UNIVERSITY OF VIRGINIA
MEDICAL CENTER OPERATING BOARD FOR THE UNIVERSITY OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
Thursday, February 18, 2016
8:30 – 9:00 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)  

II. OPERATIONS AND FINANCE REPORT (Dr. Shannon to introduce Ms. Michelle D. Hereford and Mr. Michael S. McDaniel; Ms. Hereford and Mr. McDaniel to report)
A. Discussion of Fiscal Year 2016 Year To Date Financials
B. Operations Update

III. POST-ACUTE SERVICES (Robert D. Powers, M.D.)  

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.
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 an update of significant operations of the hospital occurring since the last MCOB meeting.

Michelle Hereford joined the University of Virginia Health System in 2009. As Chief of Community Hospitals and Post-Acute Division, 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.

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.

A. Finance Report

The TCH ended the period of July 1, 2015 through December 31, 2015 with operating income of $1,511,157, compared to the budgeted operating income figure of $335,193. The positive operating income number is attributed to payor mix and collections on several patient accounts that were over a year past due. Twenty-six percent of TCH’s discharged cases involved commercial primary payors. Of the 188 discharged cases, 42% were vent wean and respiratory complex. During this same period, average length of stay (ALOS) was 30.79 days, which is
0.67 days above the budget of 30.12. The All Payor Case Mix Index of 1.23 was 2% lower than the budgeted figure of 1.26. The Medicare Case Mix Index of 1.24 was 3% lower than the budgeted figure of 1.28. Total worked full-time equivalents (FTEs) were 140, 2% below the budgeted FTEs of 143.

B. Operations Report

During the first six months of Fiscal Year 2016, TCH reported 188 admissions. Of the 188 total admissions, 135 were from the Medical Center. The 135 Medical Center admissions represent 3,891 patient days or approximately 21 beds per day for the Medical Center. The 135 admissions to TCH contributed to a 0.28 reduction in the Medical Center’s ALOS. These metrics further demonstrate the importance and value of the long term acute care services in the continuum of care.

Clinical Operations

Clinical Operations includes an array of services focused on three discharge areas: Respiratory, Wound-Care, and Rehabilitation Services.

Respiratory Services continue to exceed expectations in weaning patients from ventilators. From July 1, 2015 to December 31, 2015, 52 patients were admitted for vent weaning and teaching. Of those patients, 81% 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 December 31, 2015, 31% of patients discharged from the TCH 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 within the continuum of care. TCH has sought the guidance of experts in the field and recently applied for wound care certification. We anticipate a site visit from The Joint Commission (TJC) in the spring of 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 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.

**Care Management**

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 from July 1, 2015 through December 31, 2015 totaled 629. Of the 629 patients, 188 were admitted, for a conversion rate of 30%. During this period, 72% of the admissions originated from Medical Center and 28% originated from 14 outside facilities.

For the same period, the average length of stay was 30.79 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 after 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 December 31, 2015, TCH discharged 188 patients. Of the 188 discharges, 29% were discharged to home or home health, 24% to a skilled nursing facility, 23% to the Medical Center, 18% to an inpatient rehabilitation facility, and 3% to hospice. In addition, 3% of these patients expired.
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, as evidenced by our Quality and Patient Safety Dashboard. TCH participates with the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) for device-related infection benchmarking, as well as the Centers for Medicare and Medicaid Services' Long-Term Care Hospital Quality Reporting Program. TCH has submitted its first quarter of data to the Vindicet Hospital Data System (VHDS) for additional quality outcomes and LTACH-specific benchmarking.

The TCH has implemented the “Be Safe” Program, which involves staff at all levels of the organization and uses scientific methodology to eliminate preventable harm and improve care outcomes and efficiency. We are focusing on seven metrics as priorities for preventing harm on the journey to becoming the safest Long Term Acute Care Hospital to both receive and provide care for Fiscal Year 2016:

- 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 through the second quarter of Fiscal Year 2016. Specific accomplishments include 25 months without a ventilator associated pneumonia, a ventilator-wean success rate exceeding the established target, and maintaining below mean rates for device utilization and hospital-acquired pressure ulcers. 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.
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 its targeted goals through the second quarter of Fiscal Year 2016, with average scores of 4.7-4.8 on a five point scale. Likelihood to recommend TCH to others is currently rated at 4.9 on a five point scale.

The rate at which surveys were returned declined during the month of December. This is being investigated to see if it was due to potential survey distribution errors.
DISCUSSION:

The success of the TCH is attributable to the management of the patient’s condition in a controlled environment. It has often resulted in a decrease in a patient’s short term acute care length of stay and an increase in acute care access (bed availability), as well as a reduction in the overall cost of care. However, long term acute care is only one component of the continuum of care. It has been demonstrated that care across that continuum can be fragmented, as patients pass through the care of multiple providers, and the providers do not consistently and accurately communicate information about the course of treatment to all those involved in the patient’s care. Post-acute care, in particular, is often delivered in more intensive care settings, where payments and expenses are higher, when effective and appropriate care can be delivered in a lower intensity setting. Therefore, improving the management of post-acute care has become a key component to any successful effort to reform and enrich care delivery.

In 2011, the Medicare Payment Advisory Commission (MedPAC) examined Medicare fee-for-service regional spending variation in three composite sectors: acute inpatient, including short-term inpatient and psychiatric care; ambulatory care, including physicians, ambulatory surgical centers, and labs within
hospital outpatient facilities; and post-acute care, which combined home health agencies (HHA), skilled nursing facilities (SNF), long term care hospitals (LTCH), and inpatient rehabilitation facilities (IRF). MedPAC's analysis found that the post-acute care sector showed the greatest variation, with spending of $60 per member per month in the lowest-use area to almost $450 in the highest-use area. In 2013, the Institute of Medicine's Committee on Geographic Variation analyzed Medicare post-acute care spending in 2007 through 2009 by SNFs, HHAs, hospice facilities, LTCHs, and IRFs to determine the extent to which variation in post-acute care spending contribute to the variation in total, all-cause Medicare spending. The Committee discovered that 40% of all variation in Medicare spending is explained by variation in utilization of post-acute care services.

The U.Va. Health System recognized the need to address this well documented situation and, as a result, a focus on the post-acute care sector has become a priority in the development of the post-acute service line. This service line includes the TCH, the UVA HealthSouth Inpatient Rehabilitation Hospital, U.Va. Continuum Home Health and Home Infusion Services, and the utilization management of hospice and SNF services.