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Article

ED-to-Hospice Referrals: A Baseline Survey of One Hospital's Experience

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Abstract

Hospice and palliative care improve quality of life for patients with advanced illness, yet referrals from emergency departments (EDs) remain limited. This study aimed to establish a baseline rate of ED-initiated referrals from the Northwell's Long Island Jewish Medical Center to its Health's Hospice and Palliative Care Program between August and December 2024. Using an institutional database, we reviewed 262 referrals and identified referral sources, documentation of ED goals-of-care (GOC) discussions, and patient disposition. Only 5.3% of all palliative care referrals and 3.0% of actual hospice placement referrals originated from the ED, with a decline in ED GOC discussions over the study period. Nearly all referred patients were admitted or placed in observation rather than discharged home or directly to hospice. Persistent cultural, educational, and workflow barriers may limit integration of palliative care within the ED. Improved interdisciplinary communication, provider training, and structured ED-to-hospice pathways may increase appropriate referrals, reduce unnecessary hospitalizations, and promote goal-concordant end-of-life care. Establishing this baseline provides a foundation for future quality improvement initiatives aimed at enhancing patient-centered outcomes for Northwell patients with advanced illness.

Keywords: emergency medicine; hospice; palliative care; referral patterns

Introduction

Hospice and palliative care are increasingly-recognized as essential components of comprehensive, patient-centered care for individuals with advanced or terminal illnesses [1]. These programs aim to improve quality of life (QoL), provide symptomatic relief, and support patients and families through complex medical and emotional decisions at the end of life. Despite this, hospice care remains underutilized in the emergency department (ED), which is one of the most frequent points of contact for patients nearing the end of life [2].

The ED plays a critical role in providing acute and often life-sustaining care, with more than 140 million visits recorded annually in the United States [3]. As the average age of the population continues to rise, EDs have increasingly become sites where patients with severe or terminal illnesses seek care near the end of life [4]. This trend places considerable strain on already-burdened acute care systems, which are typically optimized for immediate intervention rather than the nuanced demands of end-of-life (EOL) care.

Studies show that approximately 75% of patients visit the ED within six months of death, and over half do so within the final month of life [5]. Timely referrals from ED-to-hospice programs can reduce unnecessary hospital admissions, lower re-admission rates, and ensure patients receive care consistent with their values and goals [6]. Early hospice and palliative care involvement has been associated with improved patient satisfaction, better symptom control, and reduced utilization of aggressive life-sustaining treatment in the final stages of illness [7]. Additional benefits of an ED Palliative Care Consult (PCC) include:

- Lower hospital readmission rates: Hospice care reduces unnecessary hospitalizations for patients with terminal illnesses by managing symptoms in home or hospice settings [8,9].)
- Reduced ED length of stay: When palliative or hospice pathways are established early, patients spend less time in the ED waiting for placement or treatment decisions [10].
- Reduced hospital length of stay: Patients identified early for hospice transition may be admitted briefly for stabilization or symptom control, then transferred to appropriate hospice care settings[11].
- Increased multidisciplinary care: Successful ED-to-hospice transitions require close collaboration between ED physicians, palliative care specialists, and social workers, fostering a multidisciplinary approach that supports both patients and families.

ED patients with end-stage conditions, including cancer, congestive heart failure, and chronic obstructive pulmonary disease, can benefit greatly from a palliative care consult (PCC). Palliative care programs supporting individuals in a terminal state who transfer from the ED may ease the burden on the ED and also prove beneficial to the patient, as they can receive long-term oriented care aligned with their values rather than the acute care the ED provides. However, little has been done to improve communication between palliative care and emergency medicine providers to facilitate this.

Northwell Health has a system-wide Hospice and Palliative Care Program with a goal to increase the number of referrals to the program. This study aims to determine the baseline number and percent of referrals between August and December 2024 to Northwell’s Hospice and Palliative Care Program specifically at LIJ (not at other LIJ facilities) came from LIJ’s ED (not from LIJ’s inpatient wards or clinics). This will serve as the basis to explore the current process, raise awareness, and increase the number of referrals from LIJ’s ED to Northwell’s Hospice and Palliative Care Program at LIJ.

Methods

This study was conducted at LIJ, part of the Northwell Health system, which includes 28 hospitals and 890 outpatient facilities across New York. LIJ is a 700-bed tertiary-care academic hospital that provides care to a diverse population across a range of racial and socioeconomic backgrounds. The study focused on patients admitted to the LIJ adult ED, which handles approximately 100,000 patient visits annually.

Northwell’s Palliative Care and Hospice Program at LIJ maintains an MS Excel database with details about referral sources between August 2024 and December 2024. We reviewed each record in the database to determine:

1. Data of referral
2. Patient name
3. Patient's date of birth
4. Whether an ED Goals of Care Discussion (ED GOC) was documented
5. Whether the referral was from LIJ’s ED, as indicated by whether an ED-to-Hospice discussion was documented
6. Whether an ED-to-Hospice referral (for actual hospice placement from the ED) was made
7. Disposition (admit/observation vs. discharge)

We calculated the baseline number and percent of referrals that came from LIJ's ED in each study month and the cumulative number and percent over those 5 months.

The study was reviewed by the Northwell’s Institutional Review Board and deemed exempt on the basis of it being a project related to "health care operations" (submission #: 25-0917-LIJ).

Results

Between August and December 2024, 262 patients were referred from the LIJ ecosystem (ED, inpatient, clinics) to the Hospice and Palliative Care program. Of these, 5.3% came from LIJ’s ED, as indicated by documentation of an ED-to-Hospice discussion. Of referrals to hospice for actual hospice placement, only 3.0% came from LIJ’s ED. Between August and December, there was a decrease in ED GOC conversations as well as in the percent of palliative care referrals that came from LIJ’s ED. (Figure 1) Nearly 100% of patients were admitted or put in the ED’s observation unit. (Figure 2)

Percent of Referrals to Northwell Hospice and Palliative Care Program that Involved the ED, by Month

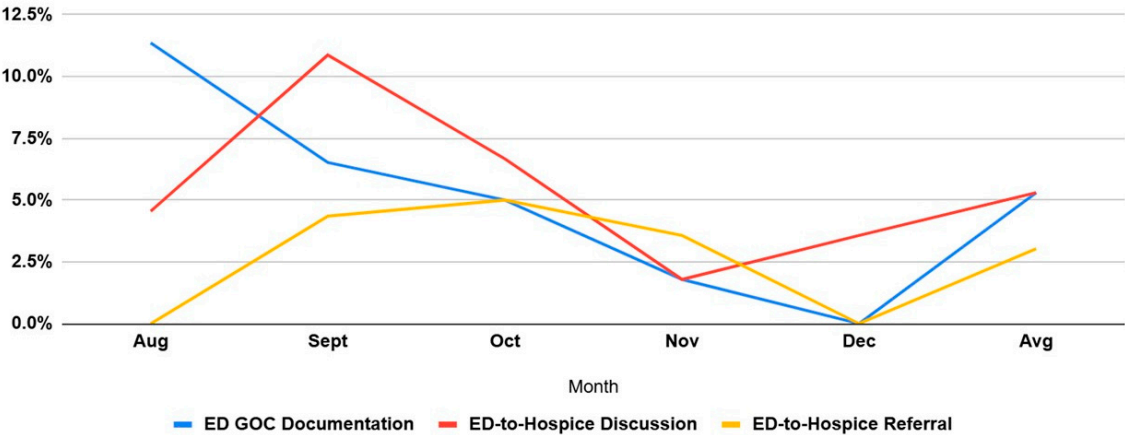


Figure 1. Percent of Referrals to Northwell Hospice and Palliative Care Program that Involved the ED, by Month.

Percent dispositioned to "Admission or Observation," by Month

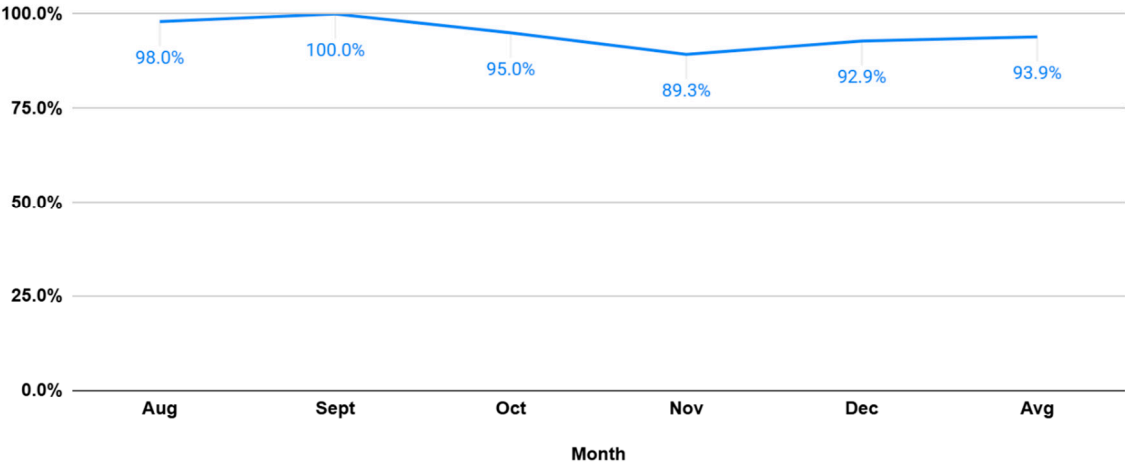


Figure 2. Percent dispositioned to Admission or Observation, by Month.

Discussion

Palliative and hospice care has been a growing field. Programs have more than doubled in the past 20 years and are expected to continue to grow to keep up with the aging population [12]. Patients with terminal cancer who die at home have a better QoL with EOL care than patients who die in hospitals [13]. It is important to remember that advanced illness patients are likely to receive aggressive therapies in the ED. While this may prolong their life, it can also directly conflict with the patient’s wishes [14].

Despite numerous advantages, many institutions, including those within the Northwell Health hospital system, report limited ED-initiated hospice referrals. Barriers such as lack of awareness, limited time, and provider discomfort with end-of-life discussions often impede the referral process

[15,16]. Given these challenges, Northwell Health's Hospice and Palliative Care Program has prioritized increasing ED-initiated hospice referrals. Understanding current referral patterns at LIJ provides a crucial foundation for improving processes, enhancing provider education, and promoting patient-centered end-of-life care.

This study found only a small number of referrals to Northwell's Hospice and Palliative Care Program at LIJ originated from LIJ's ED. Low documentation of ED GOC discussion was also present. This suggests systematic, cultural, and educational barriers continue to limit integration between emergency and palliative medicine. A high percentage (93.94%) of these patients were either admitted or put in observation status; it is possible that had there been coordination between the ED and palliative care providers, some of these patients may have been dispositioned directly to hospice.

Not all ED providers understand palliative care and its potential coordination with life-sustaining therapy [17]. Providers note difficulty attempting to address goals of care with a patient. Some shared that their role within the ED was more -aligned towards with more-aggressive treatment than the nuances of palliative care [18]. Patients needing a PCC often receive them days after admission due to the high volume of ED visits [19]. Hospitals are beginning to provide more -streamlined programs that provide PCC earlier in the process instead of waiting for the patient to be admitted. This modern approach has already shown merit by improving patient outcomes, lowering costs, and decreasing length of stay (LOS) [20–22].

EDs function as a catch-all to manage patients in all walks of life and with various conditions. They function best in time-restricted environments and quickly establish effective treatments for patients to manage conditions in the short term. However, they are not as well versed when it comes to dealing with more chronic EOL conditions, as patients with these conditions require a different approach [23]. Many emergency physicians are trained to prioritize stabilization and acute interventions rather than long-term goals of care, leading to missed opportunities for early hospice discussions [24]. High patient volumes, limited time, and emotional complexity further inhibit effective communication regarding end-of-life preferences.

ED-to-Hospice referrals are not only possible, but pilot programs have shown promising results [25–27]. Provider hesitancy is often compounded by uncertainty about identifying hospice-appropriate patients. Without standardized screening tools or an electronic health record notification, eligible patients may be overlooked. Screening methods such as the "Would you be surprised if this patient died within the next 12 months?" questions have been shown to help clinicians recognize suitable candidates for palliative care earlier [28].

To address these gaps, structured referral pathways and multidisciplinary collaboration are essential. Involving palliative care liaisons within the ED and providing targeted education can increase comfort and confidence among emergency physicians [29]. Hospitals that adopt these models report higher hospice referral rates, reduced hospital admissions, and improved patient and family satisfaction [30].

Limitations

This study has several limitations. First, it is a sample from a single hospital, and, therefore, may not represent patterns of goals-of-care discussions or palliative/hospice care referrals at other hospitals. However, we chose this sampling because this was intended to serve as a baseline assessment prior to a more-comprehensive effort to increase such activities. Second, the sample represents only a five-month time period. Had we extended the timeframe, we may have found different behavior patterns. Finally, we did not survey ED providers to understand the reasons behind the low rates of documenting goals-of-care or referring to palliative/hospice services.

For Northwell Health, these findings highlight opportunities to enhance interdisciplinary communication, optimize referral criteria, and improve the patient experience at the end of life. Increasing ED-to-hospice referrals aligns with institutional goals of compassionate, value-driven care while also reducing resource constraints across the health system.

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