**Saint Thomas Health Foundation**

**Civil Monetary Penalty Improvement**

**Palliative Care Transitional Program**

**Quarter 1 Report (February 1, 2018-April 30, 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 Feb.1-April 30, 2018 include but are not limited to:**

1. Weekly NHC admissions work list that is reviewed by program leadership.
2. PRN status phone calls with Mary Price, Saint Thomas Health (STH) Program Director, and Dr. Slandzicki, NHC Chief Medical Officer. These phone calls review progress and address any program concerns.
3. Introductory NHC-STH meetings were held with all four NHC locations to establish on-site champions and work list sharing. Discussions were held about the program and Nurse Practitioner Susan Parker’s access to NHC patient records.
4. NHC project champion Christina Jones was appointed to communicate with champions at each site:
	1. Richland Place: Christina Jones and Joan Stephens
	2. Murfreesboro: Lynn Foster
	3. Cool Springs: Misty Tummins
	4. Trace: Bethany Crutcher
5. Weekly audits were developed to identify variance metrics. – The NHC admission list is generated by Wayne Davis, NHC and audited by Program Director Mary Price in the Cerner electronic medical record of STH. A master Excel worklist is maintained by Mary Price to track if an advance directive, healthcare agent, POST form, or DNR order was part of the STH hospitalization prior to transfer to NHC. Patients to be audited at Murfreesboro and Cool Springs are faxed to Susan Parker. Josh Fralix of NHC audits and reports to Mary Price those same metrics for Richland Place and Trace from their electronic medical records. STH Nurse Practitioner Susan Parker manually audits and emails reports of those metrics at NHC Murfreesboro and NHC Cool Springs locations since they don’t have electronic health records. Mary Price reconciles STH/NHC documents and sends a list to Christina Jones of those patients who have a DNR POST variance between the hospital record and the NHC record and requests that the NHC POST be faxed to STH. Christina sends each NHC site their list to be faxed. Each site emails Ms. Price a confirmation of date faxed is sent. Ms. Price audits Cerner STH to confirm scanned POSTs and emails Christina a list of missing documents.
6. Development of weekly phone call with Susan Parker to enable Mary Price to plan education content and to verify expenses for week.
7. Identified medical records STH fax line to submit NHC copies of POST forms.
8. After receiving the March 28 State of Tennessee memo regarding POST forms being offered rather than required, the Grant Partnership team identified that the hospital DNR order could prompt NHC admissions teams to ask STH for the POST if it was not in discharge documents received at NHC prior to offering the POST at NHC. This would allow validation of an existing POST as the first step with a patient. Currently, a process review is underway at STH and NHC to determine feasibility.
9. Development of two metrics to be audited quarterly to track resident outcomes that are compared with resident directives to confirm care concordant to POST.
10. Developed Dashboard for NHC/STH leadership reporting.



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| 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: A well-defined process has been developed for activities during the grant period. Refer to detail in Key Activity #5. A review is underway for the feasibility of a post-grant process that would become a written policy. Saint Thomas has integrated a process but has not yet written a policy. The program has identified how the process can happen but we are working on how the process can be implemented into a sustainable policy. Saint Thomas believes that, at the time of transfer, if the hospital DNR order can be part of the NHC admission packet, then the admission process would automatically request a POST from the hospital before generating a new POST conversation.  |
| **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 195 patient records in Q1. |
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| 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 transitional event selected was the variance in POST forms when a DNR order has been requested by the patient. The Dashboard monthly report lists the number of resident directives submitted to the hospital to provide latest documentation in the event of readmission. |

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

***February-April 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. Richland Place monthly C.M.T. meetings targeted for four consecutive training sessions on advance directives. Dates being determined. Learning objectives and curriculum in design by STH.
* Submit quarterly report to the State of TN of CMS – May Quarterly Report submission on time.