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

Quarter 6 Final Report (May 1, 2019-June 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 May 1, 2019-June 30, 2019 include but are not limited to:

1. Met with NHC Murfreesboro Administrator, Social Worker, APN, Medical Officer, and NHC Advantage APN to establish ongoing Palliative relationship will be related by phone calls from NHC to Saint Thomas Rutherford Palliative APN when residents transfer and consult needed.

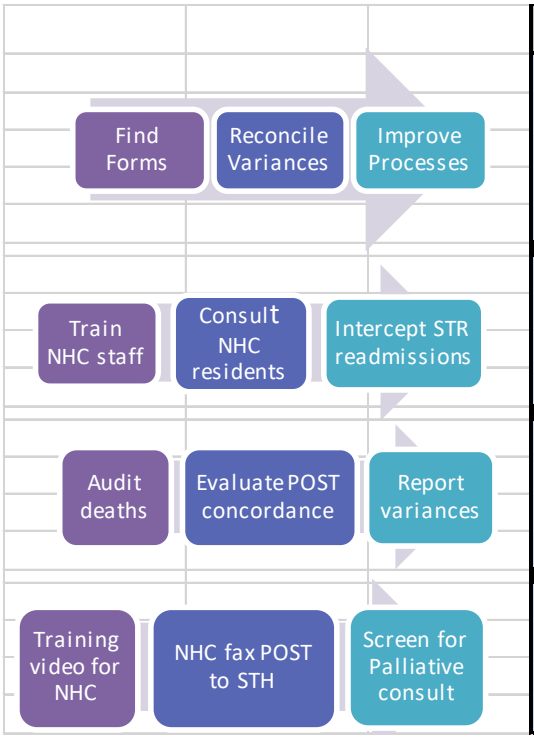
2. NHC implemented ongoing HIM process for admission POST to be faxed to Saint Thomas Health HIM for medical record inclusion with disclaimer on POST that it must be verified as the active POST.

3. Completed final audit of deaths within 372 Phase One population for concordance. No additional NHC deaths; three additional STH deaths; all were concordant.

4. Completed video of advance directive training for use by NHC at all sites.

5. Weekly NHC/STH readmission audits identified 4 with DNR POST that NHC Social Worker then communicated request for Palliative inpatient consult after transfer to hospital. Three of the four requested did have inpatient Palliative consult.

6. Presentation for July 2 Dept. of Health Parade of Programs submitted to State.



Palliative Grant Dashboard		
PHASE ONE Q1 FEB-APR18	Feb. 1, 2018 through June 30, 2019	Total
	Expenses	$ 29,784
	Admissions Reviewed	372
	DNR with POST variances	123
	POST faxes to STH HIM	100
PHASE TWO Q2-5 MAY18-MAR19	Technician v Prof Training Participants	77 v 83
	Provider Consults NHC	16
	NHC transfers with POST DNR	75
	STR Palliative Consults ED v IP	0 v 9
PHASE THREE Q6 APR-MAY19	Audit of discordant deaths during grant	372
	STH 20	2
	NHC 7	0
CLOSURE JUN19	Video for NHC advance directive training	
	Weekly readmission review for PC hosp consult	
	NHC adm POST fax to STH	

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 implemented policy faxing admission POSTs to STHS HIM with acknowledgement latest dated POST is the active POST. Palliative consults when DNR patient discharges from STH to SNF/LTC are audited monthly for POST completion. July 2018-May 2019 294 out of 333 (88%) POST completion rate.
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	**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

care medical records.	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 within the 372 audited admissions through May 2019: NHC had 7 deaths- all concordant. STH had 20 deaths-18 were concordant. Two discordant cases reported to CMO and Ethics.
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 Dashboard quarterly report includes cumulative metrics for all three Phases in six quarters.

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

February 2018 -June 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.
- Completed 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 (372) and NHC Murfreesboro transfers to Saint Thomas Rutherford emergency room in phase two (75).
- 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 expert, trains SNF staff in procedures for following resident advance care plans. Completed four training sessions with LPNs and CNAs and post-test. Developed advance directive training video for NHC use across sites.
- Submit quarterly report to the State of TN of CMS – June Final Quarterly Report submitted June 30, 2019
- Submit 5 day Follow Up Monitoring report and Six month Final Monitoring report-online reports initiated and saved for completion.