UNIVERSITY OF VIRGINIA
BOARD OF VISITORS

Meeting of the Medical Center Operating Board for the University of Virginia Transitional Care Hospital

June 8, 2017

UNIVERSITY OF VIRGINIA
MEDICAL CENTER OPERATING BOARD FOR THE UNIVERSITY OF VIRGINIA
TRANSITIONAL CARE HOSPITAL

June 8, 2017
12:45 – 1:00 p.m.
Education Resource Center Auditorium

Committee Members:

L.D. Britt, M.D., Chair
Frank M. Conner III
William H. Goodwin Jr.
Tammy S. Murphy
James B. Murray Jr.
James V. Reyes
Frank E. Genovese, Advisor
Nina J. Solenski, M.D., Advisor
A. Bobby Chhabra, M.D., Faculty Consulting Member

Public Members:

Hunter E. Craig
Victoria D. Harker
Michael M.E. Johns, M.D.
Constance R. Kincheloe
Babur B. Lateef, M.D.

Ex Officio Members:

Teresa A. Sullivan
Dorrie K. Fontaine
Patrick D. Hogan
Thomas C. Katsouleas
Richard P. Shannon, M.D.
Pamela M. Sutton-Wallace
Scott A. Syverud, M.D.
David S. Wilkes, M.D.

AGENDA

PAGE

I. OPERATIONS AND FINANCE REPORT (Dr. Shannon to introduce Ms. Christine Matt; Ms. Matt to report)

A. Operations and Fiscal Year 2017 Year to Date Financials 1
B. ACTION ITEM: Fiscal Year 2018 Operating and Capital Budgets 6

II. EXECUTIVE SESSION

- Discussion of proprietary, business-related information pertaining to the operations of the Transitional Care Hospital, where disclosure at this time would adversely affect the competitive position of the Transitional Care Hospital, specifically:

- Confidential information and data related to the adequacy and quality of professional services, patient safety in clinical care, and patient grievances for the purpose of improving patient care at the Transitional Care Hospital; and
- Consultation with legal counsel regarding the Transitional Care Hospital compliance with relevant federal reimbursement regulations, licensure, and accreditation standards, all of which will involve proprietary business information of the Transitional Care Hospital and evaluation of the performance of specific Transitional Care Hospital personnel.

The relevant exemptions to the Virginia Freedom of Information Act authorizing the discussion and consultation described above are provided for in Section 2.2-3711(A) (1), (7), and (22) of the Code of Virginia. The meeting of the Medical Center Operating Board is further privileged under Section 8.01-581.17 of the Code of Virginia.

UNIVERSITY OF VIRGINIA
BOARD OF VISITORS AGENDA ITEM SUMMARY

BOARD MEETING: June 8, 2017

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: I.A. Operations and Fiscal Year 2017 Year to Date Financials

ACTION REQUIRED: None

BACKGROUND: The University of Virginia Transitional Care Hospital (TCH) prepares a periodic report, including write-offs of bad debt and indigent care, and reviews it with Executive Leadership before submitting the report to the Medical Center Operating Board (MCOB). The TCH also provides a report of significant operations of the hospital occurring since the last MCOB meeting.

Christine K. Matt, RN joined the University of Virginia Health System in 1978 and has served in various leadership roles across the organization since 1981. As Interim Associate Chief of the Transitional Care Hospital, she oversees all operations of this long-term acute care facility.

FINANCE REPORT

The TCH ended the period of July 1, 2016 through March 31, 2017 with a net operating income figure of $748,737, compared to the budgeted net operating income figure of $308,199. The positive net operating variance is attributed TCH's total operating expenses being 12% below budget. As volumes being 15% below budget, TCH has been able to control expenses (variable expenses) that are associated with supplies, pharmaceuticals and salaries.

During the third quarter of Fiscal Year 2017, TCH reported an All Payor Case Mix Index (CMI) of 1.16 compared to a budgeted CMI of 1.26. The negative variance in CMI is a direct result of fewer ventilator support cases than budgeted. During the first nine months of Fiscal Year 2017, 26% of discharges had a ventilator support diagnosis (compared to prior year at 33%). Ventilator support cases carry a relatively high CMI of 1.85. TCH has seen a shift in lower acuity referrals with diagnosis of Infectious Disease, Renal and Respiratory Complex. This has an impact on net revenue per case as a result of significantly lower average CMI of 0.80. The percentage of Wound cases has remained consistent to prior year (approximately 26% of total discharges).

During this same period, average length of stay (ALOS) was 25.48 days compared to budget of 29.02. Cases with a shorter length of stay (short-stay outliers) reduced both average daily census and net revenue per case. Substantially, all Medicare short-stay outlier cases are reimbursed at an IPPS MS-DRG payment rate, which is below TCH cost.

In addition, Payor Mix also contributed to the operating income variance. TCH has experienced a shift in payor mix with the largest shift reflected in the category of self-pay. For the third quarter in Fiscal Year 2017, TCH reported this figure to be 6% compared to a budget of 3%.

The total paid full-time equivalents (FTEs) were 124 which was 11% below the budgeted FTEs of 139. In addition, total operating expenses were 12% below budget. The positive expense variance is due to the below budgeted volume and variable expenses that are directly related to volume.

During the third quarter of Fiscal Year 2017, TCH reported 311 admissions. Two hundred and forty-one of those admissions were from the Medical Center and represent 6,132 patient days or approximately 22 beds of capacity per day for the Medical Center. The 241 admissions to TCH also contributed to a 0.29 day reduction in the Medical Center's average length of stay. These metrics further demonstrate the importance and value of long term acute care services in the continuum of care.

As TCH prepares for the future, it will be presented with financial challenges related to payment policies. The Pathway for SGR Reform Act of 2013 directed The Centers for Medicare & Medicaid Services (CMS) to change the Inpatient Prospective Payment System (IPPS) and the Long-Term Acute Care Hospital Prospective Payment System. The final rule directs CMS to establish two different types of LTACH Prospective Payment System (PPS) payment rates depending upon whether the patient meets certain clinical criteria:

- The LTACH PPS standard Federal payment rate, and
- A new LTACH PPS site neutral payment rate generally comparable to the IPPS payment rates.

In order for an LTACH discharge to be paid the higher LTACH PPS standard Federal rate rather than the lower site neutral payment rate the patient discharged must:

- Not have a principal diagnosis related to a psychiatric diagnosis or rehabilitation,
- Be immediately preceded by a discharge from an acute care hospital, and
- Either the acute care hospital stay must have included 3 days' stay in an ICU or the discharge from the LTACH must have included ventilator services for at least 96 hours.

CLINICAL OPERATIONS REPORT

Clinical Operations encompasses an array of services focused on furthering our goals of becoming the safest place to receive and provide care. Providing this care requires talented, well-educated team members. TCH is currently supporting 26 team members in degree-granting programs. Additionally, we have had 24 team members receive degrees in the past two years. Seventy percent of our nursing staff is educated at the baccalaureate level or above.

Meanwhile, patients in need of Respiratory Services continue to be our largest percentage of patients served and TCH continues to excel in the delivery of these services. From July 1, 2016 to March 31, 2016, 73 patient admissions were for vent weaning. Sixty-five of those patients (84%) achieved that goal. We have submitted our application to The Joint Commission for Certification in Respiratory Failure. We anticipate a survey before the end of the fiscal year.

Complex Wound Management remains a significant Diagnostic Related Group (DRG) discharged from TCH. Despite CMS regulatory changes, patients who require this care have not dissipated, and TCH remains a center of excellence in the provision of wound care for UVA Health System patients. For the period of July 1, 2016 to March 31, 2017, 26% of TCH patients discharged were admitted for complex wound care needs. The care of patients with wounds crosses all professional boundaries and much work has been done as a result of our intra-professional patient care culture. The focus in this area continues to lie in the provision of complex wound care across the professional continuum.

Rehabilitation Services is comprised of Physical Therapy, Occupational Therapy, and Speech/Language Pathology program. It continues to serve our population well and contributes to patient satisfaction as well as to clinical improvement. These therapy services continue to be in high demand as a result of acuity levels and complicating factors, including a high proportion of morbidly obese and/or debilitated patients in need of rehabilitation therapy. Patient satisfaction with these services remains high, and our patients continue to respond well physiologically as a result of this care. Beginning in April of 2016, CMS for the first time began collecting quality data in this arena. In the third quarter of Fiscal Year 2017, 79% of TCH patients showed improved function of > 10% and 54% showed improvements > 20%.

CARE MANAGEMENT REPORT

TCH combined the Case Management program with the Clinical Liaison program to establish a Department of Care Management. This partnership strengthens communication, knowledge, and collaboration throughout the process of patient selection and admission through discharge.

New patient referrals for the period of July 1, 2016 through March 31, 2017 totaled 1,096. Of the 1,096 patients, 311 were admitted to TCH, for a conversion rate of 30%. During this period, 77% of the admissions originated from UVA Medical Center and 23% originated from 22 outside facilities.

For the same period, the average length of stay was 25.48 days, which is 0.42 days lower than the minimum CMS requirement of 25 days. Factors resulting in a shorter length of stay include the SGR Reform Act of 2013; clinical conditions that are too expensive to manage at a lower level of care or too complex to manage safely at a lower level of care and which require a short period of continued medical management at the LTACH level of care;

the number of patients with managed-care payers authorizing a shorter LTACH stay. Other factors resulting in an abbreviated length of stay include clinical conditions necessitating a return to a Short Term Acute Care Hospital, a change in the patient's treatment goals (e.g., selecting palliative care or hospice), and faster than expected clinical improvement.

During the period of July 1, 2016 through March 31, 2017, TCH discharged 310 patients: 25% were transferred to UVAMC, 75% were discharged to the community/other facilities, and mortality represented 2% of the total. Of the 237 patients discharged to the community/other facilities, 44% were discharged to home, 20% were discharged to an Inpatient Rehabilitation Facility, 30% were discharged to a Skilled Nursing Facility, 3% were discharged to Intermediate Care Facility, and 3% were discharged to Hospice.

Due to the increased number of managed Medicaid programs, the number of patients discharging to the Intermediate Care level has increased significantly.

QUALITY, PATIENT SAFETY, AND PERFORMANCE IMPROVEMENT REPORT

Quality and Patient Safety

The TCH monitors clinical outcomes and performance using external and internal benchmarking. Interdisciplinary committees and teams work together to develop and implement improvement strategies when needed and evidenced by our Quality and Patient Safety Dashboard. TCH participates with the CDC's National Healthcare Safety Network (NHSN) for device-related and hospital-acquired infection benchmarking as well as the Centers for Medicare and Medicaid's Long-Term Care Hospital Quality Reporting Program. TCH also submits data to the Vindicet Healthcare Data System (VHDS) on additional quality outcomes for LTACH-specific benchmarking. The TCH has implemented the "Be Safe" Program, which involves staff at all levels of our organization and requires the use of a scientific methodology to eliminate preventable harm and improve care outcomes and efficiency. We are focusing on six metrics as priorities for preventing harm on the journey to become the safest Long Term Acute Care Hospital in which to both receive and provide care:

- Mortality
- Team Member Safety: Patient handling injuries and Staff member blood and body fluid exposures
- Hand Hygiene Compliance
- Hospital Acquired Pressure Ulcers (Stages II, III and IV)
- Unplanned 30-day readmissions to the UVA Medical Center
- Hospital Acquired C-Difficile Infections

The first mandatory reporting of standardized quality data for LTACHs, which was not risk adjusted or publically reported, did not start until October 1, 2012. Risk-adjustment methodologies have since been developed by CMS and public reporting of a few quality metrics began in October 2016 (only reporting on Medicare recipients, not all

patients). Thus, it has been a challenge for the LTACH industry to utilize meaningful, external data "benchmarks", but with the help of CMS, standardized data to use for comparisons is slowly becoming available for this industry. We are currently in the process of implementing for Fiscal Year 2018 a new benchmarking system for Long-Term Acute Care Hospitals known as "LTRAX." This provider offers a larger and more robust membership database.

Available National Benchmarks for UVA Transitional Care Hospital Quality Metrics for Fiscal Year 2017:

Metric	Data/Report Source
Mortality	Vindicet Healthcare Data System (VHDS)
Hospital Acquired Pressure Ulcers (Stage2, 3, 4)	Vindicet Healthcare Data System (VHDS)
Hospital Acquired Infections: C-Difficile Infections	National Healthcare Safety Network (NHSN)

Patient Satisfaction

TCH continues to seek and use feedback from patients and families. This feedback is invaluable in guiding efforts to improve and provide exceptional service to our patients. TCH met our target goals in Fiscal Year 2017 Quarter Three, with average scores of 4.4-4.6 on a 5-point scale. TCH is ranked at the 62nd percentile for the Press-Ganey LTACH database (n=15) for the first nine months of Fiscal Year 2017.

Our discharged patients consistently rated us as a 4.6 in the category of "likelihood to recommend" and as a 4.6 in "overall assessment." TCH scored at the 73rd percentile among the Press-Ganey LTACH database (n=15) in "Overall Assessment." TCH's physician staff also were ranked as the top performers in TCH's Press-Ganey comparative group.

UNIVERSITY OF VIRGINIA
BOARD OF VISITORS AGENDA ITEM SUMMARY

BOARD MEETING: June 08, 2017

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: I. B. Fiscal Year 2018 Operating and Capital Budgets

BACKGROUND: The TCH's operating and capital budgets are consolidated with the Medical Center's overall budget, which the Board of Visitors acts on at its June meeting, based on a recommendation from the Medical Center Operating Board.

DISCUSSION: The TCH Fiscal Year 2018 financial plan has been developed taking into consideration the challenges facing healthcare in general and Long-Term Acute Care specifically. The costs associated with providing quality patient care will continue to have upward pressure due to increases in medical supply, pharmaceutical, and medical equipment expenses, as well as stricter admissions criteria. For Fiscal Year 2018, the TCH expects to continue its volume growth of high acuity patients, while at the same time facing regulatory challenges to caring for those patients.

Fiscal Year 2018 Operating and Capital Budgets

BUDGET AND OPERATING ASSUMPTIONS

Market conditions: For Fiscal Year 2018, discharges are budgeted with a slight 2% growth from Fiscal Year 2017 projected levels. The growth will be facilitated by increased focus on the ventilated patient population and expansion of our referral base. The following table includes historical and projected patient volumes:

	Actual FY2016	Projected FY2017	Budget FY2018
Discharges	389	405	413
Average Length of Stay	30	27	28
Patient Days	11,479	10,936	11,680

Revenues: The TCH Fiscal Year 2018 budgeted payor mix reflects an increase in Medicare cases from prior year. One of the TCH's largest challenges is the unwillingness of government payors to increase payments commensurate with the increases in medical delivery costs, particularly with complex wound and bariatric patients and hemodialysis patients. Growth in revenues will result from the impact of increasing volume, higher acuity patients, and managing length of stay.

Rate changes: The Centers for Medicare & Medicaid Services (CMS) proposed base rate for Fiscal Year 2018 is $41,497 per case, which is a 2% reduction from prior year. With a

Medicare case mix index (CMI) of 1.20, this will result in a total Medicare reimbursement rate of $49,800 per LTCH CMS full PPS payment per case. This rate also includes full participation in the Hospital Inpatient Quality Reporting Program and meets the four claims-based measures. It is projected that 30% of the Medicare cases will not meet the full LTACH base payment of $50K due to the three-day intensive care unit (ICU) requirement on wound cases. The Fiscal Year 2018 budget reflects the net revenue reduction for site-neutral cases.

Expenses: Expenses per patient day from operations are budgeted to be 4% above projected Fiscal Year 2017 based on anticipated increases in medical supplies, pharmacy costs, and medical center contracts. In addition to a 3.5% increase in salary, wages and fringe benefits for market adjustments, merit, and health insurance costs.

Staffing: The TCH's paid FTEs are planned at 136, an increase of 10 FTEs from the current Fiscal Year projection of 126 FTEs. The variance of 10 FTEs is due to staffing shortage in Fiscal Year 2017. TCH has experienced a patient/nurse ratio of 5:1 to 6:1. This includes the charge nurse taking patient assignments as well as the Nurse Manager. TCH is heavily recruiting qualified clinical staff (RNs and PCAs) in order to achieve the desired 4:1 patient/nurse ratio. This variance reflects the FTE vacancies that TCH is in the process of filling. In addition, the assistant nurse manager has been vacant during Fiscal Year 2017 and interviews are currently in process to fill this position.

Operating Plan: The rapidly changing health care environment will require continuous examination of budget assumptions. Management will monitor budget versus actual performance on a monthly basis and, where appropriate, make changes to operations. Also, management will continue to identify and implement process improvement strategies that will allow for operational streamlining and cost efficiencies.

The major strategic initiatives that impact next year's fiscal plan include:

- The continuation of the collaborative effort between the TCH and the Medical Center to reduce readmissions.
- The continuation of the collaborative effort between the TCH and the School of Medicine faculty on the recruitment of clinical staff.
- The continuation of our efforts to better engage our employees and enhance patient satisfaction.
- The continuation of the collaborative effort between the TCH and the Medical Center to increase ventilator patient population.

The major risk factors that impact the ability to accomplish the fiscal plan include:

- A nationwide shortage of health care workers that could negatively impact our ability to maintain appropriate staffing.
- Maintaining an adequate number of physicians in areas experiencing a national shortage.

- Advancements in medical technology that could alter expenses and/or revenues very quickly.
- Inflation for medical equipment and pharmaceutical goods that could exceed the budget assumptions.
- Commercial payors denying LTACH authorization more frequently based upon stricter criteria for admissions.
- New CMS regulations negatively impacting LTACH reimbursement on site-neutral cases.

A summary of the TCH projected financial operating results are provided as follows:

(Millions)	Projected FY17	Budget FY18
Total Operating Revenue	$ 19.3	$ 21.3
Operating Expense	$ 18.7	$ 20.9
Operating Income/(Loss)	$ 0.6	$ 0.4
Total Margin	2.9%	2.0%

Capital Plan: Funds available to meet capital requirements are derived from operating cash flows, funded depreciation reserves, philanthropy, and interest income. Subject to funds availability, TCH management recommends $315,702 be authorized for capital requirements. Beginning July 2017, TCH will begin the renovation of having an on-site pharmacy located on the third floor and upgrade Outtakes Morrison food services.

ACTION REQUIRED: Approval by the Medical Center Operating Board, by the Finance Committee, and by the Board of Visitors

FISCAL YEAR 2018 OPERATING AND CAPITAL BUDGETS FOR THE UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL

RESOLVED, the Fiscal Year 2018 Operating and Capital Budgets for the University of Virginia Transitional Care Hospital, presented as a component of the Medical Center Operating Budget, are approved as recommended by the Executive Vice President for Health Affairs, the Executive Vice President and Chief Operating Officer of the University, and the Medical Center Operating Board.