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Standardizing Advance Care Planning Documentation During Medicare Wellness Visits in a Primary Care Setting: A Quality Improvement Initiative

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ABSTRACT

Introduction:
At our institution, advance care planning (ACP) discussions during Medicare Annual Wellness Visits (MAWVs) were inconsistently documented. While providers often discussed patient wishes, these discussions were often not documented. Standardization of ACP language and documentation provides a foundation to improve communication of patient ACP discussions between outpatient and inpatient settings.

Materials and Methods:
We conducted a quality improvement (QI) initiative in an academic center aimed at improving ACP documentation. A standardized documentation template was developed and embedded in the electronic medical record (EMR), automatically routing content to the ACP section of the chart. Four Plan-Do-Study-Act (PDSA) cycles focused on provider education, ACP lecture series, mid-level education and patient education were conducted. Outreach to patients via MyDirectives.com and integration with Chesapeake Regional Information System (CRISP DC), a city-wide health information exchange enabling secure sharing of ACP records across institutions.

Results:
At baseline, ACP tool utilization was 0%. Following template implementations and PSDA cycles, utilization increased to 12.9% after PDSA 1, 17.8% after PDSA 2, 24.20% after PDSA 3 and 39.70% after PDSA 4. Providers reported improved workflow integration and greater confidence discussing ACP. Documentation also became more visible and accessible across care settings.

Conclusion:
Implementation of standardized ACP documentation templates in the EMR ensures consistency, clarity and accessibility of patient preferences. Future efforts include implementing the ACP documentation template in inpatient workflows, uploading relevant legal documentation into the EMR, and expanding sharing through regional and nationwide platforms to ensure end-of-life wishes are honored across all points of care.

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Introduction

ACP has become a vital process in the United States health system that allows individuals to express their values, goals, and preferences regarding future medical care. It plays a critical role, especially in the care of an aging population and addressing the growing burden of chronic disease in the United States (1). This process ensures that treatment aligns with patient wishes during times when individuals may be unable to communicate for themselves (2). ACP has demonstrated improved patient satisfaction, reduced unnecessary interventions, and enhanced alignment between care delivered and patient goals, however, ACP remains underutilized in ambulatory care settings across the United States (2)

MAWVs present a unique opportunity to integrate ACP into routine care, recognizing their importance in promoting preventive and patient-directed care. However, in practice, ACP conversations during MAWVs are often omitted or improperly documented. Barriers include limited provider training, time constraints, discomfort discussing end-of-life issues, and the lack of standardized documentation workflows(3). Even when ACP is addressed, documentation is frequently fragmented in the EMR, making it difficult for other clinicians to locate and use the information when it is most needed (4).

Academic primary care clinics face additional challenges in documenting ACP(5,6). Frequent changes in rotating residents and high patient turnover contribute to documentation inconsistency and lack of standardization, yet the educational environment provides a friendly environment for system-level interventions led by trainees. Resident-led QI efforts can promote sustainable practice changes while reinforcing core competencies in patient communication and system-based practice. Studies in the past have shown that standardized template improve documentation of this types of conversation(7). Based on this context, we designed and implemented a multi-faceted QI initiative at a university-affiliated internal medicine clinic aimed at standardizing ACP documentation and improving its visibility within the EMR. Our approach focused on integrating a simple SmartPhrase tool into provider templates, delivering targeted education to residents, faculty, and advanced practice providers, and engaging patients through outreach. By aligning clinical workflow, provider training, and patient communication, we sought to improve ACP documentation during MAWVs in a sustainable and standardized way.

Materials and Methods

This QI initiative was conducted at an academic primary care clinic between June 2023 and March 2024. The clinic serves a diverse Medicare population and functions as a teaching site for internal medicine residents. The aim was to improve ACP documentation during MAWVs by embedding a standardized process in the EMR and delivering layered educational interventions.

To address inconsistencies in documentation, a multidisciplinary team of internal medicine residents, attending physicians, and hospital faculty leadership collaborated to create a standardized workflow that could be easily integrated into every-day clinical practice. A cohort of internal medicine residents who routinely conducted MAWVs and directly observed inconsistencies in ACP documentation participated in the development and implementation of the initiative. Additional hospital faculty were incorporated to ensure broader expertise, supervisory insight, and alignment with institutional workflows. At the core of this effort was the development of a customized documentation template built into EPIC using the SmartPhrase tool. The ACP SmartPhrase template was developed to guide providers through structured documentation of ACP elements during clinical encounters (Figure 1).

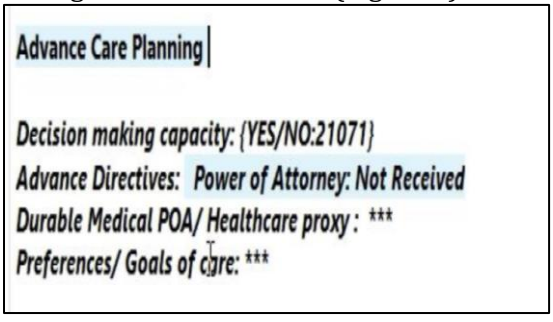

Figure 1. Advance care planning template

The template includes prompts for assessing a patient's decision-making capacity and for recording whether advance directives, such as a Power of Attorney, have been received. This guide also serves as a baseline for the patient's wishes in an absence of a durable medical power of attorney or health care proxy, as well as the patient's stated preferences and goals of care. By standardizing the language and location of this information within the electronic medical record, the template promotes consistency and ensures that important care preferences are visible and accessible across healthcare settings.

Implementation of this QI initiative occurred through four sequential PDSA cycles to record and track the implementation of the ACP documentation tool (Figure 2).

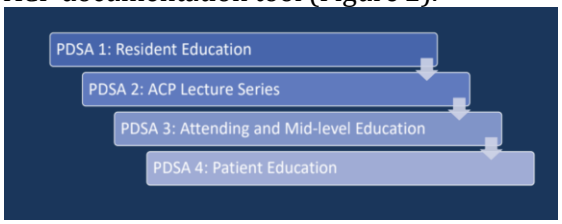

Figure 2. PDSA Cycles

PDSA cycle 1, focused on residents' education. Residents participated in a structured ACP training session covering ACP principles, assessment of decision-making capacity, goals-of-care communication techniques, and EMR documentation requirements. Live lectures of the ACP SmartPhrase within EPIC utilization was provided, and a one-page quick-reference guide summarizing key ACP elements and documentation steps was distributed. PDSA cycle 2, expanded via educational efforts to attending physicians and advanced practice providers through a lecture addressing clinical, ethical, and billing components of ACP. Examples of appropriate documentation were reviewed, and workflow walkthroughs demonstrated proper use of the ACP tab and Smart Phrase routing. Frequently asked questions and quick tips were distributed through email and posted in clinic workrooms to promote uniform adoption across the care team. PDSA cycle 3, targeted attending physicians and advanced practice providers to promote consistent use of the standardized documentation process across the entire care team. PDSA cycle 4, centered on patient engagement, multiple efforts were implemented to encourage active engagement with ACP. A standardized EMR dot phrase containing ACP instructions, resources, and relevant links was incorporated into routine health maintenance visits. This provided patients with guidance on completing and uploading advance care documents. Patients with active MyChart accounts also received pre-visit messages encouraging them to reflect on ACP preferences and complete or upload advance care documents, including electronic forms from MyDirectives.com. During clinic visits, patients were offered printed DC Medical Orders for Scope of Treatment (MOST) forms. Providing these materials in person supported patient understanding and increased the likelihood of completing and submitting legally recognized documents. These documents were linked to the regional health information exchange (CRISP DC), enhancing accessibility across care settings. Throughout the intervention, documentation rates were tracked monthly. Stakeholder feedback was incorporated in real time to refine implementation and address barriers.

Ethics

This initiative met criteria for quality improvement and was not considered human subjects research under institutional policy; therefore, formal IRB review was not required.

Results

Over a nine-month period, the implementation of a standardized ACP documentation process during MAWVs led to a sustained increase in documentation rates. At baseline in June, there were zero documented ACP discussions out of 275 eligible visits (0%) Figure 3.

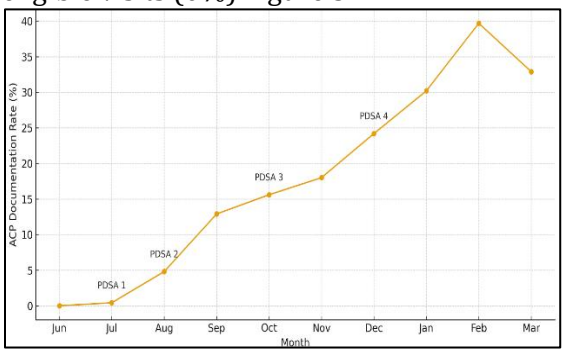

Figure 3. ACP Documentation Rates Over Time

PDSA Cycle 1, launched in July, focused on educating internal medicine residents on ACP principles, EMR navigation, and use of the newly created SmartPhrase. Following this initial effort, documentation increased marginally to 0.42% (1/240).

In PDSA Cycle 2, implemented in August and September, educational efforts expanded to include attending physicians and advanced practice providers, while workflow support was reinforced through EMR template customization. These efforts were associated with documentation rates rising to 4.8% (16/336) in August and 12.9% (36/280) in September. PDSA Cycle 3, initiated in October, Focused on reinforcing documentation practices among attending physicians and advanced practice providers. Educational materials distributed through MyChart, and MyDirectives.com were promoted to encourage patients to initiate ACP conversations and complete advance directives. Documentation continued to increase, reaching 15.6% (53/339) in October and 18.0% (53/298) in November.

In December, the rate rose to 24.2% (77/318), and in PDSA Cycle 4, which focused on reinforcing documentation practices and ensuring use of the ACP tab rates peaked in January and February at 30.2% (56/185) and 39.7% (83/209), respectively. In March, the rate remained steady at 32.9% (75/228), representing a more than 75-fold increase from baseline. Throughout the initiative, ACP documentation was automatically routed to the designated ACP tab in EPIC, ensuring visibility across clinical settings. Providers reported improved comfort and consistency in documenting ACP using the structured SmartPhrase, and patient engagement through MyChart contributed to growing awareness and initiation of ACP conversations. While the project did not formally assess conversation quality or patient outcomes, the significant and sustained increase in documentation reflects successful integration of ACP into routine preventive care workflows.

Discussion

In this QI project, our internal medicine residents and attendings successfully developed and implemented an EMR-integrated documentation tool that introduced a standardized template for ACP during MAWVs. This intervention made a more accessible approach for physicians to initiate and record these important conversations, ensuring that patients' preferences are captured consistently and stored in an accessible location within the electronic medical record.

Several recent studies have developed and tested standardized ACP initiatives in primary care to improve consistency of documentation, increase ACP discussions, and integrate ACP into routine clinical workflows. For example, Henage et al. implemented interprofessional ACP training across 13 ambulatory clinics, redesigned clinic workflows, and used quality improvement coaching; the intervention more than doubled the frequency of ACP discussions and increased the number of ACP documents appropriately incorporated into the electronic medical record(8).

Similarly, Sandoval et al., used a clinic-level quality initiative across nine primary care clinics. They embedded ACP form completion into preventive care protocols, built standardized workflows for printing and distributing health care agent forms, and achieved a sustained increase in ACP form completion rates that was several-fold higher post-implementation (9). Other initiatives with a similar approach reported positive results, noting that the structured format improved comprehensiveness and reduced omissions compared with usual documentation practices (10).

Further continued efforts should prioritize education for both healthcare providers and patients to emphasize the importance of ACP. The use of structured templates for documenting ACP improve consistency and comprehensiveness of records compared with free-text notes, highlighting the value of standardized tools in reducing variability and omissions in ACP documentation (7).

Ongoing education in both inpatient and outpatient settings, through oral presentations, case-based discussions, and interactive workshops, can help build a culture in which patient goals and values are consistently prioritized in medical decision-making. These conversations allow patients to articulate their goals, values, and preferences regarding future medical care.

They also support physicians in aligning treatment decisions with what matters most to the patient. For providers, clear documentation of ACP can reduce uncertainty during complex clinical situations and promote more person-centered care.

This initiative offers an adaptable model that can be translated to other clinics and healthcare settings with minimal resource investment. Since the standardized documentation tool was built using widely available EMR features, such as SmartPhrases and ACP tabs within EPIC, it can be easily replicated at institutions that use similar platforms. Even in systems with different electronic medical records, the underlying principles of workflow integration, provider training, and patient engagement remain applicable.

Embedding ACP documentation into routine preventive care and emphasizing its relevance across different specialties and other practices can promote meaningful conversations, improve documentation consistency, and ensure that patient preferences are honored in a variety of clinical environments. Integration of platforms like CRISP DC, or other regional health information exchanges, can significantly impact ACP documentation and allow patients to have secure healthcare information at a statewide or larger level. A regional/national exchange of information can positively affect patient care in a multiple of health-related concerns. Utilization of these types of platforms can ensure patients to have consistent aligned information in multiple healthcare settings.

During this study we ran into a few limitations, first, we did not measure the quality of these conversations, patient health literacy is a vital part of ACP as patients must be able to truly understand what this means in terms of their health. Second, practical barriers like time limitations during the MAWVs could have affected the outcomes of this study.

Despite these limitations, this study was able to increase the frequency of ACP documentation during MAWVs. While implementation required adaptation of EMR workflows, the approach was feasible and scalable within an academic primary care setting. Continued emphasis on education, workflow integration, and collaborations with platforms like CRISP DC can help sustain and expand the impact of these efforts.

Conclusions

This QI initiative successfully standardized advance care planning documentation during MAWVs through EMR integration and educational interventions. The intervention significantly improved documentation rates and enhanced provider confidence and workflow efficiency. Broader adoption of structured ACP tools may help ensure patient preferences are respected across care transitions.

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