UNIVERSITY OF VIRGINIA
BOARD OF VISITORS
MEETING OF THE
MEDICAL CENTER
OPERATING BOARD
FOR THE UNIVERSITY
OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
SEPTEMBER 15, 2016
I. OPENING REMARKS FROM THE CHAIR (Dr. Britt)  
II. OPERATIONS AND FINANCE REPORT (Dr. Shannon to introduce Mr. Michael McDaniel; Mr. McDaniel to report)  
III. CLOSED 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 and privileged 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.

The relevant exemptions to the Virginia Freedom of Information Act authorizing the discussion and consultation described above are provided for in Section 2.2-3704 and 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.
BOARD MEETING: September 15, 2016

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: I. Opening Remarks from the Chair

ACTION REQUIRED: None

BACKGROUND: L.D. Britt, M.D., is the Chair of the Medical Center Operating Board (MCOB).

DISCUSSION: The Chair will inform the MCOB of recent events that do not require formal action.
UNIVERSITY OF VIRGINIA
BOARD OF VISITORS AGENDA ITEM SUMMARY

BOARD MEETING: September 15, 2016
COMMITTEE: Medical Center Operating Board
AGENDA ITEM: II. Operations and Finance Report
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 MCOB. The TCH also provides an update of significant operations of the hospital occurring since the last MCOB meeting.

Michael McDaniel, Associate Chief of Transitional Care Services for the TCH, is in his 26th year with the University of Virginia Health System. He holds an undergraduate degree in Economics from West Virginia University, a M.B.A. from the Darden School of Business, and a nursing degree from the University of Virginia School of Nursing. He has been a Registered Nurse for 20 years.

DISCUSSION:

FINANCE REPORT

The TCH ended the period of July 1, 2015 through June 30, 2016 with an operating income figure of $2,181,972, compared to the budgeted operating income figure of $1,032,964. The positive operating variance is attributed both to payor mix and approximately $80,000 in bad debt collections on several patient accounts that were over 365 days past due. Twenty-four percent of TCH’s discharged cases had commercial insurance as their primary payor. Of the 389 discharged cases, 46% were vent wean & respiratory complex. During this same period, average length of stay (ALOS) was 30.10 days compared to budget of 30.00. The All-Payor Case Mix Index of 1.25 was 1% lower than the budgeted figure of 1.26. The Medicare Case Mix Index of 1.26 was 2% lower than the budgeted figure of 1.28. Total paid full-time equivalents (FTEs) were 136, which was 6% below the budgeted FTEs of 145.
During Fiscal Year 2016, TCH reported 383 admissions. Two-hundred and sixty-six of those admissions were from the Medical Center and represent 7,695 patient days or approximately 21 beds of capacity per day for the Medical Center. The 266 Medical Center admissions to TCH contributed to a 0.33 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 and 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 Long Term Care Hospital (LTCH) PPS payment rates depending on whether the patient meets certain clinical criteria:

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

In order for a LTCH discharge to be paid the higher LTCH PPS standard Federal rate and be excluded from the 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 three days of ICU care or the discharge from the LTCH must have included ventilator services for at least 96 hours.

TCH’s Fiscal Year 2017 budget reflects this anticipated reduction in net revenue. It is estimated that 30% of TCH’s discharges will be affected by this new ruling. The majority of those cases will be complex wound care patients who do not have an ICU stay prior to being admitted to TCH. TCH has developed a plan to address the anticipated impact of these new rules.

TCH’s plan to effectively adapt to the new criteria is as follows:
• Collaborate with referral sources to accurately identify and refer qualifying cases.
• Manage the site-neutral cases by distinguishing between "long-stay" site-neutral and "short-stay" site-neutral cases.

OPERATIONS REPORT

Clinical Operations

Clinical Operations encompasses an array of services focused on furthering the goal of becoming the safest place to receive and provide care. Providing this care requires talented, well-educated team members. TCH is currently supporting 22 FTEs in degree-granting programs. Additionally, 19 current team members have received degrees in the past two years. Fifty-eight percent of the nursing staff is educated at the baccalaureate level or above.

Respiratory Services continue to exceed expectations in the weaning of patients from ventilators. From July 1, 2015 to June 30, 2016, 109 patients were admitted for vent weaning. Eighty-eight of those patients (81%) achieved that goal, compared to the established ventilation weaning benchmark of 64%.

Wound Management is the second highest Diagnostic Related Group (DRG) discharged from TCH. For the period of July 1, 2015 through June 30, 2016, 32% 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 TCH's intra-professional patient care culture. The focus in this area continues to lie in the provision of complex wound care within the continuum. TCH received its site visit from a Joint Commission surveyor on June 23, 2016 and was awarded Joint Commission Disease-Specific Certification for Wound Care. TCH is the first healthcare organization in the Commonwealth to achieve this certification and the 27th in the nation to do so.

Rehabilitation Services is comprised of Physical Therapy, Occupational Therapy, and Speech/Language Pathology program. It continues to serve the TCH 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 patients continue to respond well physiologically as a result of this care.

**Care Management**

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 selection through discharge.

New patient referrals for the period of July 1, 2015 through June 30, 2016 totaled 1,318. Of the 1,318 patients, 383 were admitted to TCH, for a conversion rate of 30%. During this period, 70% of the admissions originated from the Medical Center and 30% originated from 14 outside facilities.

For the same period, the average length of stay was 30.10 days, which exceeds the minimum CMS requirement of 25 days. Factors resulting in a longer length of stay include 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, time delays associated with provision of services and consultations by other providers, services that are not provided in an outpatient setting post discharge (i.e., dialysis for acute kidney injury), lack of family and other social support services, and the lack of available community resources, specifically skilled nursing facilities. 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, 2015 through June 30, 2016, TCH discharged 389 patients: 28% were transferred to the Medical Center, 70% were discharged to the community and other facilities, and mortality represented 2%. Of the 272 patients discharged to the community, 22% were discharged to home, 42% were discharged to an Inpatient Rehabilitation Facility, 34% were discharged to a Skilled Nursing Facility, and 2% were discharged to Hospice.
Quality, Patient Safety and Performance Improvement

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 infection benchmarking as well as the CMS Long-Term Care Hospital Quality Reporting Program. TCH began data abstraction and submission for the Vindicet Hospital Data System (VHDS) for additional quality outcomes for LTACH-specific benchmarking.

The TCH has implemented the “Be Safe” Program, which involves staff at all levels of the organization and requires the use of a scientific methodology to eliminate preventable harm and improve care outcomes and efficiency. TCH’s efforts will focus on seven 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 Injuries
- Patient Fall with Injury
- Catheter-Associated Urinary Tract Infection (CAUTI)
- Central Line Associated Blood Stream Infection (CLABSI)
- Hospital Acquired Pressure Ulcers (HAPU)
- Wound Improvement

The TCH was awarded the NALTH 2016 Quality Achievement Award for “Improving Quality Outcomes and Satisfaction Through the use of Peripheral Midline Catheters.” This is the TCH’s second nationally recognized achievement award in three years.

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 exceeded target goals in Fiscal Year 2016 Quarter Four, with average scores of 4.6-4.8 on a 5-point scale.
Discharged patients consistently rate TCH as a 4.8 in the category of "likelihood to recommend" and as a 4.9 in "overall assessment." TCH’s wound care team and speech therapist also continue to be sources of high satisfaction for long term patients.

Human Resources

Employee Engagement

TCH’s employee engagement scores for Fiscal Year 2016 were lower than anticipated. Despite a slight increase in “Overall Satisfaction” and individual areas such as “having the materials and equipment needed” and “opportunity to do my best every day,” our “Grand Mean” slipped from the 51st to the 48th percentile. In addition to using Town Hall and Employee Retreat meetings to generate activities focused on improving engagement, TCH will also attempt to identify where its efforts fell short.