Institute *for*
Healthcare
Improvement

Care at the End of Life

Leadership Alliance Accelerator 2025

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ihi.org

Introduction

Providing continuity of care that honors a patient's unique goals, values, and preferences at the end of life is a cornerstone of high-quality health care. Yet, one of the most critical challenges occurs during transitions of care—such as transfers between hospitals, skilled nursing facilities, or hospices.

During these transitions, communication gaps can lead to interventions that conflict with a patient's wishes. The result is unnecessary suffering and a loss of trust between patients, families, and the health care system.. This tool will aid in establishing a measurable standard of care that obligates clinicians and institutions to facilitate warm handoffs of patients as they move from exhaustion of curative care options to exploration of the timing and circumstances of a patient's planned or anticipated death. This effort is intended to define a continuum of care for patients as they progress from curative care, to palliative care, to hospice care, to final care planning, including ending life care interventions such as Medical Aid in Dying (MAiD), Voluntarily stopping eating and drinking (VSED), and the various forms of palliative sedation.

About This Toolkit

The Care at the End-of-Life Transition Toolkit is the result of a collaborative initiative within the IHI Leadership Alliance, designed to achieve breakthrough improvements in the quality and experience of end-of-life care. This toolkit serves as a guide for health care professionals to standardize communication during transitions of care, helping to ensure that every receiving facility has complete, actionable information about a patient's end-of-life directives and /or values so care remains consistent, respectful, and aligned with what matters most to the patient.

About the IHI Leadership Alliance *Care at the End-of-Life* Accelerator

The Institute for Healthcare Improvement (IHI) has a long-standing commitment to transforming end-of-life care. Through the Leadership Alliance, system leaders collaborate to test and scale new models of care.

The Care at the End-of-Life Accelerator brings together diverse organizations to tackle improvement challenges through shared learning and best practice development. This work supports professionals across settings—from hospital leaders and community social workers to physicians and end-of-life care nurses—by enabling them to define and communicate every patient's end-of-life care wishes, no matter where they receive care.

Important Disclaimer

This toolkit is intended for use by qualified health care professionals. It provides a framework for communication and documentation. It does not constitute medical or legal advice. Health care providers must comply with applicable federal, state, and local laws regarding advanced directives, medical orders, and end-of-life care. When in doubt, consult with ethics committees, palliative care specialists and/or legal counsel.

Nine Core Toolkit Components

The following nine components constitute a comprehensive end-of-life care transition checklist. Each component should, if possible, be integrated into the EMR/EHR system with appropriate data fields, dropdown menus, and tooltip guidance for users.

1. Current Orders to Forgo Life-Sustaining Treatment
2. Patient's Decision-Making Capacity
3. Current Clinical Status
4. Surrogate Decision Maker Information
5. The Patient’s Voice
6. Others in Patient’s Life/Roles in Patient’s Life
7. Goals of Care Meetings /Final Discussions
8. Patient’s Specific Preferences
9. Transfer Documentation and Handoff Verification

1. Current orders to forgo life sustaining treatment

MOLST/Advance directive [A]

2. Patient’s decision-making capacity

a. Patient’s current decision-making capacity
b. Patient’s decision-making capacity history [B]
c. Information about timeline for patient’s decision-making capacity potentially changing (including chronology of assessment/prior change in decisional capacity)

3. Current clinical status [C]

[A] Identify and review most up to date MOLST/POLST

[B] What information do you have about a baseline assessment on decisional capacity?

When did they last have decisional capacity/ Capacity to make what decisions?)

[C] Include summary of relevant consultations (palliative, geriatric) (FAST and other clinically relevant scales and instruments)

4. Information about surrogate decision maker if applicable

5. The patient's voice
   a. Health Care Proxy form, other Advance Directives, Living Will, or other legal documents [D]
   b. Prior statements [E] made by the patient

D. - *5 wishes*

E. narrative recorded in a progress note testimonials from interested parties

6. Who else is in the patient's life. What is their role?
   a. Add any information about what you've done to identify people in the patient's life and anything important you've learned
   b. People who Support Decision Making [annotate/define what this person is to the patient]

7. **Last meeting to discuss goals of care [F]**
   a. Shared decision-making history

F. Date, participants, outcome, if applicable

8. **Patient’s specific preferences**[G]
    a. Code Status DNR/AND[H]
    b. airway management DNI[i]
    c. Artificial /assisted oral nutrition and hydration
    d. Hospitalization
    e. Pain and symptom management
    f. VSED (patient choice to voluntarily stop eating and drinking)
    g. Medical aid in dying (M.A.i.D.)
    (add tooltip, this does require pt participation, agreement and implementation)

9. **Documentation of hand off**
    a. Receiving facility name, date, clinician/coordinator
    b. Confirmation that all necessary documents are complete and sent to receiving facility

G. Note the below listed options A through E can be decided by a surrogate, F and G cannot

H. Do Not Resuscitate/ Allow Natural Death

I. Do Not Intubate