UNIVERSITY OF VIRGINIA
BOARD OF VISITORS
MEETING OF THE
MEDICAL CENTER
OPERATING BOARD
FOR THE UNIVERSITY
OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
September 13, 2012
AGENDA

I. REPORTS BY THE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF THE TRANSITIONAL CARE HOSPITAL (Mr. Howell)
   A. Vice President’s Remarks
   B. Operations and Finance Report (Mr. Howell to introduce Ms. Michelle D. Hereford; Ms. Hereford to report)

II. EXECUTIVE SESSION
   • To consider proposed personnel actions regarding the appointment, reappointment, resignation, assignment, performance, and credentialing of specific medical staff and allied health professionals, as provided for in Section 2.2-3711(A)(1) 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.
   • 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: September 13, 2012

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: I.A. Vice President’s Remarks

ACTION REQUIRED: None

DISCUSSION: The Vice President and Chief Executive Officer of the University of Virginia Transitional Care Hospital will inform the Medical Center Operating Board of recent events that do not require formal action.
BACKGROUND: The University of Virginia Transitional Care Hospital began operations on August 4, 2010. It 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. The University of Virginia Transitional Care Hospital also provides an update of significant operations of the hospital occurring since the last Medical Center Operating Board meeting.

Michelle Hereford joined the University of Virginia Health System in 2010. As Chief of the Transitional Care Hospital, 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 healthcare experience serving in a broad range of roles.

FINANCE REPORT

The University of Virginia Transitional Care Hospital ended the period of July 1, 2011 through May 31, 2012 with an operating loss of $2,681,340, compared to the budgeted operating income figure of $1,070,036. During this same period, inpatient discharges were 186 compared to the budget of 248. Average length of stay was 27.77 days, which is less than the budget of 29.0. The Medicare Case Mix Index of 1.31 was less than the budget of 1.55. Total full-time equivalents (FTEs) were 108, including 11 contracted employees, which is below the budget of 116 FTEs.

The Transitional Care Hospital reported a net operating loss of $2,681,340 due to the following:

- Volumes were 25% below budget.
Ten percent of discharges were Medicaid patients compared to a budget of 3%. All of the Medicaid patients were admitted from the Medical Center.

Case Mix Index was below budget due to fewer vent weaning cases and more wound cases. A vent wean diagnostic related weight is 2.02 compared to an average weight of 0.80 for wound cases.

Thirty-nine percent of discharges were short stay cases resulting in fewer reimbursement dollars per case.

Contract labor for FY 12 through May 31, 2012 was $1,298,918 for a total of 11 FTEs. This equates to an average annual salary of $118,083 per FTE. The Transitional Care Hospital’s average annual salary with benefits for a Registered Nurse is $68,000.

**OPERATIONS REPORT**

Access to services at the Transitional Care Hospital is guided by the collaborative efforts of clinicians, insurance providers, patients, and families. The Transitional Care Hospital employs clinical liaisons who are deployed to the community to identify appropriate candidates and evaluate referrals. These referrals are often received directly from providers and through the use of an electronic program known as E-discharge. New referrals are brought to an interdisciplinary team and reviewed every morning.

For the period from July 1, 2011 through May 31, 2012, the Transitional Care Hospital received 577 referrals which resulted in 198 total admissions. One hundred and forty-six of those admissions (74%) were from the Medical Center. The 146 Medical Center admissions represent 4,054 patient days or approximately 12.1 Medical Center beds per day which would not have been available without the Transitional Care Hospital.

**Clinical Operations**

Clinical services at the Transitional Care Hospital are provided by physicians, registered nurses, registered respiratory therapists, rehabilitation professionals, and support personnel, including patient care assistants, diagnostic radiology technicians, and pharmacists. These disciplines work collaboratively to develop a plan of care which is evaluated weekly in an interdisciplinary meeting. In addition, daily multidisciplinary rounds provide an opportunity to communicate a daily plan and recent changes in patient status.
Respiratory Complex, Wound Management, and Rehabilitation Services comprise a majority of the defined patient population.

Respiratory Services

Led by the Pulmonary Medical Director, Sharon Esau, M.D., and managed by a registered respiratory therapist, the Respiratory Program had a productive quarter. From April 1 to June 30, 2012 357 vent days were recorded. Seventeen patients were admitted for vent weaning, and 14 (82.4%) achieved that goal, exceeding the 60.1% national benchmark. In addition, a joint educational series with Emergency Medicine Services was implemented to teach airway management competency to Licensed Independent Practitioners and Respiratory Therapists. The first educational session was held in March 2012 and was well received by all participants.

Wound Management

The wound management program is actively recruiting a Nurse Practitioner to run the service and lead our efforts to obtain Joint Commission certification. Progress towards certification has been made, but Joint Commission requirements are complex and will require time to complete.

Rehabilitation Services

The Physical Therapy, Occupational Therapy, and Speech Language Pathology program continues to serve our population well and contribute to patient satisfaction and 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 Report

The Transitional Care Hospital 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

A significant broadening of the referral base has occurred this quarter. New patient referrals have been received from more than 22 outside facilities, and the conversion rate (referral to admission) has increased to 34%. This has been a result of the ongoing efforts of two clinical liaisons and a recent staffing shift to focus on marketing, with an emphasis on the areas north and east of Charlottesville.

Case Management

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 Interqual Criteria. Our goal has been 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 May 31, 2012, the average Medicare length of stay for FY 12 was 29.2 days, and the overall length of stay for all payors was 27.77 days.

Factors resulting in an extended length of stay have been 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, and the lack of community resources, specifically skilled nursing facilities.

Factors resulting in an abbreviated length of stay, i.e. 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.

We will continue to strengthen and further develop the relationships with our referral sources. Planned areas of focus include communication of and access to patient clinical information from outside hospitals and proactively agreeing to transfer plans should care need to be escalated.

Human Resources

The Transitional Care Hospital is currently staffed with 97 Medical Center FTEs and 11 contracted FTEs. As the Transitional Care Hospital continues to grow and develop, it is imperative that we acquire and retain talented employees.
Recruitment

For the period from January 1, 2012 through June 30, 2012, we successfully recruited 57 permanent staff: 27 Registered Nurses, six Licensed Practical Nurses (LPN), seven Patient Care Assistants, five Health Unit Coordinators, five Respiratory Therapists, two Inpatient Case Managers, one Administrative Assistant, one Physical Therapist, one Hospital Educator, one Nurse Manager, and one Human Resources Consultant. With the addition of a Human Resources Consultant dedicated primarily to the Transitional Care Hospital, we expect to recruit full-time staff to replace our five traveling nurses. We are also recruiting LPNs, a caregiver group we believe will provide high-quality and cost-effective support to our patient population.

Quality and Performance Improvement

For the past 18 months, the Transitional Care Hospital has maintained and grown our census as well as our dedicated staff. This growth and stability provides us with reliable data to use to assess our strengths and weaknesses and to establish improvement opportunities. Using our outcomes data and our Quality Reporting program, we have and will continue to upgrade our orientation and education programs, to work with EPIC staff on potential electronic aides, and to further refine our Wound Program in order to address identified opportunities for improvement.

Patient Satisfaction

Recognizing that more than 50% of our discharged patients are transitioned directly to another level of care from the Transitional Care Hospital (e.g. Acute Inpatient Rehabilitation or Skilled Nursing Facility) and are not home to receive a mailed Patient Satisfaction Survey, TCH has worked with our survey company, Press-Ganey, to change our process. Instead of mailing surveys to the patients’ home two weeks after discharge, patients will receive a copy of the survey prior to their discharge from TCH. Press-Ganey will provide a self-addressed stamped envelope to return the survey. This process change will start on August 12, 2012.

External Benchmarking

The Centers for Medicare and Medicaid Services has established a quality reporting program for Long Term Acute Care Hospitals. Data collection for this program will begin on
October 1, 2012. Non-compliance will result in a 2% reduction in annual payment updates. The three quality measures to be reported are Central Line Associated Blood Stream Infections, Catheter Associated Urinary Tract Infections, and Hospital Acquired Pressure Ulcers (new or worsened).

The Transitional Care Hospital has been collecting data on these three quality measures for almost two years, and a TCH representative attended the training offered by the Centers for Medicare and Medicaid Services in May 2012. We have selected a CMS-approved vendor to submit our infection data and are working with our IT department to install the CMS-approved software program to submit demographic and wound data.

**Accreditation**

As a fully accredited facility, the Transitional Care Hospital continues to focus on maintaining that status through “constant-readiness” educational sessions and regular hospital environment of care rounds.

**Community Outreach**

Through a Memorandum of Understanding with the Medical Center, the Transitional Care Hospital has implemented a volunteer program. In addition to three trained volunteers who assist with the lobby receptionist duties, we also have five Madison House volunteers and one adult volunteer who assist patients more directly though bedside visitation, answering patient call bells and unit telephones, and helping with other work on patient care units, such as stocking isolation garb at each patient room. Additional plans include offering our need for additional bird-feeders as an Eagle Scout Project (we have an interested Scout) and continuing with our horticulture program, using community members and programs whenever possible. Memorial trees have already been planted in honor of two TCH staff members who have died unexpectedly this year, and a service involving their families is being planned for the fall.