# Increasing Advanced Care Planning in the Outpatient Setting

Stefanie Abbott, DO and Amy Steinhauer, DO
Crozer Family Medicine Residency, Philadelphia PA

## Introduction

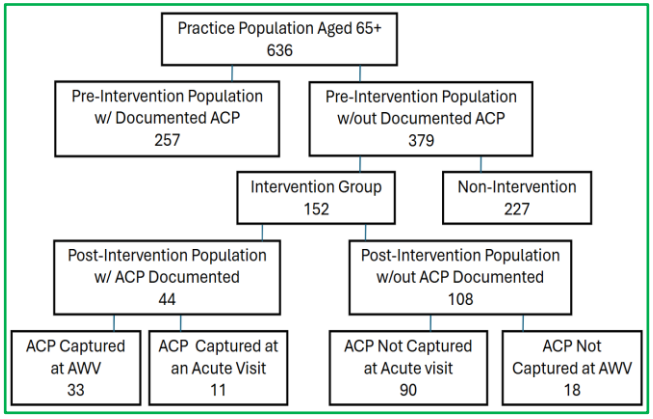
This quality improvement project aims to increase the rate of advanced care planning (ACP) discussion and documentation for patients ages 65+ within a family medicine residency practice. ACP discussions help ensure patients' values and preferences concerning their medical care are honored regarding end-of-life. This topic is often under-discussed and documented. Through enhancement of documentation of ACP discussions, providers can better align current or future medical care to patients' medical wishes and values.

## Methods

A retrospective review. The intervention involved an ACP educational lecture for residents on 08/27/2024, with the lecture emailed one week later to all residents. "Dot phrases" were introduced to standardize and facilitate EMR documentation. The intervention period continued until 11/06/2024, when a post-intervention report was generated. There were 643 patients who met inclusion criteria (current practice patients aged 65+ seen within the last 3 years), however 7 patients were later excluded due to missing data. 257 (40%) had previously documented ACP discussions while 379 (60%) did not. From the 379 patients, 152 were seen during the intervention period, leaving 227 who were not seen. Of the 227, 156 were due for a wellness visit either before or during the intervention. Results analyzed using chi-squared method.

## Results

ACP documentation was newly completed for 44 of the 152 intervention group patients, reflecting a 29% improvement among the previously undocumented group (p-value<0.0001). Furthermore, 33 of these 44 ACP discussions took place during annual wellness visits (p-value<0.0001). For 108 of the 152 intervention group patients, there was no post intervention documentation of ACP discussions. Notably, 83% (90) of the 108 patients not documented post-intervention were seen for an acute visit only. For those not included in the intervention, 68% were due for a visit before 11/2024 (end of intervention).




## Resources

AMA Code of Medical Ethics - Advance Care Planning. code-medical-ethics.ama-assn.org. Accessed August 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/advance-care-planning
Quinn T, Morgan A, Mullen D, Pine D. Advance Care Planning: Using the Health Care Team to Make Hard Conversations Easier. Family Practice Management. 2022;29(3):10-14. Accessed October 2024. https://www.aafp.org/pubs/fpm/issues/2022/0500/p10.html#fpm20220500p10-b1
Sabatino CP. The evolution of health care advance planning law and policy. Milbank Q. 2010;88(2):211-239. doi:10.1111/j.1468-0009.2010.00596.x
Yadav KN, Gabler NB, Cooney E, et al. Approximately one in three US adults completes any type of advance directive for end-of-life care. Health Affairs. 2017;36(7):1244-1251. doi:https://doi.org/10.1377/hlthaff.2017.0175

## Conclusion

This project illustrates the effectiveness of targeted education and standardized documentation in enhancing ACP discussions, especially during the annual wellness visit. By equipping providers with both knowledge and practical resources, this intervention facilitated a substantial improvement in ACP engagement, contributing to a more patient-centered approach to care. Despite these improvements, there are areas for further patient engagement. There was a small population that did not have documentation at annual wellness visits. There is also a large part of the patient population in the non-intervention group that should have been seen during the intervention period, but were not. In future quality improvement projects, it would be beneficial to thoroughly review patients in this category that are lost-to-follow up and evaluate methods to encourage attendance of these visits. Future initiatives may integrate ACP training into residency programs, to ensure patient's values and goals towards end-of-life care are being honored.