Saint Thomas Health Foundation
Civil Monetary Penalty Improvement
Palliative Care Transitional Program

Quarter 5 Report (February 1, 2019-April 30, 2019)

1. **Grantee Name:** Saint Thomas Health Foundation
2. **Grant Contract** Edison Number: 169280
3. **Grant Term:** Feb.1, 2018 – June 30, 2019
4. **Grant Amount:** $101,212

5. Narrative Performance Details: *(Description of program goals, outcomes, successes and setbacks, benchmarks or indicators used to determine progress, any activities that were not completed)*

Goals and Outcomes

The overarching goal of the Saint Thomas Health 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.

The Saint Thomas program is closely working with NHC leadership and staff and is being implemented in four NHC Skilled Nursing Homes in Middle Tennessee: Richland Place and The Trace in Nashville; NHC Murfreesboro in Murfreesboro; and Cool Springs in Franklin.

Key activities from February 1, 2019-April 30, 2019 include but are not limited to:

1. Monthly onsite meetings between Susan Parker and Dr. Catherine Steuart to review NHC Murfreesboro consulted cases documentation and planning. There have been sixteen billed cases through March 14, 2019. NHC leaders Lynn Foster and Casey Reese cite no barriers other than low census for eligible palliative consults.

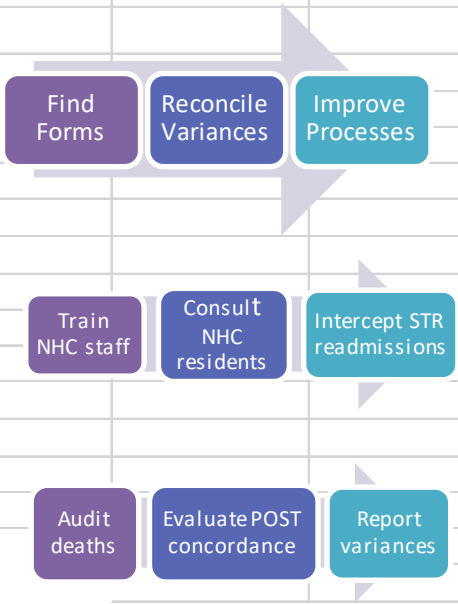
2. Phase Two process change implemented is STHS system policy on End of Life that standardizes POST completion guidelines. Still pending is the agreement by NHC to initiate HIM process of faxing new DNR POSTs to STHS HIM for inclusion in electronic medical record as standard with admissions to NHC. Awaiting development of legal disclaimer on POST that it must be verified as the active POST.

3. Phase Two monthly audits of transfers between NHC Murfreesboro (MB) and Saint Thomas Rutherford Hospital (STR) ED to identify patients with DNR POST to trigger Palliative consult in the ED with Dr. Catherine Steuart or Susan Parker APRN has continued. The NHC transfer list is generated by Wayne Davis, NHC and audited by Program Director Mary Price in the Cerner electronic medical record of STH. A monthly Excel worklist is maintained by Mary Price to track if a DNR POST is present and if a Palliative consult was initiated in the ED or inpatient stay.

2018 NHC MB to STR ED	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Visits	33	17	18	16	23	20	15	17	15	20		
Patients	27	15	15	14	19	19	14	15	13	17		
POST DNR	18	11	10	5	8	7	8	4	4	4		
Palliative consult in hosp	5	1	1	0	0	0	0	0	2	2		
ED referrals to PC	0	0	0	0	0	0	0	0	0	0		

4. Continuation of weekly phone call with Susan Parker to enable Mary Price to plan education content and to verify expenses for week.
5. Discussion surrounding online curriculum to be developed after NHC MB training for access by all NHC sites.
6. Updated Dashboard to include conclusion of Phases 1-3.
7. Phase Three discordant deaths audit was done in January and will be repeated in June.
8. Phase Four was initiated in a meeting with NHC VP Greg Bidwell March 23 to identify sustainable activities after grant completed.
    a) Since there are about sixty current residents at NHC Murfreesboro who have elected a Medicare Advantage type program targeted to patients expected to stay over ninety days, the onsite NHC NP managing those patients will consult STHS Palliative care if a consult is medically indicated as part of a transfer admission to Saint Thomas Rutherford. The STHS Palliative provider will validate the need for a consult with the admitting physician. Discharge transition of care communication for patients returning NHC would include STHS Palliative provider contact to NHC with plan of care, advance directives and POST forms.
    b) NHC/STHS weekly readmission review added identification of a Palliative inpatient consult or a POST with a DNR status. This is noted by social worker to trigger an inpatient request for Palliative consult at any subsequent transfer back to Saint Thomas Rutherford.

Palliative Grant Dashboard		
PHASE ONE	Feb. 1, 2018 through April 30, 2019	Total
	Expenses	$ 25,842
	Admissions Reviewed	372
	DNR with POST variances	123
	POST faxes to STH HIM	100
PHASE TWO	Technician Training Participants	77
	Professional Training Participants	83
	Provider Consults NHC	16
	Provider Consults STR ED	0
PHASE THREE	Audit of discordant deaths during grant	
	STH 20/372	2
	NHC 7/372	0



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. Results: Saint Thomas implemented an End of Life policy that includes guidance for POST. NHC is implementing the faxing new DNR POSTs to STHS HIM once legal stamp to acknowledgement latest dated POST is the active POST. Palliative consults when patient expires are reviewed for POST and concordant care. Discordant cases are reported as safety events to Ethics and Medical Leadership.
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. Results: Program Director Mary Price audited 372 patient records in Q1-2.
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. Results: Patient deaths were audited and concordant care determined. NHC had 7 deaths and all were concordant. STH had 17 deaths and 15 were concordant. Two discordant cases reported in Safety Event system and discussed with CMO and Ethics. Final audit in June.
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. Results: The Phase One transitional event selected was the variance in POST forms when a DNR order was requested by the patient. The Phase Two transitional event includes ED admissions from NHC when a DNR POST exists. The Dashboard monthly report includes both Phases, NHC consults,

	NHC transfers, and STR ED consults.

The following milestones were included in the proposal. Results are related to each milestone.

February 2018 -April 2019 Milestones

- Interview and hire for Palliative Care Transitional Coordinator (PCTC) APRN (candidate identified already). Completed.
- Commence weekly meetings with NHC Palliative Interdisciplinary Team Completed.
- Begin audits of hospital, emergency department, and resident outpatient medical records and verify visibility of current POST during the IDT meetings. Completed – all 4 sites have been audited during phase one and the NHC Murfreesboro transfers in phase two.
- NHC Interdisciplinary Team (IDT) consults with residents and families to reconcile POSTs. STH Program Director and Nurse Practitioner are working with NHC and reviewing resident charts to determine any variances during resident transitions between facilities. Refer to Measurable 4 Results.
- Saint Thomas and NHC IDT Program team jointly develop process and written policy for reconciling resident POST. Refer to Measureable 1 Results.
- Saint Thomas and NHC IDT Program team jointly develop metrics for tracking resident outcomes as compared to POST. Refer to Measureable 3 Results.
- NHC with Saint Thomas as subject matter experts trains SNF staff in procedures for following resident care plans. Completed four training sessions with LPNs and CNAs and post-test.
- Submit quarterly report to the State of TN of CMS – April (5th) Quarterly Report submitted June 6, 2019 after clarification received from Jacy Weems that extended date June 30, 2019 did not replace quarterly reports.