

Marta Kazandjian, MA CCC SLP BCS-S

Maureen Peters, ACSW, LCSW, ACHP-SW; Fernando Kawai, MD, FACP; John Zaravinos, MD; Michael Gale, MD; Cynthia X Pan, MD, AGSF, FACP

## BACKGROUND

Seriously ill patients with complex medical problems undergo many transitions across hospital and NH. These patients experience reduced continuity of care as important goals of care information may not be transmitted.

Silvercrest Center for Nursing and Rehabilitation (SCNR) is a 320 bed post acute facility that contains 90+ vent/ pulmonary beds, with chronically, critically ill patients at high risk for recurrent admissions. SCNR is closely affiliated with New York Presbyterian/Queens (NYPQ) where the hospice & palliative medicine (HPM) fellowship is based.

We used the hospital HPM fellowship training model to link the interdisciplinary team (IDT) in the NH to the palliative care IDT at the hospital. ACGME mandates NH rotation for HPM fellows. A typical rotation in a NH would be brief, e.g., one month. We chose a longer, longitudinal experience (weekly, half-day, rotation over a year) to provide continuity for both patients and physicians. This exposure allowed fellows to develop relationships and continue goals of care discussions as patients transferred between NH and hospital, as their disease progressed. This also allowed conversations to continue when initiated at either site when patient/families were not ready to make decisions.

## OBJECTIVES

- 1) To illustrate a unique model for integrated palliative care services across NH and hospital. It uses HPM fellowship rotations to foster IDT relationships between hospitals, fellowship programs and NHs.
- 2) To measure number of hospitalizations among NH patients before and after IDT palliative care consults.
- 3) To measure the number of advance directives completed in NH patients before and after palliative care consults.

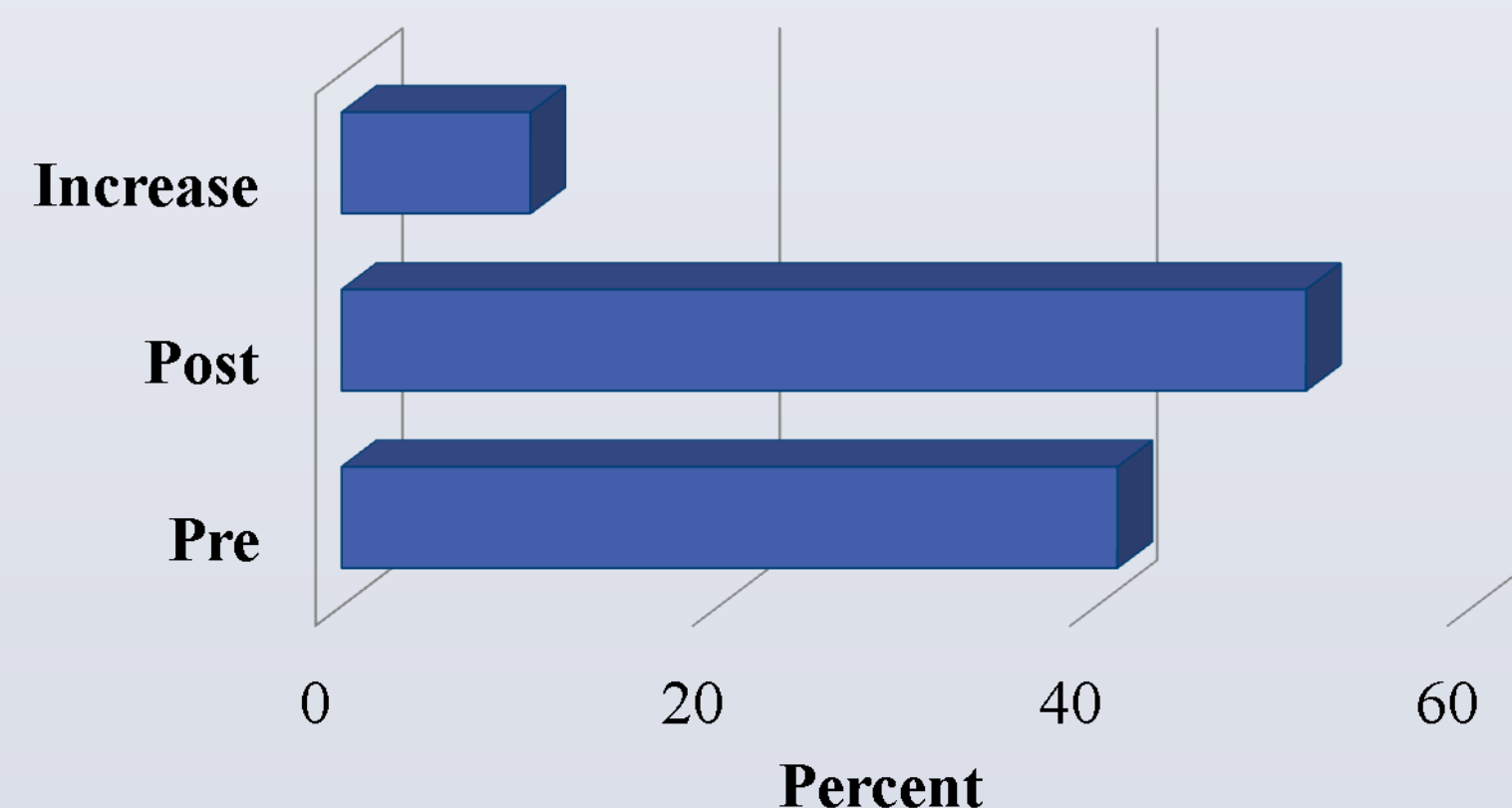


## METHOD

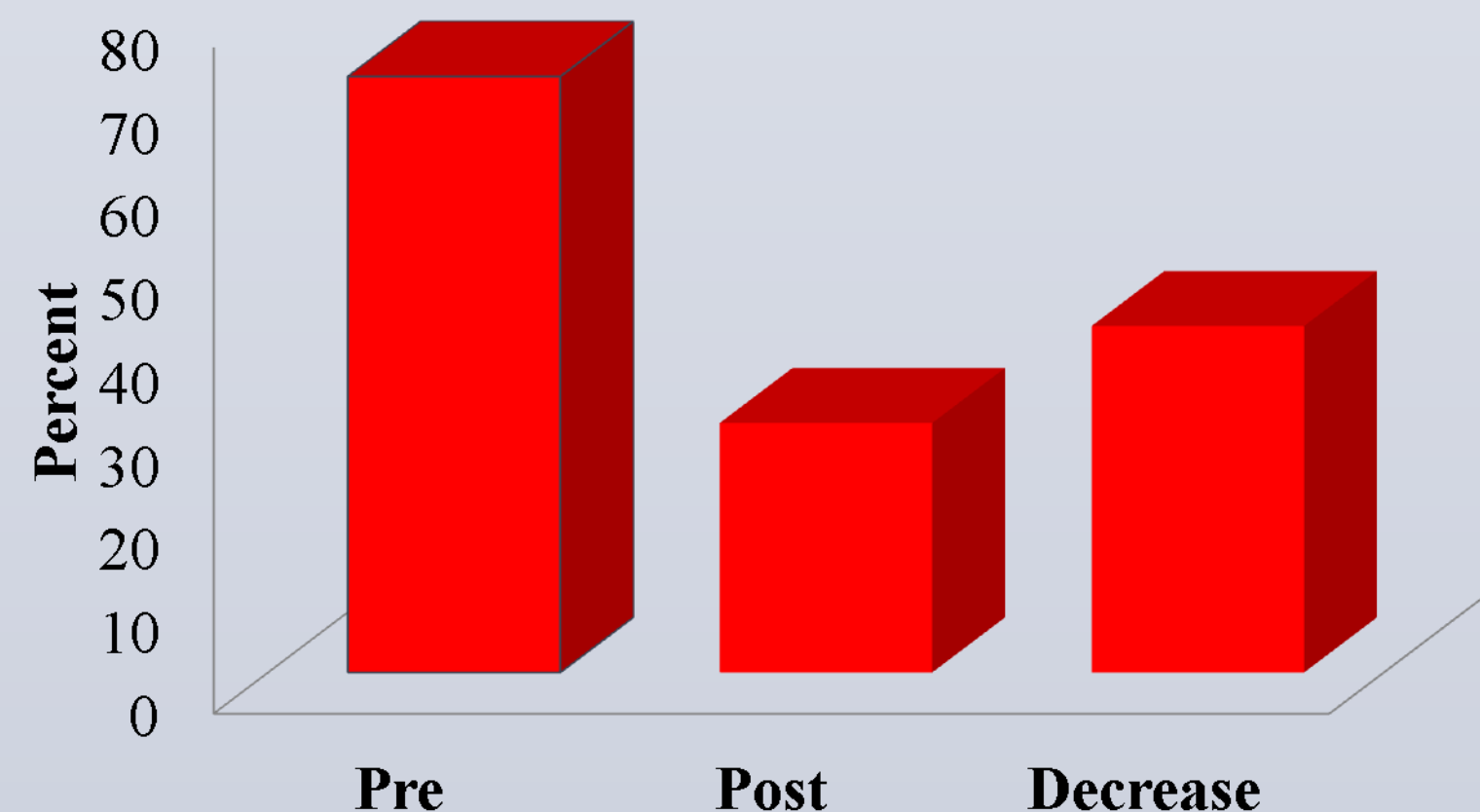
Prospective study of seriously ill patients referred for palliative care consults at (SCNR) from August 2015 to June 2016. Each week, NYPQ physicians (palliative care attending and fellow) along with NH-IDT members (SW, speech pathologist, NP, dietician, CNA, integrative health coach) provided PC consults at the request of primary care physicians. The team provided pain and symptom assessment and management, goals of care reviews, family meetings, and options for withdrawing burdensome life support measures if consistent with patient/family goals.

## RESULTS

### Advance Directives



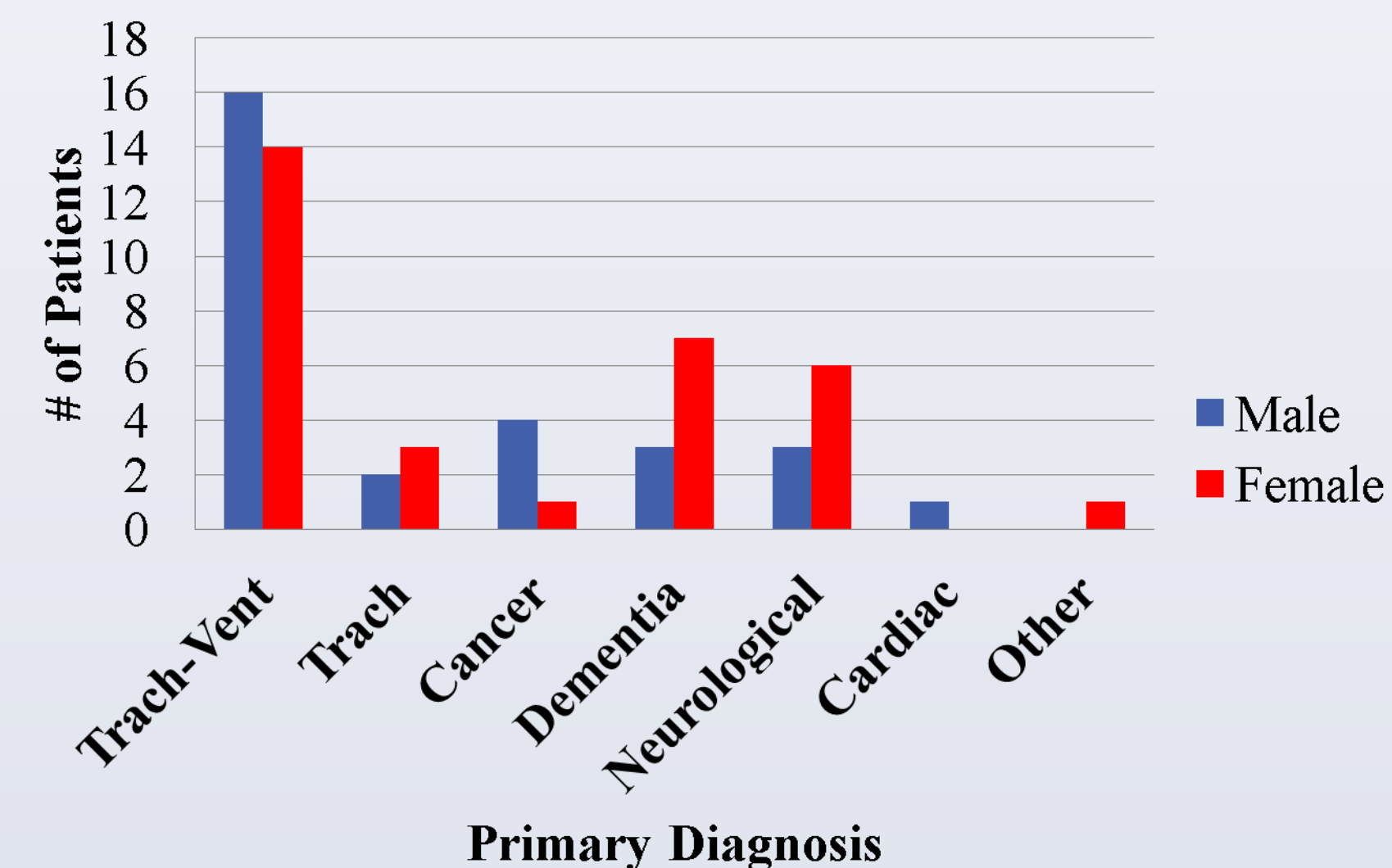
### Hospitalizations



## RESULTS

A total of 61 seriously ill patients (29 M, 32 F) received palliative care consults, resulting in 115 total visits during the study period.

### Demographics



## CONCLUSION

The increasing recognition of the role of palliative care provided many opportunities to improve patient experience and family satisfaction. This HPM fellowship training model provided enhanced continuity of care and IDT collaboration between hospital and NH. It also provided more opportunity to educate and implement positive culture change toward recognizing the role of comprehensive palliative care and strengthening community healthcare relationships. This interdisciplinary model reduced avoidable hospitalizations and increase advance directives completion.

