

CREATING REGIONAL PARTNERSHIPS TO IMPROVE CARE TRANSITIONS

## Care Transitions Programs: Supporting Patients Who Are Nearing the End of Life

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When an elderly patient or a patient with a serious or complex illness is discharged from the hospital, that person is particularly vulnerable. As patients move from one care setting to another, problems such as lack of follow-up care and miscommunication among clinicians often occur and can put patients at risk for serious complications and hospital readmission. Some patients have additional problems such as depression, social isolation, or a lack of housing or transportation that may increase their risk of hospital readmission. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, at a cost of more than \$26 billion every year.<sup>1</sup>

Several Aligning Forces for Quality (AF4Q) Alliances have implemented or are partnering in care transitions programs using care transitions coaches to ensure patient care that is coordinated across care settings. Care transitions coaches are discovering that they have an important role to play in starting conversations with patients about planning for end-of-life care. Health care providers and family members are frequently uncomfortable with broaching this topic and may wait to do so until a patient is very ill. Coaches can help patients make decisions about treatment goals and get access to resources like palliative and hospice care earlier, which can improve their overall quality of life.

Here's how two organizations found ways to give patients the information and tools they need to make choices about their future care.\*

## CASE STUDY

### WellSpan Health

At WellSpan York Hospital and WellSpan Gettysburg Hospital in central Pennsylvania, patients who have a terminal illness and are nearing the end of life often seek treatment in the emergency department. Amy Shuttlesworth, manager of case management and social work at WellSpan Health, said that her team has learned, however, that it's difficult to start conversations about end-of-life care with these patients in the ED. "It's a labor-intensive conversation," she said. "You need time to build trust and rapport, to find out what's important to the patient, and to learn about their cultural background and family traditions." WellSpan Health is a partner organization of Aligning Forces for Quality—South Central Pennsylvania.

Typically, the physicians in the ED don't know the patient and family and don't have much time to spend with them. They might wind up having a brief conversation with the patient in the middle of the night about considering hospice care. "It's not the best setting for getting comfortable with the topic and making such an important decision," Shuttlesworth explained.

To help address this problem, WellSpan Health partnered with a local hospice organization called Hospice & Community Care that agreed to offer informational visits for patients starting in the spring of 2014. Various hospital staffers—including physicians, palliative care team members, the case management social worker, and the case management nurse—identify patients that could benefit from an informational visit.

After making sure that the patient and family are receptive to it, a physician puts in an order to set up the visit.

A social worker or nurse from Hospice & Community Care is available 24/7 to meet with the patient at the ED, at an inpatient unit, or at home any time they choose. Hospice & Community Care provides the visit free of charge as a community service. During the visit, the social worker or nurse asks the patient and family about their treatment goals and explains the differences between active treatment and comfort care. She describes the services that hospice and palliative care agencies offer and the locations that care can be delivered, including the home, nursing home, or on an inpatient hospice unit. She also explains how Medicare or other insurance covers particular hospice services.

## HOW TO HELP PATIENTS UNDERSTAND OPTIONS FOR END-OF-LIFE CARE

- Recognize that the patient's physicians and family members may not be bringing up end-of-life planning decisions and that care transitions teams can play a role in starting that conversation earlier.
- Whenever possible, discuss end-of-life care decisions with patients in settings in which they feel more relaxed and in control—for example, during a home visit rather than at the hospital.
- Partner with a hospice and palliative care agency that can provide free informational visits to patients.
- Tell patients about tools they can use to make decisions about and communicate their preferences for end-of-life care, such as "Five Wishes" and the Conversation Project's "Conversation Starter Kit."

After touching base with Hospice & Community Care to find out how the visit went, a physician or case management social worker from WellSpan Health follows up with the patient. If the patient decides to pursue hospice care and stop active treatment, they don't necessarily have to choose Hospice & Community Care. The physician or social worker will tell them about all the hospice agencies in the area that accept their insurance.

Shuttlesworth points out that one of the advantages of this approach is that patients can get a lot of information about their options and think them over before taking the next step. "We want them to have enough facts to be comfortable with whatever decision they make," she said.

## CASE STUDY

### Healthy Community Alliance

As the director of the Cattaraugus County Department of the Aging in Olean, NY, Cathy Mackay looks for ways to help local seniors start thinking and talking with their families about end-of-life planning issues before they become seriously ill or have an emergency. “People need to think about long-term care planning while they still have choices instead of when they are in crisis, choices are limited, and time is no longer their friend,” Mackay said.

She discovered two resources: *Deathoverdinner.org*, which offers materials to help organizations and families plan a dinner to discuss end-of-life issues, and *Theconversationproject.org*, which offers tools to help people start thinking and talking about their preferences for end-of-life care. Inspired by these projects, Mackay and her colleagues at the Cattaraugus County Department of the Aging teamed up with several other organizations to host a free event called “Let’s Have Dinner and Talk About Death” at the John Ash Community Center in Olean in April 2014.

They promoted the event to local seniors by sending a press release to newspapers across the county, airing a radio spot, and sending flyers to senior housing communities and to clients who receive Meals on Wheels. People signed up in advance, and many brought along younger family members. Three sponsors—United Way of Cattaraugus County; Casey, Halwig, and Hartle Funeral Home; and The Wilday Group at Morgan Stanley—enthusiastically agreed to pay for the food and for printing flyers and handouts.

At the dinner, Mackay and her team set up 10 tables around the room. To encourage intimate conversation, they sat six to eight participants at each table. A volunteer facilitator from the Department of the Aging, the United Way, or another local organization was assigned to each table to moderate the discussion.

The evening began with a toast to deceased friends and family members, which built camaraderie in the room. While the participants ate a spaghetti dinner, they listened to talks by experts on funeral planning, financial planning, and legal issues. These experts shared personal stories about taking care of their own aging parents or about clients they worked with, rather than just focusing on describing the services they offer.

While dessert and coffee were served, Mackay and Amy Snyder, a social work manager at HomeCare & Hospice, stood at the front of the room and read questions from the Conversation Project’s “Conversation Starter Kit” that were selected to spark discussions at the tables. These covered topics like: “What matters to me at the end of life is...”, “What role do you want your loved ones to play [in your end-of-life care]?”, and “How long do you want to receive medical care?” The facilitator at each table guided a 5-to-10-minute discussion about each question.

Sharon Mathe, executive director of Healthy Community Alliance, Inc., in Gowanda, NY, served as one of the facilitators. Healthy Community Alliance, Inc., is a partner of the P<sup>2</sup> Collaborative of Western New York, which leads the AF4Q initiative in Western New York. Mathe said the questions prompted the younger family members at her table to ask the older ones whether they had created a will. Also, an uncle told his niece where to find his important paperwork in a particular desk drawer if anything were to happen to him. “Some people in the room were in their 50s, and the conversation helped them to begin to prepare early for the end of life, and others had a terminal disease and wanted to have these difficult discussions in case they didn’t survive it,” noted Mathe.

Local agencies and businesses such as a skilled nursing facility, a managed long-term care plan, and an organ donation organization set up tables around the room with info on end-of-life issues. Participants could pick up materials and ask questions throughout the evening.

#### PLANNING FOR END-OF-LIFE CARE: FIVE WISHES

Catherine Ponder, RN, BSN, team lead for the Care Transitions Support Team at St. Mary Mercy Livonia Hospital in Michigan, recommends telling patients with chronic illnesses about *Five Wishes*. Patients can fill out this easy-to-use form to express to family members and doctors how they want to be cared for in case they become seriously ill. *Five Wishes* covers medical, legal, and spiritual matters, and it meets the legal requirements for an advance directive in 42 states. To order copies in the mail or fill out the form online, go to: <http://www.agingwithdignity.org/five-wishes.php>

They also wrote down things they hoped to accomplish during their life on a kind of bucket list called the “wall of wishes.” On a large roll of brown paper, they shared wishes like “spend more time with my grandkids,” “learn to ski,” and “travel to Europe.”

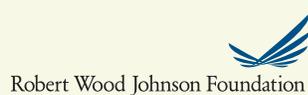
Mackay says that you shouldn’t hesitate to lighten the mood at a “death over dinner” event with a wall of wishes or by including a cartoon of a grim reaper on a dinner plate or a skeleton in a chef’s hat on the program flyers. People clearly appreciated the relaxed atmosphere. In fact, the dinner was so popular that she is planning to host a similar event in 2015—possibly a brunch on the other side of the county. She is aiming to try different times and venues in order to reach the most people.

Mathe suggests that care transitions teams work with a local Office for the Aging to organize “death over dinner (or brunch)” events in their community and then tell their patients how to sign up. In addition, they can spread the word to patients when they find out that other organizations are hosting these events nearby.

\*This “peer-to-peer” meeting about care transitions was held on August 21, 2014, in Detroit. Aligning Forces for Quality organized and funded the meeting, with a goal of sharing strategies and tools for sustainability planning, staffing, physician engagement, and serving patient subsets. Attendees and subsequent interviewees were involved in the Center for Medicare & Medicaid Services (CMS) Community-Based Care Transitions Program. Attendees included Lisa Mason from the Greater Detroit Area Health Council; Caitlin Gerlach from MPRO; Tina Abbate Marzolf and Barbara Lavery from Area Agency on Aging 1-B; Sandy Kiesel from Go Lean, Inc.; Micheline Sommers from Oakland Family Services; Carrie Hays McElroy and Cathy Ponder from St. Mary Mercy Livonia Hospital; Dave Wilson and Jason Maciejewski from The Senior Alliance/Area Agency on Aging 1-C; Barbara Bremer and Denise Robertson from St. John Providence Health System; Susan Miller and Sara Gleicher from Adult Well-Being Services; Cathy Davis, Trent DeVreugd, and Cathy Lauridsen from the Kansas City Quality Improvement Consortium; Lori O’Connor from Elder Services of the Merrimack Valley; Melissa Pessefall from Akron Canton Area Agency on Aging; Dee Moore from Brewster Place Topeka Kansas; Megan MacDavey from the P2 Collaborative of Western New York; Sharon Mathe from Healthy Community Alliance; Jerry Bartone from Community Concern of WNY; Deanna Ruff from the York County Area Agency on Aging; Amy Shuttlesworth, Winnie Reineberg, and Mandi Waltemyer from WellSpan Health.

## REFERENCES

<sup>1</sup>*The Revolving Door: A Report on U.S. Hospital Readmissions*. 2013. Princeton, NJ: The Robert Wood Johnson Foundation.



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