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

Quarter 2 Report (May 1, 2018-August 31, 2018)

1. **Grantee Name:** Saint Thomas Health Foundation
2. **Grant Contract** Edison Number: 169280
3. **Grant Term:** Feb.1, 2018 - Jan.31, 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-August 31, 2018 include but are not limited to:

1. Weekly NHC admissions were audited to identify POST variances as Phase One.
2. Phase one of grant activities completed June 30 with 372 charts audited. There were 123 POST variances and 100 POST forms were faxed to STHS HIM for insertion into the patient electronic medical record.
3. Phase one process changes include: a. STHS system policy on End of Life that standardizes POST completion and b. Discussion with 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.
4. Meetings with NHC June 26 and July 6 planning initiation of NHC Phase 2 on July 2. NHC Murfreesboro (MB) site contract of NP services generated with STHS and 1-3 cases per week targeted as volume. Focus on patients readmitted to Saint Thomas Rutherford Emergency Department and then returned to NHC MB.
5. Onsite State visit NHC-STH meeting held July 19 to review Feb 1-June 30 results. Discussions were held about Phase two of the program including approval of Nurse Practitioner Susan Parker's billing not being redundant with grant expensing while consults done at Murfreesboro NHC. Six patients have had consults.
6. STHS Phase 2 uses monthly audits of transfers between NHC MB and STR ED to identify patients with DNR POST to trigger Palliative consult in the ED with Dr. Catherine Steuart. 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 order or DNR POST were present and a Palliative consult was initiated. In July-August there were

2018 NHC MB to STR ED	July	Aug
Visits	33	17
Patients	27	15
No Cerner note	2	1
POST DNR	18	11
Palliative consult in hosp	5	1
Palliative declined in hosp	1	0
Potential PC ED impact	2	2
ED referrals to PC	0	0

7. Continuation of weekly phone call with Susan Parker to enable Mary Price to plan education content and to verify expenses for week.
8. Wrote curriculum and planned monthly advance directive teaching for LPNs and CNAs in August, September, November, and December at NHC MB to align all Phase two activities in one site.
9. Planned for online curriculum to be developed after NHC MB training for access by all NHC sites.
10. Completed training pretest at Aug. 14 & 16 education at NHC MB.

The following is the list of eight True/False pretest questions distributed to 17 L.P.N.s and 30 C.N.A.s.

1. Pain is managed, relationships optimized, and the dying person's wishes honored in a "Good Death"
2. Only a patient can sign a Living Will
3. A person's Power of Attorney can request CPR even if the POST says DNR
4. A Living Will can't be followed by the EMS team
5. Once a doctor fills out the POST form it can't be changed by the patient
6. TN Advance Care Plans document Healthcare agents and Living Will content
7. On admission to a post-acute facility a nurse practitioner may sign a POST form without the physician or patient signature
8. If the family is upset when the patient dies it is a "Bad Death"

The test results by testing groups and questions are in the following table that shows the baseline of their value indicators (Questions 1 and 8) and their knowledge base of factual information (Questions 2-7)

Training	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8
Aug 14&16 Pre-Test	Percent % Correct							
17 L.P.N.s	100%	35%	12%	18%	100%	88%	82%	100%
30 C.N.A.s	90%	40%	57%	33%	77%	87%	60%	97%

11. Updated Dashboard to include conclusion of Phase 1 and beginning of Phase 2.
(RP: Richland Place; MB = Murfreesboro; CS = Cool Springs; TR= Trace at the Place)

	NHC Grant Dashboard				
	Patient admission dates to NHC	**June 3-June 30**	**July 1-July 31**	**Aug 1-Aug 31**	**Total Q1-2**
	Expenses	$ 3,275.94	$ 3,365.99	$ 2,271.23	$ 21,292.11
PHASE 1	**Admissions Reviewed**	18	NA	NA	372
	RP	7	0	0	145
	MB	1	0	0	79
	CS	1	0	0	21
	TR	9	0	0	127
	DNR with POST variances	5	NA	NA	123
	RP	2	0	0	48
	MB	1	0	0	34
	CS	0	0	0	4
	TR	2	0	0	37
	POST faxes to STH HIM	13	NA	NA	100
	RP	3	0	0	46
	MB	7	0	0	31
	CS	1	0	0	4
	TR	2	0	0	19
PHASE 2					
	Technician Training Participants	NA	NA	30	
	Professional Training Participants	NA	NA	17	
	Provider Training/Consults	NA	5	1	

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 has written and approved and End of Life policy that includes guidance for POST. NHC is reviewing the feasibility of faxing new DNR POSTs to STHS HIM .
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 will be audited and concordant care determined. NHC/STH are examining methods for identifying patient deaths that occur within the grant period with the intention to track 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. Results: The Phase one transitional event selected was the variance in POST forms when a DNR order has been 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 and include NHC consults as well as STR ED consults.

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

February-August 2018 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.
- 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 curriculum, administered pre-test, conducted first of four training sessions with LPNs and CNAs.
- Submit quarterly report to the State of TN of CMS – August Quarterly Report submission.