February 21, 2017

Mr. Vincent Davis
State Survey Agency Director
655 Mainstream Drive, 2nd Floor
Nashville, TN 37243

RE: Nursing Home Civil Monetary Penalty Quality Improvement (CMPQI) Program Implementation Funding Opportunity, RFA # 34305-22417

Dear Mr. Davis,

Saint Thomas Health is pleased to submit our proposal for the implementation of the Palliative Care Transitional Program. It is an innovative pilot program that ensures the access to and portability of physician ordered life sustaining treatment documents (POLST) for patients during transition to/from hospitals and residency at skilled nursing facilities (SNFs). The overarching goal of the program is to improve patient-centered care by increasing the numbers of patient care conversations that are conducted with and implemented for palliative care patients/residents during transfers to and residencies at skilled nursing facilities.

Saint Thomas Health is a family of Tennessee hospitals and physician practices united by a single mission: to provide spiritually centered, holistic care that sustains and improves the health of the communities served. Saint Thomas Health, with an existing partnership with National Health Corporation (NHC), will collaborate with NHC and implement the Palliative Care Transitional Program into four NHC Skilled Nursing Facilities. The Saint Thomas Health Palliative Care Transitional team will serve as subject matter experts to NHC staff. Together, they will develop written processes, protocols, and metrics to support the successful transfer of residents' medical care plans. The team will convey to SNF staff the methodology and skills that are necessary to engage residents and their families in goals of care conversations and shared decision-making. The need for POLST conversations among skilled nursing facility residents and reconciliation of those goals with hospital providers is clearly needed and is a national initiative to reduce the numbers of events when resident/patient goals of care are not identified and followed, particularly in emergency situations.

Saint Thomas Health is the lead applicant for this proposal with a request for $97,912 to support the activities of a Palliative Care Transitional Care Advance Practice Registered Nurse and a Physician Preceptor/Supervisor. Our projected goal for this pilot program is to provide reconciled POLSTs for 176 NHC Skilled Nursing Facility residents. Saint Thomas is committed to the program and looks forward to its successful implementation. Should you have any questions about the program, please do not hesitate to contact me at dawn.rudolph@sth.org.

Sincerely,

Dawn Rudolph
Chief Experience Officer

Saint Thomas Health

102 Woodmont Blvd., Suite 800
Woodmont Centre
Nashville, TN 37205
SaintThomasHealth.com

REQUEST

Date of Application: 02 / 21 / 2017
MM / DD / YYYY

PART I: Background Information

Name of the Organization: Saint Thomas Health Foundation

Address Line 1: 4220 Harding Road

Address Line 2:

City, County, State, Zip Code: Nashville, Davidson County, Tennessee 37205

Tax Identification Number: 58-1663055

CMS Certification Number, if applicable: ☐☐-☐☐☐☐

Medicaid Provider Number, if applicable: ☐☐-☐☐☐☐

Name of the Project Leader: Mary Price

Address: 102 Woodmont Blvd, #800

City, County, State, Zip Code: Nashville, Davidson County, Tennessee 37205

Internet E-mail Address: mprice@sth.org

Telephone Number: 615-594-7459

Mobile Number: 615-594-7459

Have other funding sources been applied for and/or granted for this proposal? ☐ Yes ☑ No

If yes, please explain/identify sources and amount.

N/A

PART II: Applicable to Certified Nursing Home Applicants

Name of the Facility: N/A

Address Line 1: _____

Address Line 2: _____

City, County, State, Zip Code: _____

Telephone Number: ☐☐☐-☐☐☐-☐☐☐☐

CMS Certification Number: ☐☐-☐☐☐☐

Medicaid Provider Number: ☐☐-☐☐☐☐

Date of Last Recertification Survey: ____ /____ /_____
MM DD YYYY

Highest Scope and Severity Determination: (A – L) _____

Date of Last Complaint Survey: ____ /____ /_____
MM DD YYYY

Highest Scope and Severity Determination: (A – L) _____

Currently Enrolled in the Special Focus Facility (SFF) Initiative? ☐ Yes ☐ No

Previously Designated as a Special Focus Facility? ☐ Yes ☐ No

Participating in a Systems Improvement Agreement? ☐ Yes ☐ No

Administrator's Name: _____

Owner of the Nursing Home: _____

CEO Telephone Number: ☐☐☐-☐☐☐-☐☐☐☐

CEO Email Address: _____

Name of the Management Company: N/A - See Attachment for NHC SNF Stakeholders

Chain Affiliation (please specify) Name and Address of Parent Organization: _____

_____

Outstanding Civil Money Penalty? ☐ Yes ☐ No

Nursing Home Compare Star Rating: _____ (can be 1, 2, 3, 4 or 5 stars)

Date of Nursing Home Compare Rating: ____ /____ /_____
MM DD YYYY

Is the Nursing Home in Bankruptcy or Receivership? ☐ Yes ☐ No

If an organization is represented by various partners and stakeholders, please attach a list of the stakeholders in the appendix.

NOTE: The entity or nursing home which requests CMP funding is accountable and responsible for all CMP funds entrusted to it. If a change in ownership occurs after CMP funds are granted or during the course of the project completion, the project leader shall notify CMS and the State Agency within five calendar days. The new ownership shall be disclosed as well as information regarding how the project shall be completed. A written letter regarding the change in ownership and its impact on the CMP Grant application award shall be sent to CMS and the State Agency.

Part III: Project Category

Please place an "X" by the project category for which you are seeking CMP funding.

- [X] Direct Improvement to Quality of Care
- [ ] Resident or Family Councils
- [ ] Culture Change/Quality of Life
- [ ] Consumer Information
- [ ] Transition Preparation

☐ Training

☐ Resident Transition due to Facility Closure or Downsizing

☐ Other: Please specify _____

_____

Part IV: Funding Category

Please specify the amount and place an "X" by the funding category.

Amount Requested: $ 97,912

☐ $2,500 or less	☐ $10,001 – $25,000
☐ $2,501 – $5,000	☐ $25,001 – $50,000
☐ $5,001 – $10,000	☒ Over $50,000

Part V: Proposed Period of Support

From: 07 (MM) / 01 (DD) / 2017 (YYYY) (e.g. 06/01/2010) **To:** 06 (MM) / 30 (DD) / 2018 (YYYY) (e.g. 12/01/2010)

Part VI: Purpose and Summary

PROJECT TITLE

Include a cover letter to the State Agency Director with the application. The cover letter should introduce your organization, explain the purpose of the project and contain a summary of your proposal. The letter should include the amount of funding that you are requesting, the population it will serve, and the need it will help solve. Make a concerted effort to bring your project to life in the cover letter and actively engage the reader.

X: Dawn Rudolph

Printed Name: Dawn Rudolph

Job Title: Chief Experience Officer- Saint Thomas Health

ATTACHMENT 2

GRANT BUDGET

(BUDGET PAGE 1)

ADDITIONAL IDENTIFICATION INFORMATION AS NECESSARY

APPLICABLE PERIOD: The grant budget line-item amounts below shall be applicable only to expense incurred during the period beginning July 1, 2017, and ending June 30, 2018 for the Saint Thomas Health Palliative Care Transitional Program.

POLICY 03 Object Line-item Reference	EXPENSE OBJECT LINE-ITEM CATEGORY [1] (detail schedule(s) attached as applicable)	GRANT CONTRACT	GRANTEE PARTICIPATION	TOTAL PROJECT
1	Salaries[2]	$62,800.00	$2,680.00	$65,480.00
2	Benefits & Taxes	$18,800.00	$800.00	$19,600.00
4, 15	Professional Fee/ Grant & Award [2]	$11,712.00	$0.00	$11,712.00
5	Supplies	$0.00	$0.00	$0.00
6	Telephone	$0.00	$0.00	$0.00
7	Postage & Shipping	$0.00	$0.00	$0.00
8	Occupancy	$0.00	$0.00	$0.00
9	Equipment Rental & Maintenance	$0.00	$0.00	$0.00
10	Printing & Publications	$0.00	$0.00	$0.00
11, 12	Travel/ Conferences & Meetings[2]	$4,600.00	$0.00	$4,600.00
13	Interest [2]	$0.00	$0.00	$0.00
14	Insurance	$0.00	$0.00	$0.00
16	Specific Assistance To Individuals[2]	$0.00	$0.00	$0.00
17	Depreciation [2]	$0.00	$0.00	$0.00
18	Other Non-Personnel [2]	$0.00	$0.00	$0.00
20	Capital Purchase [2]	$0.00	$0.00	$0.00
22	Indirect Cost (% and method)	$0.00	$0.00	$0.00
24	In-Kind Expense	$0.00	$0.00	$0.00
25	**GRAND TOTAL**	$97,912.00	$3,480.00	$101,392.00

1 Each expense object line-item shall be defined by the Department of Finance and Administration Policy 03, Uniform Reporting Requirements and Cost Allocation Plans for Subrecipients of Federal and State Grant Monies, Appendix A. (posted on the Internet at: https://www.tn.gov/assets/entities/finance/attachments/policy3.pdf).

2 Applicable detail follows this page if line-item is funded.

ATTACHMENT 2 (continued)

GRANT BUDGET LINE-ITEM DETAIL

(BUDGET PAGE 2)

SALARIES									AMOUNT
Program Director provides oversight of total program = .08 FTE of annual salary of $109,221	0.08	x	109221	x	1 year			(Longetivity, if applicable)	$8,738.00
Program Coordinator implements the program with 4 partner Skilled Nursing Homes = .5 FTE of annual salary of $108,160.	0.5	x	108160	x	1 year			(Longetivity, if applicable)	$54,080.00
ROUNDED TOTAL									$62,800.00
BENEFITS AND TAXES									
Benefits and Taxes @ 30 Percent for .08 FTE Program Director with annual salary of $109,221	0.08	x	109221	x	1 year	x	0.3		$2,621.00
Benefits and Taxes @ 30 Percent for .5 FTE Program Coordinator with annual salary of $108,160	0.5	x	108160	x	1 year	x	0.3		$16,224.00
ROUNDED TOTAL									$18,800.00
PROFESSIONAL FEE/ GRANT & AWARD									AMOUNT
Physician Supervisor provides oversight for Palliative Care Advance Practice Care Nurse to abide by all State and Federal licensing laws.	8 hrs/mo	x	$122/hr	x	12 mos				$11,712.00
ROUNDED TOTAL									$11,712.00
TRAVEL/ CONFERENCES & MEETINGS									AMOUNT
Roudtrip Mileage from Saint Thomas West to NHC Cool Springs at Federal 2017 rate of	40 mi RT	x	0.535	x	5 trips/mo				$1,284.00
Roudtrip Mileage from Saint Thomas West to NHC Murfreesboro at Federal 2017 rate of $.535/mi.	74 mi RT	x	0.535	x	5 trips/mo				$2,375.00
Roudtrip Mileage from Saint Thomas West to NHC Place at the Trace at Federal 2017 rate of $.535/mi.	24 mi RT		0.535		5 trips/mo				$770.00
Roudtrip Mileage from Saint Thomas West to NHC Murfreesboro at Federal 2017 rate of $.535/mi.	4 mi RT		0.535		5 trips/mo				$128.00
SPECIFIC, DESCRIPTIVE, DETAIL (REPEAT ROW AS NECESSARY)									$0.00
ROUNDED TOTAL									$4,600.00
INTEREST									AMOUNT
SPECIFIC, DESCRIPTIVE, DETAIL (REPEAT ROW AS NECESSARY)									$0.00
ROUNDED TOTAL									$0.00
SPECIFIC ASSISTANCE TO INDIVIDUALS									AMOUNT
SPECIFIC, DESCRIPTIVE, DETAIL (REPEAT ROW AS NECESSARY)									$0.00
ROUNDED TOTAL									$0.00
DEPRECIATION									AMOUNT
SPECIFIC, DESCRIPTIVE, DETAIL (REPEAT ROW AS NECESSARY)									$0.00
ROUNDED TOTAL									$0.00
OTHER NON-PERSONNEL									AMOUNT
SPECIFIC, DESCRIPTIVE, DETAIL (REPEAT ROW AS NECESSARY)									$0.00
ROUNDED TOTAL									$0.00
CAPITAL PURCHASE									AMOUNT
SPECIFIC, DESCRIPTIVE, DETAIL (REPEAT ROW AS NECESSARY)									$0.00
ROUNDED TOTAL									$0.00

KEY PERSONNEL JOB DESCRIPTION

Job Description: Program Coordinator/Palliative Care Advance Practice Nurse

Primary Functions:

1) Develop process and tools to confirm portability of code status and advance directive decisions documentation, access, and treatment impact on readmission.
2) Participates in NHC Palliative Interdisciplinary Team meetings to support the NHC staff in review of goals of care conversations and expertise in how to conduct them.
3) Confers with Partner facilities' program staff to outline work plan and to discuss program tasks, responsibilities, and scope of authority.
4) Directs and coordinates activities of program to ensure program progresses on schedule and within prescribed budget.
5) Travels weekly to each of four partnering facilities to implement processes and protocols.
6) Establish operating procedures for program. Ensure procedures meet program goals.
7) Provide program content expertise, which may include delivering in-service training and direct programming.
8) Consults with program personnel to provide technical advice and to resolve problems.
9) Recognize and solve potential problems and evaluate program/program effectiveness.
10) Responsible for overall quality and management of major programs or programs.
11) Prepares program reports for management, client, or others.
12) Network with local, state and national agencies for future program development.

Job Qualifications:

- Advanced Practice Registered Nurse (APRN) and DEA active license in the state of Tennessee.
- Five years experience in palliative care.
- Demonstrated ability to establish and maintain effective relationships and partnerships with key stakeholders.
- Demonstrated experience in leading and managing programs.
- Excellent organizational skills with demonstrated ability to execute programs on time and on budget.
- Strong interpersonal, communication, facilitation and presentation skills.
- Strong analytical and problem solving skills.
- Ability to work independently and with minimal supervision.
- Demonstrated ability to work in a small team setting.
- Ability to communicate effectively, both written and verbal.

BIO SKETCHES

Program Director:

Mary Price, RN, MSN will serve as Program Director for the Palliative Transitional Care Program. Mary is currently the System Director for Supportive and Palliative Care and has had progressive leadership positions for nineteen years at Saint Thomas Health. She is a strong advocate for nursing, palliative, and hospice care and serves on the Tennessee QSource Transitioning Patients Across The Care Continuum (TPACC) committee to implement quality improvement. She participated in the Joint Commission Pilot for PAL metrics in 2015-16. She serves on the Ascension national steering committee for Palliative Care and is promoting Ascension use of Telemedicine technology for the expansion of palliative care delivery.

Dedicating 0.08% FTE to the program, the primary duties of the Program Director are:

1) Program Director plans and directs activities of designated program to ensure that goals and objectives of program are accomplished within prescribed time frame and funding parameters.
2) Reviews program plan to determine time frame, funding limitations, procedures for accomplishing program, staffing requirements, and allotment of available resources to various phases of program.
3) Establishes work plan and staffing for each phase of program, and arranges for recruitment or assignment of program personnel.
4) Reviews status reports prepared by program personnel and modifies schedules or plans as required. Prepares program reports for management, client, and State of TN.
5) Oversees budget and ensures financial accountability.
6) Hires and is responsible for supervision of personnel for program/program implementation.
7) Provide program content expertise that may include delivery of in-service training.
8) Network with local, state and national agencies for future program development.

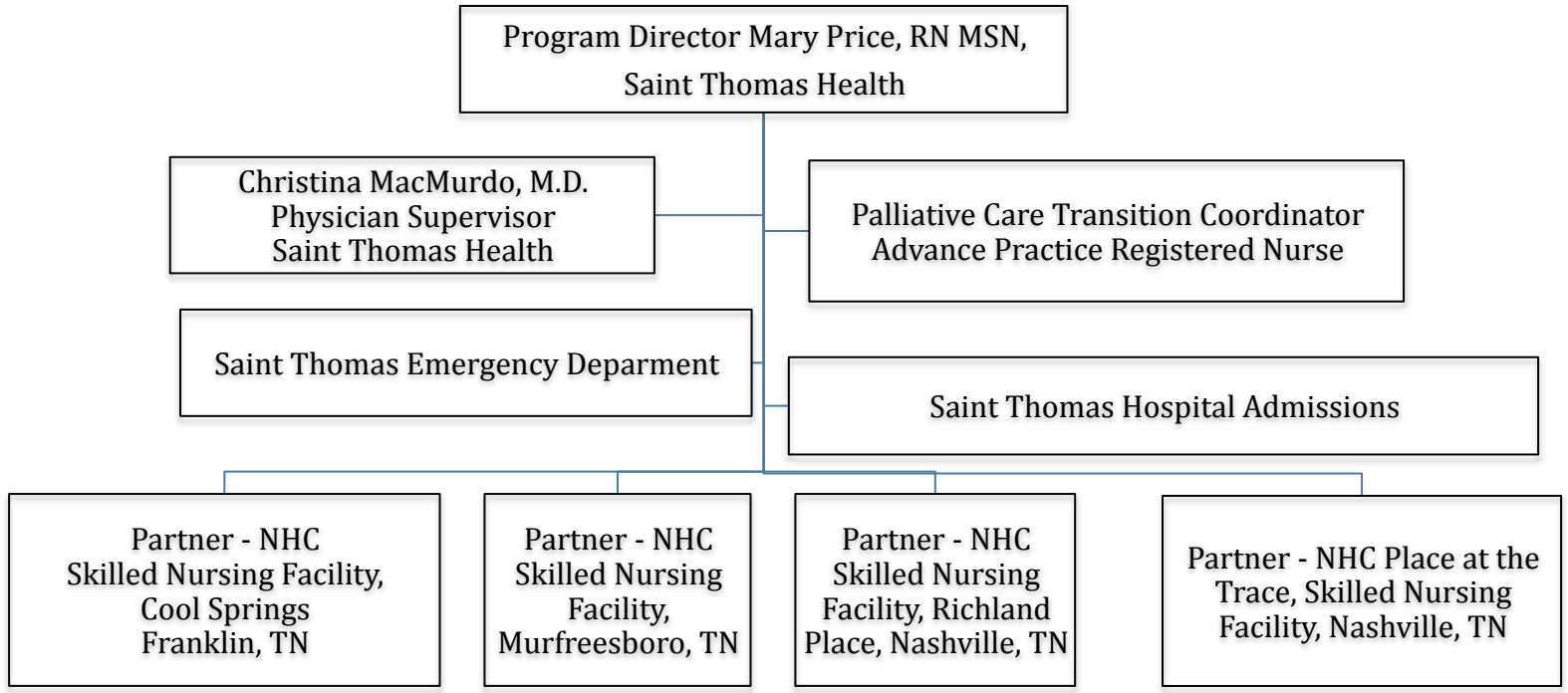
Physician Preceptor and Supervisor

Christina MacMurdo, MD is Outpatient Medical Director, Palliative Care at Saint Thomas West Hospital and is board certified in Internal Medicine and Palliative Care. She and another physician co-direct the interdisciplinary team that includes five nurse practitioners, a social worker, and a chaplain. Dr. MacMurdo received a B.A. in Human Biology from Stanford University and her Doctor of Medicine in 1997 from Vanderbilt University. She was an assistant professor of Medicine at Vanderbilt University from 2001 until 2008 when she joined Saint Thomas Hospital. She is Board Certified in Internal Medicine and Hospice and Palliative Care.

Dedicating 8 hours monthly to the program the primary duties of the Physician Preceptor and Supervisor are:

1) Supervise the Advance Practice Registered Nurse clinical practices
2) Review patient charts and audit the Nurse Practitioner's patient assessments and treatment recommendations to ensure that proper protocols are being followed.
3) Ensure all State Licensing laws pertinent to the Program are being followed.
4) Provide phone collaboration to facility based medical director regarding eligibility for readmission screening at clinic versus emergency department.

Palliative Care Transitional Program Organizational Structure and Partner Details



Saint Thomas Foundation dba Saint Thomas Health to receive award funds; no subcontracting of funds to Partners; Partner Collaboration with four National HealthCare Corporation Skilled Nursing Homes			
NHC Murfreesboro Skilled Nursing, Rehabilitative Care www.nhcmurfreesboro.com 420 North University Street Murfreesboro, TN 37130 Phone: (615) 893-2602 Lynn Foster, Administrator	**NHC Place, Cool Springs** Skilled Nursing, Assisted Living, Memory Care www.nhcplace.com 211 Cool Springs Boulevard Franklin, TN 37067 Phone: (615) 778-6800 Jerry Winton, Administrator	**Richland Place** Skilled Nursing, Rehabilitative Care www.richlandplace.com 504 Elmington Avenue Nashville, TN 37205 Phone: (615) 269-4200 Christina Jones, Administrator	**NHC Place at The Trace** Skilled Nursing, Rehabilitative Care www.nhcplaceatthetrace.com 8353 Highway 100 Nashville, TN 37221 Phone: 629-888-5800 Hunter Harris, Administrator

SAINT THOMAS HEALTH PALLIATIVE CARE TRANSITIONAL PROGRAM
EXPECTED OUTCOMES

Project Abstract

The Saint Thomas Health Palliative Care Transitional Program is an innovative pilot program that ensures the access to and portability of physician ordered life sustaining treatment documents (POLST) for patients during transition to/from hospitals and residency at skilled nursing facilities (SNFs). The overarching goal of the program is to increase the numbers of patient care conversations that are conducted with and implemented for palliative care patients/residents during transfers to, and residencies at, skilled nursing facilities.

Dedicated to Long Term Care Medicine, the Journal of American Medical Directors Association published a research article that states "Close to 1 in 5 patients admitted to a skilled nursing facility (SNF) are readmitted to the acute hospital within 30 days, and a substantial percentage are readmitted within 2 days of the SNF admission. These rapid returns to the hospital may provide insights for improving care transitions between the acute hospital and the SNF."[1]

Embedded in the situation is the frequent loss of resident's non-EMR paper physician ordered life sustaining treatment documents. Moreover, many residents who enter SNFs have recently entered into Palliative Care and have quickly worked with their physician and families to develop physician ordered life sustaining treatment documents. As a resident spends time in a SNF, care decisions often change once a "crisis" is over and the existing care treatment documents need to be reconciled to current care goals. The complexity of the situation requires close collaboration and well-defined joint processes between SNFs and hospitals.

Saint Thomas Health, with an existing partnership with National Health Corporation (NHC), will collaborate with NHC and implement the Palliative Care Transitional Program into four NHC Skilled Nursing Facilities. Mary Price, RN, MSN is the Saint Thomas Health System Director for Supportive and Palliative Care and will be the Palliative Care Transitional Program Director. Responsible for the successful implementation of the program, she will closely work with a Transitional Care Program Coordinator (an Advance Practice Registered Nurse), a Saint Thomas Health Physician Supervisor, and the NHC Palliative Interdisciplinary team (IDT). The Saint Thomas Health Palliative Care Transitional team will serve as subject matter experts to NHC staff. Together, they will develop written processes, protocols, and metrics to support the successful transfer of residents' medical care plans. The team will convey to SNF staff the methodology and skills that are necessary to engage residents and their families in goals of care conversations and shared decision-making.

Both process and quantitative measurements will be put into place to evaluate the success of the program. Measurements will include the delivery and regular execution of a written standard operating policy at NHC Skilled Nursing Facilities that specify compliance of resident's care goals and POLST. Additional measurements will examine patient and resident charts and determine whether, upon readmission to either a hospital or skilled nursing facility, an

[1] Joseph G. Oustlander, Llkin Naharci, Gabriella Engstrom, Jill Shutes, David G. Wolf, Maria Rojido, Ruth Tappen, david Newman Hospital Transfers of Skilled Nursing Facility (SNF) Patients Within 48 Hours and 30 Days After SNF Admission. 2016 www.jamda.com

individual's care directives were honored and followed. If necessary, course corrections will remedy any gaps in the processes. The primary benefit to SNF residents is that their care is truly person-centered when their medical treatment goals are realized, bringing satisfaction and peace of mind to themselves and their families.

Saint Thomas Health, based in Nashville, TN, is a leader in the healthcare industry. It is a family of Tennessee hospitals and physician practices united by a single mission: to provide spiritually centered, holistic care that sustains and improves the health of the communities served. Its health system consists of 9 hospitals, 8 community clinics, a residency partnership with the University of Tennessee, Express Clinics for urgent care, cancer and breast health centers. Saint Thomas Medical Partners is one of the region's largest medical groups with 524 physicians and providers, covering 32 Tennessee counties in 92 locations.

Statement of Need

People who have made the intentional effort to document their advance directives, living will, power of attorney, and/or end-of-life treatment decisions face an unintentional barrier in healthcare recordkeeping. Multiple and discontinuous electronic medical record systems force the use of a paper document to ensure a person's decisions are legally available and achievable when their physical care location changes. Moreover, Advance directives are not medical orders and research shows they are often not effective in completing a person's end of life wishes. [2]

A national effort is being developed across the United States to use a portable medical order, the Physician Ordered Life Sustaining Treatment (POLST) form to record patients' treatment wishes that can be used across settings of care. In a POLST conversation, also referred to as goals of care conversation, a SNF resident or hospital patient and health care professional discuss the patient's goals for care consistent with their values and beliefs, and the patient's diagnosis, prognosis, and treatment options, including end of life and the burdens of those treatment options. Together they reach an informed shared decision about what treatments the patient wants in case of medical emergency. POLST are at the heart of person-centered care and are necessary for a true continuum of care.

In most states, including Tennessee, POLST documents are still a paper process. A POLST Form always remains with the patient, regardless of whether the patient is in the hospital, at home or in a skilled nursing facility. The form should be placed in a visible location recognized by emergency medical personnel (usually the front of the refrigerator or in a medicine cabinet). In a health care facility a copy of the POLST Form should be in the medical record (http://polst.org/faq/).

A recent article in Geriatric Nursing stressed the importance of well-trained nursing staff in Skilled Nursing Facilities and the importance of their awareness of a resident's POLST. "Nursing home nurses are more confident and decisive when there is some kind of a plan in place, be it a policy, procedure, advance directive, medical care plan, hospital avoidance program, or informal plan of care or agreement." The article abstract cites "Transferring a

[2] J Duncan, Utah Department of Health, University of Utah , Electronic End-of-Life Care Registry: the Utah ePOLST Initiative. 2013 https://www.ncbi.nlm.nih.gov/pubmed/24551342

resident is a complex process and special skills, knowledge, and resources are required, but may be lacking. Efforts to formalize the transfer process and improve communication and collaboration amongst all stakeholders is needed and would be well received."[3]

Palliative care medical providers who conducted end of life conversations with skilled nursing facility residents at end of life showed less acute care use and burdensome transitions at end of life. Specialty palliative care consultations are likely to facilitate reductions in acute care use and potentially burdensome care transitions through two primary mechanisms. First, it is likely that they provide (earlier) palliative care exposure and symptom management for those who do not desire or do not qualify for Medicare hospice, such as residents receiving Medicare Part A SNF care. Second, they facilitate and begin (earlier) conversations about prognoses and person-centered care preferences. Such conversations often do not occur in NHs. Alternatively, consultation referral could be a signal of a desire to change goals of care to focus on quality of life or reflect recognition by clinicians that current care is non-beneficial. [4]

Saint Thomas Health reports that during CY 2016 it transferred 352 patients to be residents at the four NHC Skilled Nursing Facilities that are partnering in the Palliative Care Transitional Program. Of these patients 35 patients had a hospital Palliative Care consult before transfer to a SNF. With the implementation of the program, Saint Thomas predicts an annual outcome of reaching 176 patients/residents for palliative care consults. The NHC SNFs are in the process of studying the numbers of additional NHC SNF residents that could also benefit from a Palliative Care consult and goals of care conversations.

During an audit of hospitalized patients who received a palliative consult and later returned for a readmission, it was discovered that the POLST form and code status decisions made by these patients is often not scanned into the electronic medical record as a priority. It is not in a recurring banner of patient information viewable when the inpatient record is accessed by any provider, and not sent to the outpatient or emergency room patient medical record simultaneously. The Star Tribune shares the story of a woman with cancer who had an advance directive. When she presented at an emergency room they performed CPR after she went into cardiac arrest because they had not yet discussed the advance directive. So after discharge she completed a POLST form. Unfortunately, at her next hospitalization the emergency room physicians couldn't find the form in the health record (http://www.startribune.com/patient-wishes-tough-to-see-in-health-records/382583641/) and again, performed life-saving measures.

The need for POLST conversations among skilled nursing facility residents and reconciliation of those goals with hospital providers is clearly needed to reduce the numbers of events when resident/patient goals of care are not identified and followed, particularly in emergency situations. POLST is a national effort, recognized by 23 states and endorsed by another 24,

[3] Barbara O'Neill, Lynne Parkinson, Trudy Dwyer, Kerry Reid-Searl Nursing home nurses' perceptions of emergency transfers from nursing homes to hospital: A review of qualitative studies... July 2015 Geriatric Nursing www.gnjournal.com
[4] Susan C. Miller, Julie Lima, Orna Intrator, Edward Martin, Janet Bull, Laura C. Hanson, Palliative Care Consultations in Nursing Homes and Reductions in Acute Care Use and Potentially Burdensome End-of-Life Transitions. 2016 https://www.ncbi.nlm.nih.gov/pubmed/27641157

including the State of Tennessee to improve person-centered care and continuum of care. The need for a Palliative Care Transitional Program that is transportable and reproducible across Skilled Nursing Facilities in Tennessee aligns with Federal goals and directly addresses the person-centered initiative of the Nursing Home Civil Monetary Penalty Quality Improvement (CMPQI) Program. Saint Thomas Health is fully committed to this strategic priority and participates in the Nashville-based organization, Transitioning Patients Across the Care Continuum (TPACC). This Tennessee coalition is dedicated to "ensuring the right level of care at the right time for the right patient and to creating seamless transitions between care providers for patients through collaboration" (http://midtntpacc.wixsite.com/tpacc/about_us).

Program Description

The Palliative Care Transitional Coordinator (PCTC) will develop processes and tools to confirm portability of code status, POLST forms, and advance directives between the hospital and the four NHC skilled nursing facilities. The program will hire an Advanced Practice Registered Nurse to serve as the PCTC who will bring expertise and coordination for specific Saint Thomas Health patients referred to the four NHC sites. The PCTS will participate in a consulting capacity in a weekly NHC Palliative Interdisciplinary Team meeting at each of four NHC Skilled Nursing Facilities. The Interdisciplinary Team will discuss and evaluate palliative hospital care received by residents and formulate skilled nursing facility palliative care planning. If POLST forms indicate that readmissions are a resident treatment option, the PCTC will audit the hospital, emergency department, and outpatient medical records and verify visibility of current resident POLST during the team meeting. Reconciliation of NHC revisions to the POLST to Saint Thomas medical records will be completed after legal consent for record updates are received and the NHC Medical Director orders a POLST to be faxed to Saint Thomas Medical Records. If a resident has received any active treatment prescriptions from another provider within the last twelve months, the Interdisciplinary Team will determine how and if POSLT form communication to that provider is indicated.

One expected challenge is that the patients receiving palliative inpatient care will choose not to maintain the POLST form after becoming a resident at an NHC SNF. When this reversal of decision-making occurs, the PCTC will develop, with the NHC treating providers and Interdisciplinary Team, an assessment tool that tracks and identifies reasons for this reversal. Another second potential challenge is POLST forms not enacted at readmission to a Saint Thomas hospital, ED, or office visits. If this inaccuracy occurs, the PCTC will develop, with the Saint Thomas treating providers, Saint Thomas Health Quality and Ethics leadership, an assessment tool that tracks and identifies reasons for this error. Monthly reporting of the reversals and errors will be made to the NHC/STH Operational Transitions Process Improvement Team.

Goals and Outcomes

Stated earlier, the overarching goal of the Palliative Care Transitional program is to increase the numbers of patient care conversations that are conducted with and implemented for palliative care patients/residents during transfers to, and residencies at, skilled nursing facilities.

Goal 1. To collaborate with four (4) NHC Skilled Nursing Facilities to create a specific process to ensure that palliative care resident treatment directives are documented and implemented.	
Outcome 1. Within 3 months of grant award a well-defined written policy for the process of reconciling and verifying that SNF resident directives are portable is integrated into the NHC Skilled Nursing Facilities and Saint Thomas Hospital Standard Operating Procedures.	**Measurable 1**. Policy is written and integrated in Saint Thomas and NHC Standard Operating Procedures within 90 days or less.
Outcome 2. Within 12 months of grant award, the Palliative Care Transition Coordinator APRN will report that 176 SNF resident goals of care documents have been reconciled to both SNF and hospital care medical records.	**Measurable 2.** Monthly and annual reports indicate that at least 176 NHC residents have had their goals of care documents reconciled with hospital Electronic Medical Records.
Goal 2. To develop metrics that reveal a quality risk when there is a variance between residents' directives and patient care outcomes.	
Outcome 3. Within 45 days of grant award a metric is developed and is used to track resident outcomes that are compared with resident directives to confirm compliance for treatment received.	**Measurable 3.** STH and NCH implement a well-defined metric into their respective systems to track treatment compliance to resident directives.
Outcome 4. Within 60 days of grant award, the Program team develops monthly reports that document transitional events that comply with Resident directives and is used for process improvement when necessary.	**Measurable 4.** Reports are printed, analyzed and shared among the Program team and sent to executive leadership for program accountability.

Saint Thomas and its partner NHC are well positioned to quickly implement a Nursing Home Civil Monetary Penalty Quality Improvement (CMPQI) Program award once it is received. Having a strong partnership with NHC in place, Saint Thomas has designed an achievable timeline that will inaugurate the Palliative Care Transitional Program without delay.

July - September 2017 Milestones

- Interview and hire for Palliative Care Transitional Coordinator (PCTC) APRN (candidate identified already)
- Commence weekly meetings with NHC Palliative Interdisciplinary Team
- Begin audits of hospital, emergency department, and resident outpatient medical records and verify visibility of current POLST during the IDT meetings
- NHC IDT consults with residents and families to reconcile POLSTs
- Saint Thomas and NHC IDT Program team jointly develop process and written policy for reconciling resident POLST
- Saint Thomas and NHC IDT Program team jointly develop metrics for tracking resident outcomes as compared to POLST

- NHC with Saint Thomas as subject matter experts trains SNF staff in procedures for following resident care plans
- Submit quarterly report to the State of TN of CMS

October 2017 – June 2018 Milestones

- Weekly meetings continue with Saint Thomas and NHC Palliative Interdisciplinary Team
- Monthly reports track resident treatment outcomes as compared to POLST; reports sent to NHC and Saint Thomas executive leadership
- Saint Thomas and NHC IDT Program team review metrics and process implementation for quality improvement
- NHC trains any new SNF staff in procedures for following resident care plans
- Submit quarterly reports to the State of TN of CMS

RESULTS MEASUREMENT

Some evaluative measures are embedded into the chart indicating Goals and deliverable Outcomes. A well-written and executable process that is integrated into both Saint Thomas and NHC standard operating procedures is essential to the work of the program and will be produced in three months or less. Moreover, the constant training of staff on the policy is a measureable and will be validated in NHC and STH staff surveys that evaluate their understanding and use of the policy and its respective protocols. Metrics about the number of Palliative Care consults and whether POLST have been implemented for residents will be identifiable through the metric created and the subsequent monthly reports. Reports will be analyzed for compliance and improvement in the numbers of resident POLST documents followed.

Both Saint Thomas and NHC will monitor the program for unintended results and suggest program course corrections and quality improvement when necessary or appropriate. The program team will address any process implementation, POLST reconciliation audits, or staff training gaps. All required reports due to CMS and the State of Tennessee Department of Health will be submitted in a timely manner.

BENEFITS TO NURSING HOME (SNF) RESIDENTS

The primary beneficiaries of the program are SNF residents and their families. At the heart of person-centered care is the ability to respect resident care conversations and carry forth on the respective treatment plans. SNF residents would benefit greatly from improved processes regarding their physician directed treatment plans knowing that their expected care goals and particularly, end-of-life wishes will be met. The process improvements for person-centered care will bring peace of mind to both residents and their families and could save unnecessary stress and anxiety in addition to often unwanted and expensive medical procedures.

SNF staff and hospital medical providers will have direct benefit from the program. Knowledgeable and well-trained staff who are confident that resident treatment plans are clearly defined gives them the assurance that they are executing appropriate care for residents. Similarly, should a resident need transport to and care at a hospital, reconciled treatment plans offer clarity about residents' wishes. A subsequent benefit from this is that unnecessary emergency room visits or readmissions to hospitals will be decreased and less economic stress placed upon hospital systems.

CONSUMER/STAKEHOLDER INVOLVEMENT

NHC will take an active role in the Palliative Care Transitional Program through its Palliative Interdisciplinary Team. They are committed to frequent and continuous care conversations with residents and their families – a primary task of the team. They will work with the Saint Thomas Health program team during weekly meetings at each facility and draw upon them as subject matter experts. As seen in the Letter of Support signed by their corporate officer, NHC is fully committed to the Palliative Care Transition Program and is dedicated to improving processes within four of their Skilled Nursing Facilities and potentially, many more in the future. The Interdisciplinary Team will account to each of the local four NHC executive teams about program for reporting back to corporate NHC.

FUNDING

Palliative Transitional Care Program Budget Narrative on budget of $97,912

Salaries (rounded to $62,800)

Program Director. Mary Price will serve as Program Director and is responsible for overseeing program plans and directs activities to ensure that program goals and milestones are accomplished within funding parameters. She is responsible for the hiring and supervision of program personnel and has budget oversight and financial accountability. Her role is essential to the continuous communication with CMS and the State of TN and networking with local, state and national agencies for future program development. The Program Director will commit .08 FTE% of her time to this project for the year (0.08% x annual salary of $109,221 = $8,738).

Program Coordinator APRN. The Program Coordinator (an Advance Practice Registered Nurse) will be hired to develop process and tools to confirm portability of code status and advance directive decisions documentation, access, and treatment impact on readmission by participating in IDT meetings for Saint Thomas patients, verifying POLST form visibility in both NHC and ST West medical records. The Program Coordinator will confer with NHC facilities' program staff to outline the work plan and to discuss program tasks, responsibilities, and scope of authority. The Program Coordinator will travel weekly to each of four partnering facilities to implement program processes and protocols and ensure activities are on schedule and within prescribed budget. The Program Coordinator is budgeted at 50% FTE time and effort (.50 x annual salary of $108,160 = $54,080).

Grants Manager. The Grants Manager will provide grants implementation assistance, program report support, and financial checks and balances for the program. Saint Thomas Health provides a matching contribution of $2,680.

Benefits & Taxes (rounded to $18,800)

Saint Thomas Health budgets 30% for employee fringe benefits (FICA, medical, retirement, taxes, etc.). Benefits and taxes for the program are calculated at .30 x $8,738 = $2,621 for the Program Director and .30 x $54,080 = $16,224 for the Program Coordinator APRN. The total request for Benefits and Taxes is rounded $18,800. A matching contribution of Benefits and Taxes for the Grants Manager is calculated at $800.

Professional Fee / Grant & Award ($11,712)

Physician Preceptor and Supervisor. Dr. Christina MacMurdo will supervise the Advance Practice Registered Nurse program activities to ensure that patient assessments and treatment recommendations and proper protocols are being followed. The Physician Preceptor and

Supervisor will ensure that all State Licensing laws pertinent to the program are being followed and will devote 8 hours monthly to the program x $122/hour for an annual total of $11,712.

Travel / Conferences & Meetings (rounded to $4,600)

Mileage. A total of $4,600 (rounded) is budgeted for mileage for one weekly trip for Program Coordinator APRN to each of the four NHC Skilled Nursing Facilities and one monthly trip for Program Director to each facility. Estimated annual total roundtrip miles from Saint Thomas Hospital West to participating facilities is: NHC Cool Springs ($1,284); NHC Murfreesboro ($2,375); NHC Place at the Trace ($770); and NHC Richland ($128). Mileage is calculated at 2017 Federal Mileage rate of $0.535.

Sustainability

Saint Thomas Health is committed to the success of this program and the mission of providing a standard of excellence for person-centered care. Saint Thomas Health, through its existing Palliative Care program across its hospitals has demonstrated its commitment to Palliative Care and SNF residents. Saint Thomas Health and National Health Corporation have a strong existing partnership with both organizations committed to an integrated system of seamless care for patients. Saint Thomas anticipates that the success of the Palliative Transitional Care Program pilot program will encourage Saint Thomas management to institutionlize the program and incorporate future program expenses into the Saint Thomas Health Palliative Care cost center.

G. INVOLVED ORGANIZATIONS

Saint Thomas Health is the lead applicant and will be financially responsible for all grant award funds. Mary Price, RN, MSN will serve as Program Director and primary contact. Specific contact details are: 102 Woodmont Blvd, Suite 800, Nashville, TN 37205; 615-584-7459; mprice@sth.org. Four NHC SNFs will actively participate in the program and support the goals, outcomes and activities as outlined in the Program Design. They are collaborating partners and not subcontractors. Please refer to the Letter of Support signed by corporate NHC and the organizational structure attachment for details about each NHC Skilled Nursing Facility.

H. INNOVATION AND REPLICABILITY

The national effort to use Physician Ordered Life Sustaining Treatment (POLST) documents includes 24 states that have fully implemented POLST and another 23 states developing POLST programs. Tennessee endorses POLST (http://polst.org/programs-in-your-state/). Using the POLST guidelines, the Palliative Care Transitional Program is evidence-based. The program is innovative in its methodology to develop processes to ensure that POLST documents are always reconciled with the most current information for residents and that transfer of documents and information has a smooth process.

The intention is to pilot the program within four NHC SNFs and share the results with NHC corporate. As NHC SNFs are under one umbrella organization, NHC can duplicate the program, stair stepping it into more of its facilities. NHC currently has more than 150 facilities across ten states. Saint Thomas and NHC believe that the Palliative Care Transitional Program is vital to the health of SNF residents and are committed to sharing best practices of the program with the State of TN and Federal governments and other nursing facilities.

NHC
NATIONAL HEALTHCARE CORPORATION

February16, 2017

Melissa Painter
Competitive Procurement Coordinator
Service Procurement Office
Division of Administrative Services
Andrew Johnson Tower, 5th Floor
710 James Robertson Parkway
Nashville, TN

RE: Nursing Home Civil Monetary Penalty Quality Improvement (CMPQI) Program Implementation Funding Opportunity, RFA # 34305-22417

Dear Ms. Painter,

On behalf of National Health Corporation (NHC) we are pleased to partner with and write a Letter of Support for the Saint Thomas Health Palliative Care Transitional Program. NHC is committed to person-centered care and the continuous improvement of care for our residents and their quality of life.

The Saint Thomas Health Palliative Care Transitional Program directly aligns with the NHC mission. NHC's participation in this grant will facilitate the staff at our skilled nursing facilities to make process improvements for the successful transfer of patient health care directives when patients are transferred between hospitals and skilled nursing facilities. Together, NHC and the Saint Thomas Palliative Care Transitional Program team members can augment the NHC standard of care through improved processes and protocols for the betterment of residents, families and staff.

NHC is committed to rolling out the program as a pilot within four NHC facilities located in Williamson, Davidson, and Rutherford counties. We anticipate that this program will bring both quantitative and qualitative enduring improvements in our staff's ability to provide care at a higher level of excellence. We expect measureable and ongoing increases in carrying out patients' care of conversations and subsequent increased satisfaction levels.

With our intent to sustain the program, NHC anticipates expanding the program and its best practices into our other facilities within TN. The program structure enables a smooth replication across our Skilled Nursing Facilities.

Sincerely yours,

Name: Steve Flatt

Title: CEO

GENERAL ASSURANCES

Assurance is hereby provided that:

1. This program will be administered in accordance with all applicable statutes, regulations, program plans and applications:
   a. The laws of the State of Tennessee;
   b. Title VI of the federal Civil Rights Act of 1964;
   c. The Equal Employment Opportunity Act and the regulations issued there under by the federal government;
   d. The Americans with Disabilities Act of 1990 and the regulations issued there under by the federal government;
   e. The condition that the submitted application was independently arrived at, without collusion, under penalty of perjury; and,
   f. The condition that no amount shall be paid directly or indirectly to an employee or official of the State of Tennessee as wages, compensation, or gifts in exchange for acting as an officer, agent, employee, subcontractor, or consultant to the Agency in connection with any grant resulting from this application.
2. Each agency receiving funds under any grant resulting from this application shall use these funds only to supplement, and not to supplant federal, state and local funds that, in the absence of such funds would otherwise be spent for activities under this section.
3. The grantee will file financial reports and claims for reimbursement in accordance with procedures prescribed by the State of Tennessee Department of Health.
4. Grantees awarded grants resulting from this application process will evaluate its program periodically to assess its progress toward achieving its goals and objectives and use its evaluation results to refine, improve and strengthen its program and to refine its goals and objectives as appropriate.
5. If applicable, the program will take place in a safe and easily accessible facility.

CERTIFICATION/SIGNATURE

I, THE UNDERSIGNED, CERTIFY that the information contained in the application is complete and accurate to the best of my knowledge; that the necessary assurances of compliance with applicable state/federal statutes, rules and regulations will be met; and, that the indicated agency designated in this application is authorized to administer this grant.

I FURTHER CERTIFY that the assurances listed above have been satisfied and that all facts, figures and representation in this application are correct to the best of my knowledge.

Dawn Rudolph — 2/21/17

Signature of Applicant Agency Administrator — Date Signed (Month/Day/Year)