

BACKGROUND

- Shared decision making is an essential part of medicine
- Allows a physician to promote and improve quality of life
- Physicians should ensure that patient's values and goals are aligned with their hospital care.
- One of the most important components of a hospital admission should be addressing their goals of care.
- It becomes important to avoid non-beneficial and unwanted aggressive high-intensity care especially when there is already high stress on health care workers.

“There are many reasons why patients may receive unwanted care but a key one is a lack of communication between patients, families and healthcare providers.”

Addressing goals of care starts in the primary care setting as PCPs have ongoing long standing relationships with patients. Patients' social, ethical, medical and economical factors should be honored when goals of care are discussed.

METHODS

This study aims to review data advance care planning in a community based Family Medicine associated Federally Qualified Health Center (FQHC) in sub-urban New Jersey
Data gathering from our outpatient EMR system in a community based FQHC in central New Jersey.

Inclusion criteria: 65 and older active patients from Jan 2018 till March 2021 who had POLST and advance directives and/or billing codes 497 and 498

RESULTS

1883 patients met inclusion criteria
45 patients out of 1883 had ACP visits
Approximately **2.4%** patients had ACP visits between January 2018 to March 2021.

What are the next steps?

COMMUNICATION
IS A TWO-WAY
STREET !

DISCUSSION



Based on the results, it is evident that there needs to be stronger promotion for advanced care planning in the outpatient setting.

It is important to assure patients that understand that advanced care planning is a discussion that can involve their loved ones.

New Jersey has the most ethnically diverse healthcare provider population and the third most diverse patient population in the US. It is vital for patients, families, and providers to be mindful of ethnic or cultural differences to ensure that treatment decisions genuinely follow the patient's goals of care.

FUTURE DIRECTION

Create an intervention that increases the amount of advanced care planning visits within the next 6 months and the long term goal is to measure the visit in a one year time span. We will focus on increasing the POLST completion and increase in ACP planning visits. The aim is to introduce advance care planning to patients using resources such as those available from Goals of Care Coalition of NJ and the Conversation Project.

REFERENCES

- POLST better than traditional advance directive:
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