Civil Monetary Penalty Reinvestment Reporting Tool

Please complete the survey below.

Thank you!

Response was added on 07/08/2019 9:59am.

Please select the type of report you are submitting. Select all that apply.	☐ Invoice Submission (Payment Form) ☐ Quarterly Narrative Report ☐ Quarterly Expense and Budget Report (Expenditure Form) ☐ Annual Expense and Budget Report ☐ Follow-up Monitoring Report ☒ Final Follow-up Monitoring Report (Summary Report)
Reporting Period:	February 1, 2018- June 30, 2019 (Example: January 1, 2019-March 31, 2019)
CMS Project Number	169280
TDH Contract Number	Z181169280
Project Name	Saint Thomas Health Palliative Transitional Program
Project Contact Name	Mary Price
Project Contact Email	mprice@ascension.org
If any agreements or subcontracts were developed to ensure completion of project activities, please attach.	[document]
Total number of staff trained during the entire duration of the project (If applicable):	60
Project Category:	◯ 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

Focus area:	☐ Healthcare-Associated Infections ☐ Emergency Preparedness ☐ Preventable Hospitalizations ☐ Improving nursing facilities' overall star rating ☐ Residents' Rights ☐ Quality Measures ☒ Culture Change ☐ Other
Total approximate number of nursing home residents impacted through the project:	388 (Total number impacted for all reporting periods)
What success stories have resulted from the project and how you plan to showcase successes with stakeholders?	Article of success published on page 35 of the CMS Region IV Atlanta "Civil Money Penalty Reinvestment program update 2017-2018"
Please provide any feedback that has been received from staff, family, or residents as a result of the project.	Email June 5, 2018 from Stephanie Davis, CMS Region IV :" We are pleased to see that all four nursing homes have selected project champions and that audits are underway to ensure that residents advanced directives are being received and most importantly honored by the health care system. Each and every month, the RO receives notice of an immediate jeopardy related to advanced directives. Staff either did not have knowledge of the advanced directive or staff failed to adhere to the advanced directive and the resident's wishes. The note that 176 residents had their goals of care documents reconciled with hospital HER is quite an accomplishment. We hope the facilities will continue to encourage use of the POLST form, and continue to have conversations with residents and their family members upon admission and throughout the resident's stay. This is so very important. You would be surprised by the number of people that have not completed a living will, advanced directive, etc. Email Nov. 28, 2018 from NHC Administrator Lynn Foster: "She was very compassionate with the patient and family. His death was very peaceful and comfortable because of the conversation Sue had with the patient. We also enjoyed your in-services with the Nurse's & CNA's. The partners were very interested in the information that was provided and received a good understanding of palliative care. We also had very good communication and Sue was very easy to work with. " Email Nov. 27, 2018 from NHC Nurse Manager Kristin Thomason: "Sue with Palliative from St. Thomas Rutherford has been a delight at our center. She has a very good sense of where the patients stand with their wishes. She has an incredible sense of being able to read people and explain things to them on a level that they understand."
Please attach any materials, meeting minutes, or attendee lists that have resulted from the project. Examples: toolkits, process documents, training materials, marketing materials, photos, etc.	[document]

Do you have additional materials to upload?	⊗ Yes ◯ No
Please upload any additional materials.	[document]
Please upload any additional materials.	[document]
What do you consider to be the greatest impact(s) of the work performed utilizing CMP funds?	Establishment of collaborative relationship between NHC Murfreesboro staff and inpatient palliative staff at Saint Thomas Rutherford Hospital; POST form completion monitoring as quality metric based on new system wide policy at Saint Thomas Health; New NHC policy to fax admission POST forms back to Saint Thomas Health medical records;
What best practices resulted from the project and how can other facilities or other organizations duplicate the project?	Monthly audits for POST form completion if DNR and discharge to SNF/LTC facility; faxing SNF/LTC admission POST forms to transferring hospital medical records.
What activities have occurred to ensure sustainability since the completion of the project?	NHC orientation video produced for use at all sites. NHC/STH weekly readmission screen for DNR POST reported to NHC Murfreesboro social worker to trigger inpatient Palliative consult request if another hospital admission occurs. NHC policy for all admission POSTs to be faxed to medical records at Saint Thomas Hospital.
Describe any plans for moving forward and what, if anything, you will do differently.	Potential new grant request developing primary palliative care skills for NHC Murfreesboro onsite NP managing NHC Advantage residents and onsite palliative "unit" with CMS Demonstration project participants from Indiana University.

Please list the major goals and objectives of the project and answer the following questions for each: -Did you meet the outlined goal or objective? Why or why not? Please provide a detailed response. -What impact did your activities targeted at meeting the outlined goal or objective had on nursing home residents in the facility or 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. Met Results>90 days: 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 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 20 deaths and 18 were concordant. Two discordant cases reported in Safety Event system and discussed with 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 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 report includes all Phases and metrics and has been communicated quarterly. The impact of the activities insured residents' POST form documents in hospital medical record

	were updated after transition to NHC during grant and per newly created NHC policy going forward; POST form completions were conducted for hospitalized DNR patients transferred to NHC SNF/LTC sites; advance directive training was provided for NHC Murfreesboro staff in person and by video for all NHC sites going forward; specialty Palliative consults were provided for 16 NHC residents; and NHC residents readmitted to hospital have a review for the presence of a DNR POST to trigger and achieve a hospital Palliative consult at future readmissions.
Please list any project deliverables that are outlined in the project description and answer the following for each: -Did you meet the project deliverable? Why or why not? Please provide a detailed response. -What impact did your activities targeted at achieving the project deliverable have on nursing home residents in the facility or facilities?	Goal one deliverable for written policies was met for both the NHC system (POST faxes on admission) and the Saint Thomas system (POST completions per End of Life Care). Goal two deliverable for metrics to review any variance in resident wishes and patient care outcomes was met by review of 372 residents for deaths with concordant care. There were 7 deaths and no residents who had discordant care. The hospital had 20 deaths and two were discordant and reported to safety and medical ethics leadership.
Results Measurement(s): Please indicate what measurement methods you utilized to tract progress and project success. Please provide a summary of measurable project results.	Hospital and NHC medical records were audited for POST documents and tracked in an excel file to generate which POSTs should be faxed to hospital after NHC admission at four sites. There were 372 records audited with 123 residents having a variance in the DNR status on the POST form in both NHC and hospital medical record at the time of transition. Of the 123 faxed back to the hospital, 100 POSTs were confirmed in the hospital medical record as update. Classroom training on advance directives was provided to NHC patient care staff. Technician level staff count was 77 and professional level staff count was 83 at the NHC Murfreesboro location. The pre/post test for training showed an overall improvement in test scores for those staff. The decision to provide specialty Palliative consults at NHC was an additional training method contracted for a limited time to demonstrate benefit to residents needing symptom management and goals of care discussions in the absence of any NHC Palliative program. A method to increase emergency room Palliative consults for readmissions was not successful at the Saint Thomas Rutherford Emergency Room but 75 transfers were identified as having POST forms with DNR status and 9 had a Palliative consult at that inpatient stay. Determining concordant deaths for any of the 372 residents resulted in confirmation of all 7 NHC deaths and 18/20 hospital deaths.

Results Measurement: Please upload any relevant data or graphs related to project final outcomes and/or success. Please segment all data as appropriate. Examples: -Unidentified MDS data for residents participating in the program before and after implementation; -Infection rates at baseline and after project implementation; -Number of participating residents each quarter; -Pre and post survey results; -Costs savings.	[document]
Do you have additional results measurement documentation to upload?	◯ Yes ⊗ No
Please provide any additional information you would like to include in your final report.	
Please upload any additional documentation you would like to share in your final report.	[document]