UNIVERSITY OF VIRGINIA
BOARD OF VISITORS

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

March 2, 2017
UNIVERSITY OF VIRGINIA
MEDICAL CENTER OPERATING BOARD FOR THE UNIVERSITY OF VIRGINIA
TRANSITIONAL CARE HOSPITAL

March 2, 2017
8:30 – 9:00 a.m.
Auditorium of the Albert & Shirley Small
Special Collections Library, Harrison Institute

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

I. OPERATIONS AND FINANCE REPORT (Dr. Britt to introduce Mr. Michael S. McDaniel; Mr. McDaniel to report) 1

II. EXECUTIVE SESSION

- 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 regulations and accreditation standards, including CMS Conditions of Participation and the Transitional Care Hospital Infection Prevention and Control Program Plan, 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) and (7) 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: March 02, 2017

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: I. 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 joined the University of Virginia Health System in 1990 and has served in various nursing and leadership roles. As Associate Chief of the Transitional Care Hospital, he oversees all operations of this long-term acute care facility. Mr. McDaniel has a Bachelor's degree in Nursing and a Master's degree in Business Administration from the University of Virginia. He has over 25 years of health care experience serving in a broad range of roles.

FINANCE REPORT

The TCH ended the period of July 1, 2016 through December 31, 2016 with a net operating income figure of $128,791, compared to the budgeted net operating income figure of $252,138. The operating variance is attributed to Census, Case Mix Index (CMI), and Payor Mix. For the second quarter of FY17, TCH reported an Average Daily Census of 29 compared to a budget of 34. Also during the quarter, TCH reported an All Payor Case Mix Index of 1.12 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 six months of FY17, 26% of discharges had a ventilator support diagnosis (compared to prior year at 38%). Ventilator support cases carry a relatively high CMI of 1.85. Meanwhile, the shift of cases has been towards Infectious Disease and Respiratory Complex diagnoses, which reflect a significantly lower CMI. 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 24.38 days compared to a budget of 29.10. 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 second quarter, TCH reported this figure to be 8% compared to a budget of 3%.

The total paid full-time equivalents (FTEs) were 123, which was 12% below the budgeted FTEs of 139. In addition, total operating expenses were 13% below budget. The positive expense variance is due to the below budgeted volume and variable expenses that are directly related to volume.

During the second quarter, TCH reported 216 admissions. One hundred and sixty-seven of those admissions were from the Medical Center and represent 4,295 patient days or approximately 23 beds of capacity per day for the Medical Center. The 167 admissions to TCH also contributed to a 0.30 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 LTCH PPS payment rates depending upon 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 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 LTCH must have included ventilator services for at least 96 hours.

**Clinical Operations Report**

Clinical Operations encompasses an array of services focused on furthering our goal 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.
Patients in need of Respiratory Services continue to be the largest percentage of patients served and TCH continues to excel in the delivery of these services. From July 1, 2016 to December 31, 2016, 56 patient admissions were for vent weaning. Forty of those patients (71.4%) 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 December 31, 2016, 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 2016, CMS for the first time began collecting quality data in this arena. In the second quarter of FY17, 73% of TCH patients showed improved function of > 10% and 43% 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 selection through discharge.

New patient referrals for the period of July 1, 2016 through December 31, 2016 totaled 732. Of the 732 patients, 216 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 24.38 days, which is 0.62 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; and 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 December 31, 2016, TCH discharged 214 patients: 24% were transferred to UVAMC, 74% were discharged to the community/other facilities, and mortality represented 2% of the total. Of the 158 patients discharged to the community/other facilities, 48% were discharged to home, 20% were discharged to an Inpatient Rehabilitation Facility, 29% were discharged to a Skilled Nursing Facility, and 3% were discharged 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 the 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 will focus 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

**Long Term Acute-Care Hospital (LTACH) Quality Data and Internal/External Comparisons: History of LTACHS and Quality Measurement**

Long-term acute care hospitals provide care to complex patients with acute care needs (e.g. mechanical ventilation weaning; complex wound healing) for a mean duration of stay of 25 days. They were initially created in the early 1980’s to facilitate prompt
discharge of medically complex patients from short-term acute care hospitals in an effort to decrease Medicare spending.

While academic medical centers have 30+ years of rich, validated, risk-adjusted comparison data via the University Healthcare Consortium (UHC), a benchmarking system established in 1984, and The Joint Commission Core Measures implemented in 1999, Long Term Acute Care Hospitals have not had similar resources available to provide valid (if any) benchmarks.

The National Healthcare Safety Network (NHSN) began providing LTACH-specific data in 2012, utilizing standardized data definitions, data abstraction processes, and panels of national experts to provide evidence-based criteria. They now provide percentile rankings on a monthly basis (no quarterly roll-up), but they are very protective of the information that hospitals submit to them (i.e., will not share best performers data or names). C-Difficile SIRs scores will become available in the spring of 2017.

The National Association of Long Term Hospitals (NALTH) has engaged the Vindicet Healthcare Data System (VHDS) to provide LTACHS with quality data benchmarks, utilizing standardized data definitions and abstraction rules. The TCH has participated for the past nine months.

The first mandatory reporting of standardized quality data for LTACHs did not start until October 1, 2012; that data was not risk adjusted nor publically reported. 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 FY18 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 FY17:

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<tr>
<th>Metric</th>
<th>Data/Report Source</th>
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<tbody>
<tr>
<td>Mortality</td>
<td>Vindicet Healthcare Data System (VHDS)</td>
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<tr>
<td>Hospital Acquired Pressure Ulcers (Stage2, 3, 4)</td>
<td>Vindicet Healthcare Data System (VHDS)</td>
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<tr>
<td>Hospital Acquired Infections: C-Difficile Infections</td>
<td>National Healthcare Safety Network (NHSN)</td>
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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 its target goals in second quarter, with average scores of 4.6-4.8 on a 5-point scale. TCH is ranked at the 78th percentile for the Press-Ganey LTACH database (n = 16) for the first six months of FY17.

Discharged patients consistently rated TCH as a 4.7 in the category of “likelihood to recommend” and as a 4.7 in “overall assessment.” TCH scored at the 99th percentile among the Press-Ganey LTACH database (n=16) in “Overall Assessment.” TCH’s physician staff also were ranked as the top performers in TCH’s Press-Ganey comparative group.

Human Resources

Employee Engagement

TCH’s employee engagement scores for FY16 were lower than anticipated. Despite a slight increase in “Overall Satisfaction” and in individual areas such as “having the materials and equipment needed” and “opportunity to do my best every day,” the “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, we will also attempt to identify where our efforts fell short.