UNIVERSITY OF VIRGINIA
BOARD OF VISITORS
MEETING OF THE
MEDICAL CENTER
OPERATING BOARD
FOR THE UNIVERSITY
OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
JUNE 9, 2016
UNIVERSITY OF VIRGINIA
MEDICAL CENTER OPERATING BOARD FOR THE
UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL

June 9, 2016
8:30 – 8:45 am
Auditorium of the Albert & Shirley Small
Special Collections Library, Harrison Institute

Committee Members:
L.D. Britt, M.D., Chair
Frank M. Conner, III
Hunter E. Craig
William H. Goodwin Jr.
Victoria D. Harker
Michael M.E. Johns, M.D.
William P. Kanto Jr., M.D.
Constance R. Kincheloe
Charles W. Moorman
Tammy S. Murphy
The Hon. Lewis F. Payne
James V. Reyes
Frank E. Genovese, Advisor

Ex Officio Members:
Teresa A. Sullivan
Dorrie K. Fontaine
Robert S. Gibson, M.D.
David S. Wilkes, M.D.
Patrick D. Hogan
Thomas C. Katsouleas
Richard P. Shannon, M.D.
Pamela M. Sutton-Wallace

AGENDA

I. OPENING REMARKS FROM THE CHAIR (Dr. Britt) 1

II. OPERATIONS AND FINANCIAL REPORT (Dr. Shannon to introduce Mr. Michael McDaniel; Mr. McDaniel to report)
   A. Fiscal Year 2016 Financial Report 2
   B. ACTION ITEM: Fiscal Year 2017 Operating and Capital Budgets 4
   C. Operations Update 8

III. 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.
BOARD MEETING: June 9, 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.
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, an 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.

Finance Report

The TCH ended the period of July 1, 2015 through March 31, 2016 with an operating income figure of $1,139,254, compared to the budgeted operating income figure of $650,793. The positive operating figure is attributed to payor mix and bad debt collections on several patients’ accounts that were over 365 days past due. Twenty-four percent of TCH’s discharged cases consisted of commercial primary payor status. Of the 286 discharged cases, 46% were ventilator wean and complex respirator cases. During this same period, average length of stay (ALOS) was 30.83 days, which is 0.72 days above the budget of 30.11. The All Payor Case Mix Index (CMI) of 1.24 was 2% lower than the budgeted figure of 1.26. The Medicare CMI of 1.23 was 4% lower than the budgeted figure of 1.28. The total worked full-time equivalents (FTEs) were 139, which is 4% below the budget of 144.

During the first nine months of Fiscal Year (FY) 2016, the TCH reported 278 admissions. Two hundred and two of those admissions were from the Medical Center and represent 6,065 patient days or approximately 22 beds of capacity per day for
the Medical Center. The 202 admissions to the TCH 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 the long of term acute care services in the continuum of care.
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 MCOB.

DISCUSSION: The TCH FY 2017 financial plan has been developed taking into consideration the challenges facing healthcare in general and Long Term Acute Care (LTAC) 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 a shortage of health care workers. For FY 2017, 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.

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 each operating unit then provides a cumulative operating and capital budget that contains service demand forecasts, required full-time equivalent personnel, and non-labor expenses.

Budget and Operating Assumptions

Market Conditions For FY 2017: Discharges are budgeted to grow in excess of 6% from FY 2016 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 vs. Projected vs. Budget

<table>
<thead>
<tr>
<th></th>
<th>FY2015</th>
<th>FY2016</th>
<th>FY2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharges</strong></td>
<td>352</td>
<td>382</td>
<td>428</td>
</tr>
<tr>
<td><strong>Average Length of Stay</strong></td>
<td>30.5</td>
<td>31</td>
<td>29</td>
</tr>
<tr>
<td><strong>Patient Days</strong></td>
<td>10,975</td>
<td>11,867</td>
<td>12,410</td>
</tr>
</tbody>
</table>

### Revenues:
The TCH FY 2017 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, managing length of stay, and negotiated contracts with rate increases.

### Rate Changes:
The TCH Medicare proposed base rate for FY 2017 is $40,391 per case. With a Medicare CMI of 1.28, this will result in a total Medicare reimbursement rate of $51,700 per Centers for Medicare and Medicaid Services (CMS) full Prospective Payment System (PPS) payment per case. This rate also includes TCH’s full participation in the Hospital Inpatient Quality Reporting Program and meets the four claims-based measures. It is projected that 35% of the Medicare cases will not meet the full Long Term Care Hospital (LTCH) base payment of $52,000 due to the three-day ICU requirement on wound cases. The FY 2017 budget reflects the net revenue reduction in the amount of $800K due to the new Centers for Medicare and Medicaid Services (CMS) Long Term Acute Care Hospital (LTACH) requirements.

### Expenses:
Expenses per discharge from operations are projected to decrease 11% from the FY 2016 projection. This decrease is attributed to the reduction in interest expense associated with the Medical Center buy-out of the University Physicians Group (UPG) loan to TCH.

### Staffing:
The TCH’s paid FTEs are planned at 139, an increase of one FTE from the current FY projection of 138 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 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 reduce length of stay.

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 LTCH reimbursement.

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

<table>
<thead>
<tr>
<th></th>
<th>Projected FY16</th>
<th>Budget FY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operating Revenue</td>
<td>$ 22.6</td>
<td>$ 21.8</td>
</tr>
<tr>
<td>Operating Expense</td>
<td>21.5</td>
<td>21.4</td>
</tr>
<tr>
<td>Operating Income/ (Loss)</td>
<td>1.1</td>
<td>0.4</td>
</tr>
<tr>
<td>Total Margin</td>
<td>4.7%</td>
<td>1.7%</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. Subject to funds availability, TCH management recommends $245,348 be authorized for capital requirements. Beginning July 2016, TCH will begin renovations for an on-site pharmacy located on the third floor.

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

2016-2017 OPERATING AND CAPITAL BUDGETS FOR THE UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL

RESOLVED, the 2016-2017 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 President, the Chief Operating Officer, and the Medical Center Operating Board.
Clinical Operations

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. The TCH is currently supporting 22 FTEs in degree-granting programs. Additionally, we had 19 current team members receive degrees in the past two years. Fifty-eight percent of our 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 March 31, 2016, 79 patients were admitted for ventilator weaning/teaching. Sixty-three of those patients (80%) achieved that goal compared to the established ventilation weaning benchmark of 60.1%.

Wound Management is the second most frequent Diagnostic Related Group (DRG) discharged from TCH. For the period of July 1, 2015 through March 31, 2016, 29% of TCH patients discharged were admitted for complex wound care needs. The care of patients with wounds crosses 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 within the continuum. TCH has sought the guidance of experts in the field and recently applied for wound care certification. A site visit from The Joint Commission (TJC) is anticipated in June 2016 to validate the TCH as a Wound Care Certified facility.
Rehabilitation Services is comprised of Physical Therapy, Occupational Therapy, and Speech Language Pathology programs. It continues to serve our population well and contributes to patient satisfaction and 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.

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.

New patient referrals for the period of July 1, 2015 through March 31, 2016 totaled 983. Of the 983 referrals, 278 were admitted, for a conversion rate of 28%. During this period, 73% of admissions originated from the Medical Center and 27% originated from 14 outside facilities.

For the same period, the average length of stay was 30.83 days, which exceeds the minimum CMS requirement of 25 days. Factors resulting in a longer length of stay include clinical conditions that are 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) 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 from July 1, 2015 through March 31, 2016, the TCH discharged 286 patients: 22% transferred to the Medical Center, 76% discharged back to the community, and mortality accounted for 2%. Of the patients discharged to the community, 35% were discharged to home, 18% discharged to an Inpatient Rehabilitation Facility, 45% discharged to a skilled nursing facility, and 2% went to hospice.
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 infection benchmarking and the CMS LTACH 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 our organization and requires the use of a scientific methodology to eliminate preventable harm and improve care outcomes and efficiency. We will focus on seven metrics as priorities for preventing harm on the journey to becoming the safest LTACH in which to both receive and provide care:

- Mortality
- Team Injuries
- Patient Fall with Injury
- Catheter-Associated Urinary Tract Infection
- Central Line Associated Blood Stream Infection
- Hospital Acquired Pressure Ulcers
- Wound Improvement

TCH has met or exceeded most of the targets for FY 2016 Quarter 3. Accomplishments include a ventilator-wean success rate meeting the established target, maintaining below mean rates for device utilization and below mean rates for catheter associated urinary tract infections and central line blood stream infections. Our performance has been strong thus far, and the data from VHDS and NHSN will be used to assess relative performance compared to other LTACHs across the nation. Additionally, 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

The 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 our targeted goals in FY 2016 Q3, with average scores of 4.6-4.8 on a five-point scale.

Our discharged patients consistently rate us as a 4.8 in the categories of “likelihood to recommend” and “overall assessment.” TCH’s massage therapist and speech therapist also continue to be sources of high satisfaction for long term patients.