Let's Talk About Death, Baby; Let's Talk about A-C-P: A Clinic-Based QI Project

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Background

- Advanced Care Planning (ACP) helps patients anticipate and navigate serious illness and end-of-life decisions
- Advanced Directives are useful but confusing
- Incorporating this into clinic workflow is challenging

Aims

- Improve resident comfort with ACP conversations
- Improve documentation of ACP encounters and updated SDMs
- Encourage patient completion of advanced directives

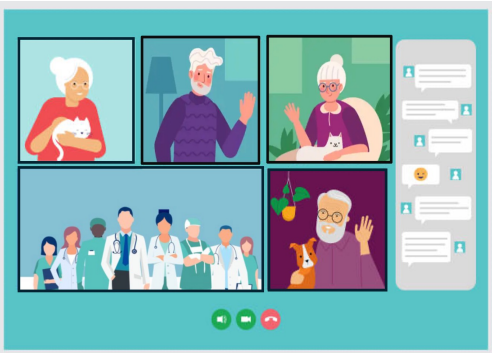
Participants

- FM Residents, PGY 1-4 at a single clinic (n=13)
- Our patients, age 65+ in an urban, hospital-affiliated family medicine clinic (n=406)

Methods

- Resident surveys
- Didactic sessions
- EHR Quality Metric Data
- PFAC

Patient Family Advisory Council (PFAC)



- 9 patient attendees
- Virtual Interview
- Queried opinions and preferences regarding ACP
- Proposed solutions and solicited feedback

Outcome Data

- 210% increase in ACP documentation (3% → 6%)
- 15% of patients have AD's in EHR, +4 during timeframe
- Patients want help with ACP and ADs, open to many formats
- 2 formal teaching sessions
- Completing our own ADs

Impact of Clinic-Based Didactics

Resident Comfort (Not at all / Very little / Somewhat / Very much)	Before (Sept)	After (April)
Accessing OR AD		
Completing an AD		

Discussion

- ACP is a component of high-quality primary care
- Didactics improve provider comfort
- Documentation gaps exist; integrated EHR tools can help
- Completion and upload of Advanced Directives takes work
- Opportunities to address this further are abundant

Limitations

- Only patients ≥65 and population changed between analyses (turning 65, death)
- PFAC not representative sample

Future Directions

- Integration of ".acp" into note template
- Offer dedicated ACP visits beyond Annual Medicare Wellness Visit
- ACP group visits and community Advanced Directive workshops