



# Collaborative Care Across the Silos: Respecting Wishes and Decreasing Unwanted Readmissions

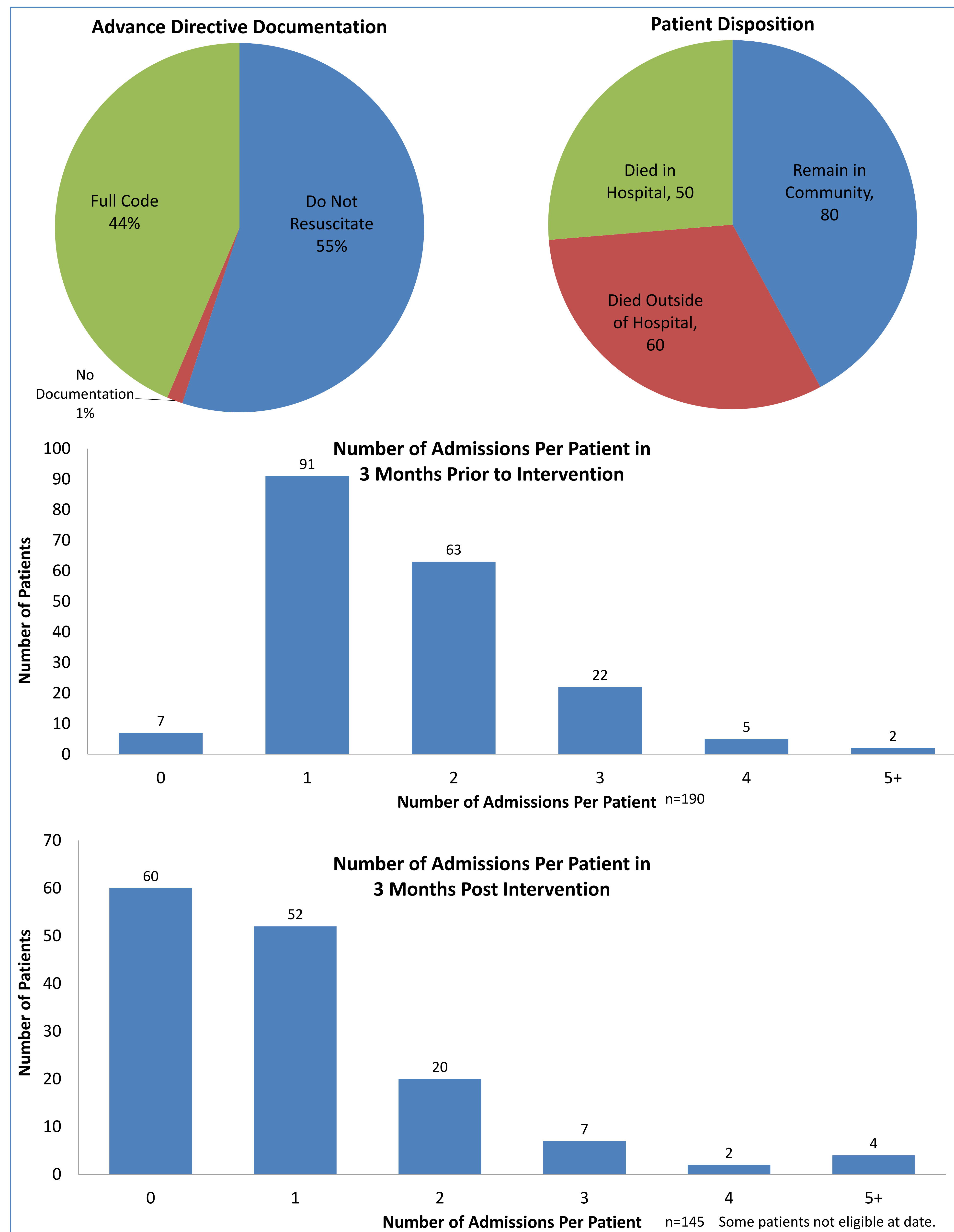
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**Background:** According to the Dartmouth Atlas, the Long Island region sees higher rates of hospital utilization in the last 6 months of life as well as higher rates of in-hospital death in this population as compared to other regions of the country. Nationally, of those who indicated a preference to die at home, 55% died in the hospital. The aim of this project is to create a collaborative among a tertiary care hospital, a nearby nursing home facility and a community agency in an effort to deliver geriatric palliative care across all settings, while reducing unwanted hospital re-admissions and inpatient deaths. The hypothesis is that palliative care coordination will lead to fewer hospital readmissions and fewer deaths in the hospital setting in a patient population known to have multiple readmissions. The goal is to provide a palliative consult on individuals with advanced illness and a history of multiple readmissions.

**Methods:** The Geriatric and Palliative (GAP) care team at Long Island Jewish Medical Center (LIJ) consulted on patients with advanced illness arriving from Parker Jewish Institute for Healthcare & Rehabilitation, a skilled nursing facility, who had been admitted to a hospital within the preceding 3 months. Upon discharge from LIJ to Parker Jewish Institute, a nurse practitioner from the GAP team consult service provided a telephone call to the designated staff member at the nursing facility. Transition of care included discussions regarding diagnosis, health status, goals of care and the established advance directives in the hospital. Data collected included: post-intervention readmissions, location and date of discharge, additional services provided (e.g. hospice and home care) and final disposition. A community agency supported these patients and families for their psychosocial needs.



**Results:** One hundred and ninety patients have been included in the study to date, with a mean age of 73.5 years and a median age of 82 years; 85 males, 105 females. Nearly all of the individuals (98.7%) have documented advance directives, 55.78% having communicated wanting “Do Not Resuscitate” orders and 44.21% expressed wanting to be “Full code”. Whereas all but five of the patients had one or more hospitalizations in the 3 months prior to the intervention, only 34.9% had a readmission to the hospital in the 3 months post-intervention, a 62% decline. Of the 190 patients that have been included, 58% to date have died. Of those that have died, 54.9% died outside of the hospital in the nursing facility, home or hospice, and 45.9% died in the hospital setting consistent with the goals of care for each patient.

**Conclusion:** As our population ages, conversations regarding advanced directives, goals of care and prognosis, proper documentation and communication to other facilities through direct hand-offs can decrease unwanted readmissions. While the overwhelming majority of patients (together with their families and caregivers) have been comfortable with documenting their advance directives, there are still a significant number that want full code status and further re-hospitalization and utilization of hospital resources. As the project progresses, findings such as this one are shedding light on the many factors that may lead to in-hospital deaths, as there are clearly both systemic, as well as human factors involved in each patient’s trajectory through the care continuum.

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