Navigating Tomorrow: Increasing Advance Care Planning Engagement in Primary Care Using the Institute of Healthcare Improvement Model for Improvement

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BACKGROUND

- Older adults (ages 65 and above) without advance care planning (ACP) are at elevated risk for futile care—high-cost, low-benefit interventions such as CPR or intubation—often misaligned with personal values (Leak et al., 2021; Rakhshan et al., 2022).
- 69% of older adults need healthcare planning, yet many lack ACP despite chronic conditions and health decline (Kahana et al., 2019)
- Establishing ACP reduce futile medical interventions and empowers individuals to define their end-of-life care preferences
- Assessing ACP readiness can support complex and sensitive conversations, promoting patient-centered care that aligns with individual preferences

ABSTRACT

- A 60-day chart review (*N = 33*) and four biweekly plan-do-study-act (PDSA) cycles were conducted using the Institute for Healthcare Improvement's Model for Improvement to integrate ACP readiness screening into annual wellness visits and complete physical exams
- A workflow modification enabled rooming staff to distribute ACP screening surveys and State of Connecticut ACP packets during annual wellness and complete physical exams.
- Patient health information, workbench reports, and provider documentation were reviewed; ACP survey completion and packet distribution were monitored using a designated binder and audit tool.
- Weekly check-ins with rooming staff provided qualitative insights that informed iterative workflow enhancements to support ACP engagement.

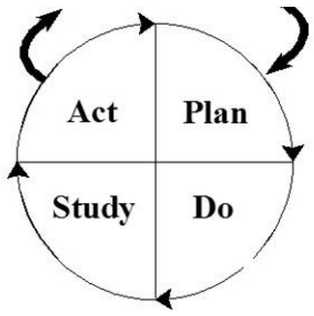
AIM

Over eight weeks, I aimed to screen 50% of patients 65 and above for readiness to engage in ACP during annual wellness visits or complete physical exams

METHODS

- Local teaching primary care practice
- Implemented a workflow change, distributing validated ACP engagement readiness surveys to patients 65 and above during annual wellness visits or a complete physical exam
- Descriptive statistics were used to quantify project measure completion rates and identify trends during four biweekly PDSA cycles.

Figure 1 *PDSA Cycle*



RESULTS

Figure 2
New Advance Care Planning Workflow

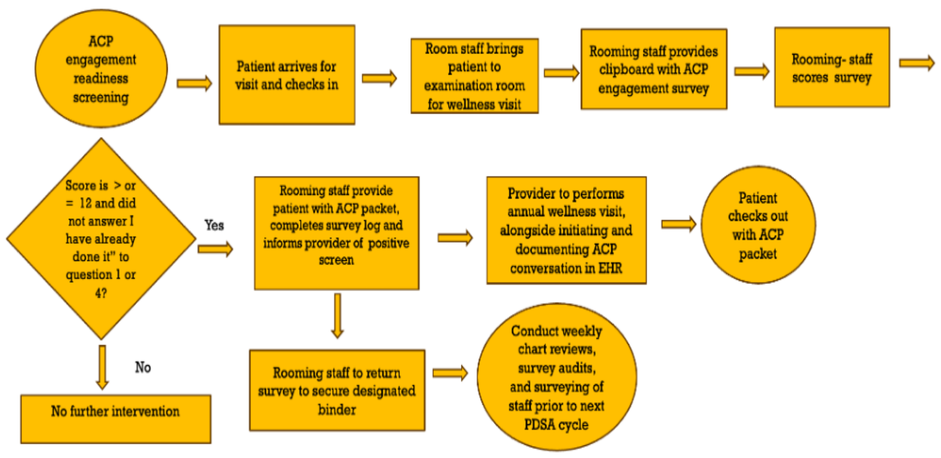


Table 1
Statistical Analysis

Measures	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Average
Outcome	50%	50%	28.5%	37.%	66.7%	16.7%	33.3%	50%	41.6%
Process (1)	50%	50%	28.5%	37.%	66.7%	16.7%	33.3%	50%	41.6%
Process (2)	100%	100%	100%	100%	100%	100%	100%	100%	100%

ANALYSIS

- The adapted workflow did not fully integrate with the primary care practice, limiting effectiveness
- The specific aim of this project was not achieved, as only 41.6% (*N = 62)* of participants were screened
- The second process measure achieved a 100% completion rate (*n = 15*), demonstrating strong feasibility for future implementation, as all positively screened patients were successfully engaged in ACP.
- Although the screening target was not met, the intervention demonstrated feasibility and sustainability, with potential to enhance ACP engagement, support patient-centered care, and reduce the incidence of futile medical interventions.

CONCLUSION

- Despite the limitations of this project, its replication appears practical and sustainable
- Broader stakeholder input from providers and residents may have revealed barriers or opportunities to improve screening rates
- Survey bias may have been introduced due to the instrument being available only in Dutch, English, Italian, Japanese, and Spanish
- Assessing readiness for ACP engagement in primary care settings can promote meaningful, patient-centered discussions about individualized healthcare goals.

REFERENCES