

# OneCity Health Innovation Fund Awardee

## Achieving Best Practices in Advance Care Planning and Hospice Referral: A Novel Nurse-Mediated Collaborative Practice Approach for Primary Care



INSTITUTE FOR INNOVATION  
IN PALLIATIVE CARE

**LEAD ORGANIZATION:** MJHS Health System/MJHS  
Institute for Innovation in Palliative Care

**JOINT APPLICANTS:** NYC Health + Hospitals/  
Gouverneur and NYC Health + Hospitals/Kings County

**NEIGHBORHOODS PROJECT INTENDS TO SERVE:**  
Chinatown, Lower East Side, Manhattan; Flatbush, East  
Flatbush, Crown Heights, Brooklyn

**BUDGET:** \$600,000

### OVERVIEW

Through this project, we will implement an innovative approach to improve both advance care planning and appropriate access to hospice care for seriously ill patients living in the community. This project is a collaboration between an organization specializing in hospice and palliative care and two large primary care practices.

The lack of documented 'serious illness conversations' between clinicians and patients and the significant underuse of the federal and state hospice benefit to provide home-based services for those with an advanced illness are highly significant impediments to high-quality, cost-effective care for the chronically ill. Through this project, we will place a full-time, highly trained nurse in each primary care setting to serve as a hospice and palliative care resource. The nurses will be the linchpin for a novel collaborative practice approach, which will create new processes for patient screening, facilitated culturally-sensitive discussions with patients and families, identification of hospice-eligible patients, and care coordination to guide hospice enrollment. The collaboration will support

real-time communication between primary care providers and specialists in hospice and palliative care, palliative care training of staff in the practice, and sharing of data to monitor progress.

### DSRIP METRICS THIS PROJECT WILL ADDRESS

This project will improve two outcomes related to DSRIP performance goals. The first is the proportion of chronically ill patients who have had serious illness conversations resulting in legally executed, accessible advance directives (e.g., a Health Care Proxy). By clarifying goals and informing both physicians and families about the patient's preferences for care, these conversations will reduce avoidable trips to the Emergency Room and hospital admissions. The second is the proportion of patients with advanced illness and short life expectancy who can avoid undesired hospitalization for end-of-life care by accessing the home-based services provided by hospice.