directive, caseloads, and commitment to the project may explain some of the directive completion variability. In a community setting in which nurses implemented directives, we found that some nurses had a larger number of clients with completed directives, independent of clients' characteristics (Patterson et al., 1997).

For VAC counselors, this type of program requires an enormous time commitment if provided routinely to clients. Given their large caseloads, counselors' time constraints may be the major stumbling block in introducing this type of program. Time constraints are associated with fewer directives completed (Molloy et al., 1997). Referral to a directive specialist within the agency, or purchase of services from outside experts, may be the best model to implement this type of program. Sixty-six percent of nurses sampled in a different study supported this model (Molloy et al., 1997).

Among veterans contacted at follow-up, the majority reported that the education component was useful and recommended that VAC offer the directive program to all veterans. Although the sample was small and limited to veterans who were educated about directives, even those who refused to complete the directive shared these opinions. This suggests that the education component provided has considerable value by itself.

This study had limitations. First, the follow-up period was short. The 6-month follow-up period may have been too short to obtain a clear picture of directive completion over time. Older adults require time to think about these issues and to discuss them with
their family and family physicians. Second, implementation of this program was dictated by a tight study timeline, and the results may not reflect normal practice. Counselors were trained and immediately given a list of 50 clients to contact and educate about advance directives, on top of their busy workloads. They had limited time to learn how to approach veterans and how to integrate the program into their practice. Normally, counselors would introduce a program like this when the opportunity arose or when they believed the veteran was ready. This may have affected acceptance of the program. The integration of advance directives into individualized care planning and the provision of adequate time for counselors to educate and complete directives with their clients would likely improve directive completion over time.

The results of this study are encouraging because 67 (81%) of the 82 interested veterans were educated about advance directives. The number of veterans with some form of directive doubled at the end of the study, totaling more than 50%. Given the limited success of advance directive interventions on improving communication between patients and health care workers (Teno et al., 1997) or improving health care provider compliance (Dans et al., 1991), this study showed that the systematic implementation of the LMD advance directive program among veterans is worthwhile. Future research should focus on the implementation of advance directive programs within more realistic time frames and determine which veterans’ and counselors’ characteristics, if any, affect willingness to complete advance directives.

References


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