Adopting a Serious Illness Communication Model for Post-Acute Care Transitions in Medicare Beneficiaries

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Longitudinal, iterative, goal-concordant care discussions for patients with progressive, serious illnesses initiated during the inpatient stay, SNF stay, & the first 45 days post-SNF discharge

BACKGROUND

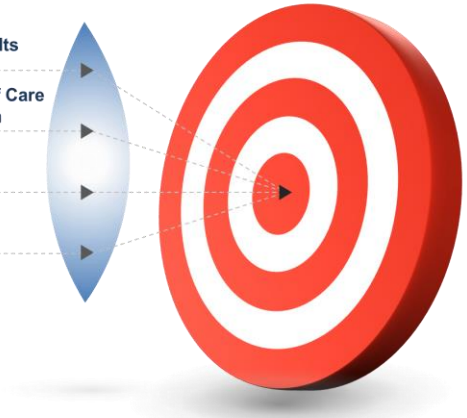
Medicare FFS beneficiaries who are readmitted from a post-acute facility are **4 times as likely to die in the 100 days after discharge**.3

48% of Medicare beneficiaries who were readmitted within 30 days from a SAR at a Northeast based urban academic hospital system **died within 12 months**.2

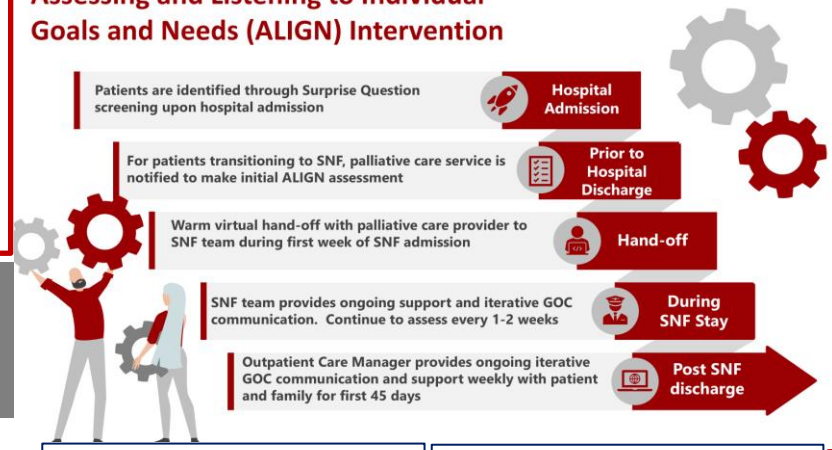
STUDY DESIGN: A pre- and post-intervention design for Medicare FFS patients transitioning from the hospital to SNF and have been identified through the Surprise Question (SQ) tool for evaluation of the new ALIGN intervention process impact

OUTCOMES

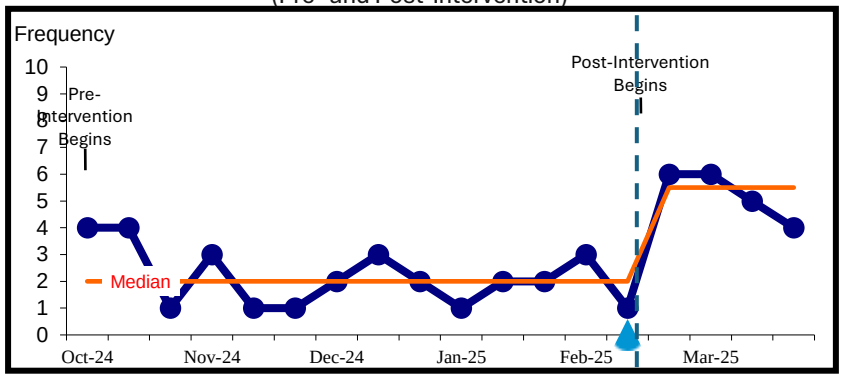
1. Palliative Care Consults
2. Frequency of Goals of Care (GOC) Communication
3. Completion of Advanced Directives
4. Hospice Orders

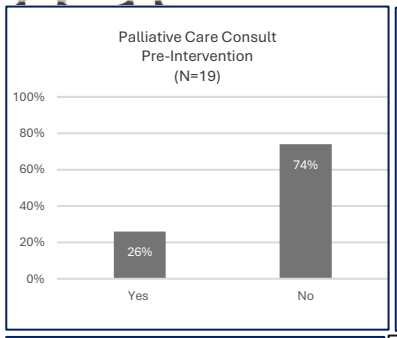


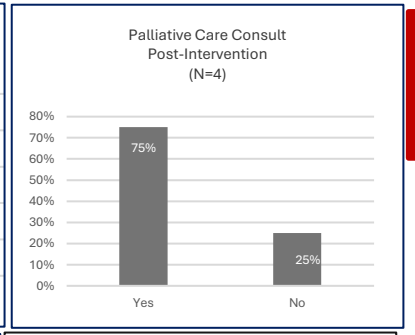
Assessing and Listening to Individual Goals and Needs (ALIGN) Intervention

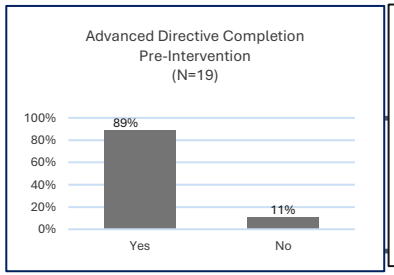


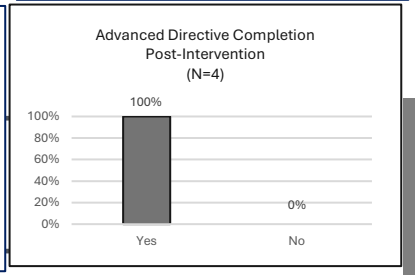
Frequency of GOC Communication
(Pre- and Post-Intervention)





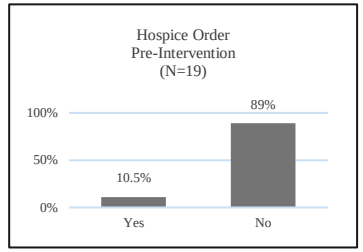


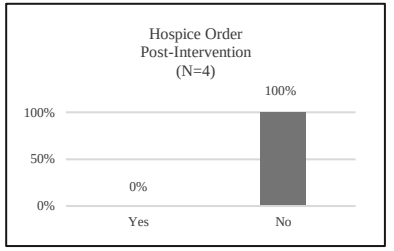




Pre-Intervention: 42% of patients were associated with a 30-day hospital readmission with a **16%** mortality rate in the 4-month pre-intervention period

Post-Intervention: 25% of patients were associated with a 30-day hospital readmission with a **0%** mortality rate during the 5-week post-intervention period





CONCLUSION: The use of the ALIGN intervention for patients with progressive, serious illness can serve as a model for proactive longitudinal goal-concordant care discussions during post acute care transitions.

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