UNIVERSITY OF VIRGINIA
MEDICAL CENTER OPERATING BOARD FOR THE UNIVERSITY OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
Thursday, June 11, 2015
8:00 – 8:30 a.m.
Auditorium of the Albert & Shirley Small
Special Collections Library, Harrison Institute

Committee Members:
Stephen P. Long, M.D., Co-Chair
Edward D. Miller, M.D., Co-Chair
L.D. Britt, M.D. William P. Kanto Jr., M.D.
Hunter E. Craig Constance R. Kincheloe
William H. Goodwin Jr. George Keith Martin
Victoria D. Harker Charles W. Moorman
Michael M.E. Johns, M.D. The Hon. Lewis F. Payne

Ex Officio Members:
Teresa A. Sullivan Patrick D. Hogan
Randolph J. Canterbury, M.D. Richard P. Shannon, M.D.
Dorrie K. Fontaine John D. Simon
Robert S. Gibson, M.D. Pamela M. Sutton-Wallace

AGENDA

I. OPENING REMARKS FROM THE CO-CHAIR

II. FINANCE REPORT (Dr. Shannon to introduce Ms. Michelle D. Hereford; Ms. Hereford to report)
   A. Fiscal Year 2015 Report 1
   B. Action Item: Fiscal Year 2016 Operating and Capital Budgets 3

III. OPERATIONS REPORT (Ms. Hereford) 7

IV. 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 11, 2015

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: II.A. Fiscal Year 2015 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 Medical Center Operating Board (MCOB).

Michelle D. Hereford joined the University of Virginia Health System in 2009. As Chief of the TCH, she oversees all operations of this long-term acute care facility. Ms. Hereford has a Bachelor’s degree in Nursing and a Master’s degree in Health Administration from Virginia Commonwealth University. She has over 20 years of health care experience serving in a broad range of roles.

DISCUSSION: The University of Virginia TCH ended the period of July 1, 2014 through March 31, 2015 with an operating income figure of $75,948, compared to the budgeted operating income figure of $716,199. During this same period, inpatient discharges were 253 compared to the budget of 314. Average length of stay was 31.06 days, which is 2.17 more days than the budget of 28.89. The All Payor Case Mix Index of 1.25 was in line with the budget of 1.25. The Medicare Case Mix Index was 1.23 compared to a budgeted figure of 1.28. Total full-time equivalents (FTEs) were 130 which is 7.0% below the overall budget of 140 FTEs. Due to volumes being 19% below budget, the average length of stay being above budget by 7.5% and the Medicare Case Mix Index being below budget by 4%, the TCH did not meet the budget year-to-date.

Summary for March, Fiscal Year 2015:

- Discharges were 19% below budget.
- During the first nine months of Fiscal Year 2015, TCH reported 36% ventilator cases which carry a Case Mix Index of 1.97.
• Payor Mix as shown below, reflects a higher than budgeted net revenue per case due to commercial payors.

<table>
<thead>
<tr>
<th>Payor</th>
<th>Actual</th>
<th>Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>62%</td>
<td>57%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>Commercial</td>
<td>12%</td>
<td>7%</td>
</tr>
<tr>
<td>Anthem</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td>Self Pay/Indigent</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

For the period from July 1, 2014 through March 31, 2015, TCH reported 260 admissions. One hundred and seventy-three of those admissions (66%) were from the Medical Center. The 173 Medical Center admissions represent 5,249 patient days or approximately 19 Medical Center beds per day which would not have been available without the TCH. In addition, the 5,249 patient days reduced the U.Va. Medical Center Average Length of Stay (ALOS) by 0.25 days.
UNIVERSITY OF VIRGINIA
BOARD OF VISITORS AGENDA ITEM SUMMARY

BOARD MEETING:       June 11, 2015
COMMITTEE:           Medical Center Operating Board
AGENDA ITEM:         II.B. Fiscal Year 2016 Operating and Capital
                     Budgets

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

DISCUSSION:  The TCH Fiscal Year 2016 plan has been developed while considering the challenge of continuing to provide a new patient care service in a new environment, developing a new workforce, and introducing teaching and training of clinical providers. The cost 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 a shortage of health care workers. For Fiscal Year 2016, the TCH expects to continue its volume growth of this high acuity patient population. The TCH continues to report increases in complex wound patients and bariatric patients and anticipates this growth will continue in Fiscal Year 2016.

The TCH budget development process is clinically focused and highly participatory. Patient care service management, support function management, and physicians have significant roles in the budget development cycle. The budget process begins with senior management developing basic budget assumptions, such as discharges, length of stay, payor mix, productivity standards which drive the number of employees, and inflation. This information is communicated to TCH Managers and results with each operating unit providing a cumulative operating and capital budget that contains service demand forecasts, required FTE personnel, and non-labor expenses.

BUDGET AND OPERATING ASSUMPTIONS

Market conditions: For Fiscal Year 2016, discharges are budgeted to grow in excess of 24% from Fiscal Year 2015 projected levels. The growth will be facilitated by increased registered nurses and hospitalist recruitment, and additional referrals from
outside facilities. The following table includes historical and projected patient volumes:

<table>
<thead>
<tr>
<th></th>
<th>Actual FY2014</th>
<th>Projected FY2015</th>
<th>Budget FY2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>316</td>
<td>361</td>
<td>450</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>30</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td>Patient Days</td>
<td>9,407</td>
<td>10,880</td>
<td>13,500</td>
</tr>
</tbody>
</table>

Revenues: The TCH Fiscal Year 2016 budgeted payor mix reflects an increase in Medicare cases from prior years. 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 and negotiated contracts with rate increases.

Rate changes: The TCH Medicare proposed base rate for Fiscal Year 2016 is $39,240 per case. With a Medicare case mix index (CMI) of 1.28, this will result in a total Medicare reimbursement rate of $50,227 per case. The Centers for Medicare & Medicaid Services (CMS) project that the Long-Term Care Hospital Prospective Payment System (LTCH PPS) payments would increase by 0.08% in Fiscal Year 2016.

Expenses: Expenses per discharge from operations are projected to decrease 11% from the Fiscal Year 2015 projection. This decrease is attributed to an increase in volume that positively affects TCH’s fixed overhead expenses.

Staffing: The TCH’s paid FTEs are planned at 145, an increase of 13 FTEs from the current fiscal year projection of 132 FTEs.

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 School of Medicine faculty on documentation of clinical care and coding.

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 reduce length of stay.

The effort to enhance care delivery and integrate information technology services through the Electronic Medical Record project.

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.

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

<table>
<thead>
<tr>
<th></th>
<th>Projected FY15</th>
<th>Budget FY16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operating Revenue</td>
<td>$ 19.8</td>
<td>$ 23.1</td>
</tr>
<tr>
<td>Operating Expense</td>
<td>19.5</td>
<td>22.0</td>
</tr>
<tr>
<td>Operating Income/(Loss)</td>
<td>0.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Total Margin</td>
<td>1.6%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>

Capital Plan: Funds available to meet capital requirements are derived from operating cash flows, funded depreciation reserves, philanthropy, and interest income. The TCH faces many challenges regarding capital funding as continued pressures on the operating margin affect cash flow, while demand for capital will increase significantly due to the need to expand. Subject to funds availability, TCH management recommends $289,950 be authorized for capital requirements. A majority of these funds
will be used for the build out of a new on-site pharmacy to support TCH and Hospice.

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

2015-2016 OPERATING AND CAPITAL BUDGETS FOR THE UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL

RESOLVED, the 2015-2016 Operating and Capital Budgets for the University of Virginia Transitional Care Hospital, presented as a component of the Medical Center Operating Budget, is approved as recommended by the President, the Chief Operating Officer, and the Medical Center Operating Board.
BACKGROUND: The TCH provides an update of significant operations of the hospital occurring since the last MCOB meeting.

Clinical Operations

Respiratory Services

This service, led by Pulmonary Medical Director Sharon Esau, M.D., and managed by Jeanne Bird, a registered respiratory therapist, continues to exceed expectations in weaning patients from ventilators. From July 1, 2014 to March 31, 2015, 77 patients were admitted for vent weaning/teaching, 86% of whom achieved that goal versus the benchmark of 60.1%.

Wound Management

This service is led by the Wound Care Medical Director, David Drake, M.D., and managed by Tara Beuscher, an experienced Wound, Ostomy & Continence Nurse Practitioner. This leadership has helped to transition the program from primarily specialist-based care to skilled care with specialist guidance. As a result, the TCH has expanded the services offered in our community by providing an increasing amount of complex wound care.

For the period of July 1, 2014 through March 31, 2014, 31% of the TCH patient population was 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.

In response to the above, TCH implemented the Wound Treatment Associate (WTA) program. This online multidisciplinary course, developed by the Wound, Ostomy and Continence Nurses Society, offers continuing education credits for nurses, physical therapists, occupational therapists, and
respiratory therapists. The initial class of 19 employees was followed by a second cohort of 15 students who enrolled in August 2014. Of this class, 50% was from outside of the TCH, thereby broadening the education offering. The February, 2015 cohort enrolled 25 students: 72% of this class is from outside of TCH, including nine participants from UVA Culpeper Hospital.

Rehabilitation Services

The Physical Therapy, Occupational Therapy, and Speech Language Pathology program continues to serve our population well, and contributes to patient satisfaction as well as to clinical status 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. Additionally, Rehabilitation Services has begun to develop an assessment tool to evaluate patient response to therapy in hopes of being able to provide predictive improvement expectations. Development of this tool is ongoing and will assist the TCH in determining additional assessment techniques utilizing the skills of the rehabilitation professional.

Care Management Report

The TCH has 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.

Clinical Liaison

New patient referrals for the period from July 1, 2014 through March 31, 2015, continued to grow and totaled 969. Of the 969 patients referred, 261 patients were admitted, for a conversion rate of 27%. Of the 708 referrals that were not admitted to TCH, 66% did not meet LTACH criteria, 15% chose another LTACH facility to remain close to home or to access specific services, 12% were due to payor denials, and the remaining 5% were due to bed availability.

A significant broadening of the referral base has occurred this fiscal year. Fifty-two (52%) percent of new patient referrals have been received from 59 outside facilities. Forty-
eight (48%) percent of the referrals were from the U.Va. Medical Center. The next largest referring facility is Inova Fairfax at 15%, with other facilities at 5% (Carilion Roanoke Memorial Hospital, Mary Washington Hospital, August Health, Loudon, and UVA Culpeper Hospital).

Since July 1, 2014, TCH experienced a significant increase in Medicare admissions from outside referral sources. This growth is reflected as an increase from 4% to 43%. The increase will assist the TCH in meeting and maintain its CMS requirement.

Case Management

The practice of Case Management includes discharge planning at the time of referral to the TCH. It is a dynamic process requiring constant monitoring and collaboration with the interdisciplinary team. Length of stay is primarily driven by the patient’s clinical condition and guided by the use of McKesson’s Long-Term Acute Care Hospital (LTACH) Interqual Criteria. The goal is to manage a patient’s stay and plan for safe discharge to an appropriate level of care on or within the target Diagnostic Related Group (DRG).

As of March 31, 2015, the average Medicare length of stay for Fiscal Year 2015 was 31.06 days, and the overall length of stay for all payers was 30.78 days. Factors resulting in a patient’s longer length of stay have been attributed to clinical conditions that are too complex to manage safely at a lower level of care, time delays associated with services and consultations from other providers, services that cannot be provided in outpatient setting due to billing (i.e., dialysis for Acute Kidney Injury), and the lack of community resources, specifically skilled nursing facilities.

Factors resulting in an abbreviated length of stay (less than the anticipated 5/6 DRG date) include clinical conditions necessitating a return to a Short-Term Acute Care Hospital; a change in the patient’s goals (e.g., selecting palliative care or hospice), and faster than expected clinical improvement.

Human Resources

The TCH is currently staffed with 130 FTEs. As the TCH continues to grow and develop, it is imperative that we acquire and retain talented employees. Therefore, the focus has been on the following:
Recruitment

For the period from July 1, 2014 through March 31, 2015, we have successfully recruited 58 permanent staff: 17 Registered Nurses, 31 Patient Care Assistants/Techs, five Registered Respiratory Therapists, one Speech Language Pathologist, two Case Managers, two Clinical Liaisons, and one Nurse Manager.

Employee Engagement

The TCH is looking forward to the May 2015 Gallup Employee Engagement Survey, an opportunity for our employees to provide honest feedback about working at the U.Va. Health System. Last year our rating exceeded expectations with an overall satisfaction rate in the 73rd percentile. That rating was an increase from the 49th percentile in the previous year. We hope to continue to enjoy strong ratings from our team, as well as to learn of opportunities to increase the engagement of our staff.

The TCH has revised the charter and name of the TCH employee-led Engagement Committee, which is now the TCH Experience Committee. The committee will continue all efforts to maintain a highly engaged staff, but will also focus on defining an ideal TCH experience for all patients, visitors, and staff who enter this building. Planning will include assessing such aspects as the look and feel of the facility and the way we interact with each other and our guests.

The TCH has continued hosting employee retreats to improve the engagement process. This process assists with the development of “Gallup Impact Plans”. These retreats are planned and led by informal leaders at the TCH, and involve participation from employees of every discipline and role. The Fiscal Year 2015 retreats were held in January, March, and April and are assisted with the continued engagement of staff through a self-governing approach. The retreats result in the generation of ideas to improve our work-life environment and our ability to deliver high quality care and services. Many of these ideas have been implemented or are in various stages of implementation. This is the second year TCH has held these retreats, and approximately 90 staff members have participated. The plan is to continue this engaging practice as further refined by the employees of the TCH.
Quality, Patient Safety and Performance Improvement Report

Quality and Patient Safety Planning

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 as evidenced by our Quality and Patient Safety Dashboard.

The TCH continues to focus on the implementation of the “Be Safe” Program. “Be Safe” 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. TCH has identified six priorities for preventing harm on the journey to become the safest Long Term Acute Care Hospital to both give and receive care:

- Mortality
- Team Incidents (e.g. staff injury)
- Patient Falls with Injury
- Catheter-Associated Urinary Tract Infections
- Central Line Associated Blood Stream Infections
- Hospital Acquired Pressure Ulcers

TCH is meeting and exceeding the performance and clinical outcome expectations for the six priorities mentioned above. The device-related infection rates and the specific device utilization rates are all improved from last year, and performance thus far exceeds the national benchmarks for Long Term Acute Care Hospitals. In Fiscal Year 2015, TCH has educated the team to Be Safe principles, A3 methodology, Root Cause Analysis, and elements of a strong corrective action plan.

Patient Satisfaction

The TCH continues to seek ways to obtain feedback from our patients and their families, which is invaluable to guiding our efforts to improve our services in our quest to exceed patients’ expectations. We are exceeding our targeted goals for Fiscal Year 2015 year-to-date (July 1, 2014 – March 31, 2015), and are now introducing an additional source of patient feedback. With the use of iPads, we will conduct “Focus Surveys” in our final quarter of this fiscal year. These surveys will consist of 5-8 questions, all validated by Press Ganey and targeting a specific topic of care and service. Surveys will be conducted with all in-house patients at that time.
Community Outreach

The TCH Volunteer Program continues to grow in numbers and strength. The volunteers provide greatly appreciated services for patients, families, and employees. These services include:

- Madison House Volunteers: These volunteers serve as bedside visitors, assistant Health Unit Coordinators, and assistants for Rehabilitation Therapists. They also provide patient education and help patients communicate with family members and friends from their communities through the use of iPads. The iPads were obtained through the inspiration of one of the Madison House volunteers after spending valuable time with TCH patients.

- Community volunteers: These community members provide an array of services including donating “distraction blankets”, shawls, lap blankets, and decorative pillow cases, providing bedside visitation to our patients and respite for their families, providing flower arrangement and delivery, playing soothing music during our quiet times, and most recently providing removable bed-rail holders for personal belongings. These hand-made holders will be used by patients to store personal items such as glasses, hearing aids, and cell phones. The holders will keep the patient’s personal items within easy reach of the patient, and will help protect these items from damage or loss. Each patient will receive the holder as a gift upon discharge.

- Junior Volunteers: This summer the TCH will have its first Junior Volunteers, who will assist with hospital functions in a variety of ways.

One of our future goals is to design and create a Healing Garden for our patients and families, with help from our community members.

External Benchmarking

The TCH continues to meet the reporting standards set forth by Centers for Medicare and Medicaid Services Long Term (Acute) Care Hospital Quality Reporting Program, now in its third year. Submitting required data in the designated manner and time frames allows us to avoid a 2% payment reduction, and hopefully
will provide external quality benchmark opportunities in the future. Each year the data elements are revised slightly and/or increased, with a long-term goal of having common, risk adjusted metrics for all post-acute care organizations.

TCH continues to participate with the Center for Disease Control’s National Healthcare Safety Network (NHSN) for device-related infection and device utilization rates comparisons. Thus far in Fiscal Year 2015, we have far exceeded expectations, and are well under national benchmarks for LTACHs in both device utilization and device-related infection rates.

Accreditation

The TCH remains in full-compliance with Joint Commission standards, having been surveyed in June 2014, and is fully accredited until June 2017. The mandated Intracycle Monitoring assessment will be submitted by June 18, 2015.