UNIVERSITY OF VIRGINIA
BOARD OF VISITORS
MEETING OF THE
MEDICAL CENTER
OPERATING BOARD
FOR THE UNIVERSITY
OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
September 19, 2013
UNIVERSITY OF VIRGINIA
MEDICAL CENTER OPERATING BOARD FOR THE UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL

Thursday, September 19, 2013
8:30 – 8:45 a.m.
4th Floor, Emily Couric Clinical Cancer Center

Committee Members:
Stephen P. Long, M.D., Co-Chair
Edward D. Miller, M.D., Co-Chair
William H. Goodwin Jr. Constance R. Kincheloe
Victoria D. Harker George Keith Martin
Andrew K. Hodson, MB.Ch.B Charles W. Moorman
Michael M.E. Johns, M.D. The Hon. Lewis F. Payne
William P. Kanto Jr., M.D.

Ex Officio Members:
Teresa A. Sullivan Patrick D. Hogan
Nancy E. Dunlap, M.D. R. Edward Howell
Dorrie K. Fontaine Richard P. Shannon, M.D.
Robert S. Gibson, M.D John D. Simon

AGENDA

I. REPORTS BY THE VICE PRESIDENT AND CHIEF EXECUTIVE OFFICER OF THE TRANSITIONAL CARE HOSPITAL (Mr. Howell)
   A. Vice President’s Remarks 1
   B. Operations and Finance Report (Mr. Howell to introduce Ms. Michelle D. Hereford; Ms. Hereford to report) 2

II. 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: September 19, 2013

COMMITTEE: Medical Center Operating Board

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

ACTION REQUIRED: None

BACKGROUND: R. Edward Howell has been the Vice President and Chief Executive Officer of the University of Virginia Medical Center since February 2002 and the Vice President and Chief Executive Officer of the University of Virginia Transitional Care Hospital (TCH) since its inception. Prior to joining the University of Virginia, he served for eight years as Director and CEO of the University of Iowa Hospitals and Clinics. He has over 30 years of experience in administration and leadership of academic medical centers.

DISCUSSION: The Vice President and Chief Executive Officer of the University of Virginia Transitional Care Hospital will inform the Medical Center Operating Board (MCOB) of recent events that do not require formal action.
BOARD MEETING: September 19, 2013

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: I.B. Operations and Finance Report

ACTION REQUIRED: None

BACKGROUND: The 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. In addition, the TCH 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 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 health care experience serving in a broad range of roles.

FINANCE REPORT

The University of Virginia TCH ended fiscal year 2013 with an operating loss of $588,626, compared to the budgeted operating income figure of $1,207,351. During this same period, inpatient discharges were 305 compared to the budget of 360. Average length of stay was 26.43 days, below the budget of 29.0. The All Payor Long Term Acute Care Hospital Case Mix Index (CMI) of 1.21 was less than the budget of 1.25. Total full-time equivalents (FTEs) were 112, below the budget of 124 FTEs.

The TCH reported a net operating loss of $588,626 due to the following:

- Discharges were 15% below budget.
- Sixteen percent of discharges were Medicaid patients, compared to a budget of 13%. Ninety percent of the Medicaid cases were admitted from the Medical Center.
- The Medicare CMI was below budget due to fewer vent weaning cases and more wound cases than budgeted. A vent
wean diagnostic related weight is 1.95 compared to an average weight of 0.80 for wound cases.

- Fifty percent of discharges were short-stay cases, resulting in lower reimbursement per case.
- Pharmaceutical expenses were $315,873 over budget due to the cost of supplies and labor associated with compounded medications prepared for patient-specific needs.

OPERATIONS REPORT

Access to services at the TCH is guided by the collaborative efforts of clinicians, insurance providers, patients, and families. The TCH 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 during a daily huddle session.

In fiscal year 2013, the TCH received 966 referrals, resulting in 315 total admissions. Two hundred and thirty-eight of those admissions (76%) were from the Medical Center. The 238 Medical Center admissions represent 6,290 patient days or approximately 17 Medical Center beds per day which would not have been available without the TCH. This has an estimated impact of 0.17 days to the Medical Center length of stay.

Clinical Operations

Clinical services at the TCH are provided by physicians, registered nurses, registered respiratory therapists, rehabilitation professionals, and support services, 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 Pulmonary Medical Director, Sharon Esau, M.D., and managed by a registered respiratory therapist, the Respiratory Program had a productive year. From July 1, 2012 to June 30, 2013, there were 2,762 ventilator days recorded. One hundred and twelve patients were admitted for vent weaning/teaching, and 78.6% achieved that goal versus a 60.1% national benchmark. In addition, the department has moved forward with the development of an internally developed tracheostomy training device, applying for and receiving a provisional patent, and working collaboratively with the department of Biomedical Engineering to evaluate the feasibility of developing a marketable version of this device. These efforts will further improve the outcomes noted above.

Wound Management

During fiscal year 2013, the TCH was fortunate to recruit a highly skilled, doctorally-prepared Wound, Ostomy & Continence Nurse Practitioner, Tara Beuscher, to oversee our wound management program. She successfully transitioned our program from primarily specialist-based care to skilled care with specialist guidance. This new direction and oversight has also led the TCH to embark upon the journey of providing wound treatment associate (WTA) certification to TCH staff. We anticipate final approval in early fiscal year 2014.

Rehabilitation Services

The Physical Therapy, Occupational Therapy, and Speech Language Pathology programs continue to serve our population well and contribute 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 to this care. In an effort to more effectively measure our outcomes in this area, we have developed a rehabilitative services outcomes measurement tool for use in fiscal year 2014.

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 from selection through discharge.

Clinical Liaison

A significant broadening of the referral base has occurred this fiscal year. New patient referrals have been received from more than 22 outside facilities, and the annual conversion rate (referral to admission) has remained steady at the industry benchmark of 33%. This has been a result of the ongoing efforts of two clinical liaisons and a focus on marketing to current and potential referral sources.

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 June 30, 2013, the average Medicare length of stay for fiscal year 2013 was 27.42 days, and the overall length of stay for all payors was 26.43 days.

Factors resulting in an extended length of stay include 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 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.

Ongoing efforts to strengthen and further develop the relationships with our referral sources remain a focus as we embark upon the next fiscal year. Planned areas of focus include communication of and access to patient clinical information from outside hospitals and collaboratively and proactively agreeing to transfer plans should care need to be escalated.

Human Resources

The TCH is currently staffed with 112 FTEs. As the TCH continues to grow and develop, it is imperative that we continue
to recruit and retain a highly skilled, highly engaged, and diverse workforce.

Recruitment

For the period from July 1, 2012 through June 30, 2013, we successfully recruited 52 permanent employees. These included:

- 30 Registered Nurses
- 10 Patient Care Assistants
- 3 Health Unit Coordinators
- 2 Licensed Practical Nurses
- 2 Registered Respiratory Therapists
- 1 Nurse Manager
- 1 Hospital Educator
- 1 Wound Care Nurse Practitioner
- 1 Pharmacy Supervisor
- 1 Physical Therapist

During same period, the TCH experienced a loss of 29 employees. Overall, the TCH reported a turnover rate of 24% for this period. This is a significant decrease from the prior fiscal year.

Employee Engagement and Retention

In July 2013, the Health System conducted an employee engagement survey for all five Health System entities. Eighty-six (86%) percent of TCH employees participated in this survey. This success is due to the multidisciplinary Employee Engagement Committee, which worked collaboratively with the leadership team to encourage participation. This team will continue to pursue its goal of increasing engagement after the results are distributed in September by analyzing those results and developing action plans in areas which need improvement. The Employee Engagement Committee remains focused and has developed many initiatives, including developing a monthly newsletter, recognizing a STAR employee of the month, hosting and promoting various HOOs Well initiatives, celebrating holidays with patients and family members, organized quarterly town hall meetings, and planning the first annual Northridge grounds health fair.

To also address retention and further enhance engagement, the TCH implemented a focused professional development education program during the second quarter of fiscal year 2013. This education, titled “Top 5”, is based on input from all employees and is refreshed each quarter to encourage employees to contribute to a quarterly selection of five educational offerings. It therefore provides employees with opportunities to learn about topics and practices which are pertinent to their daily activities. To date, 15 topics have been offered, including Introduction to Wound Care, Lift Equipment and Its
Quality and Performance Improvement

Quality Planning

The TCH met or exceeded our quality targets in 13 of 16 metrics for fiscal year 2013 and will incorporate strategies to help meet or exceed all targets in the new fiscal year 2014 Plan.

Patient Satisfaction

During fiscal year 2013, the TCH collaborated with the Health System’s Patient Satisfaction vendor, Press Ganey, to identify opportunities to increase the return rate of completed surveys. This collaboration resulted in an action plan to switch from mailed surveys after discharge to hand distributed surveys prior to discharge. The rate has improved somewhat, but we have not yet realized goal of 30%. We will continue to improve the processes (both internal and external) in an effort to increase the rate. It is important to note, however, that the TCH did meet or exceed the established targets for the five Patient Satisfaction metrics in our fiscal year 2013 Quality Plan.

External Benchmarking

The TCH met and continues to meet the new Centers for Medicare and Medicaid Services Long Term (Acute) Care Hospital Quality Reporting Program expectations, thus avoiding a 2% reduction in payment. Benchmarking data is not yet available through this program.

The TCH continues to send data to the National Association of Long Term (Acute) Care Hospital National Health Information Systems (NHIS) for external benchmarking and for the Joint Commission ORYX Non-Core Measures. At this point, the NHIS database does not include risk adjustment, and there are very few 40-bed free standing facilities participating. Additionally, effective January 2013, the Joint Commission placed a temporary hold on the submission of Oryx Non-Core Measures for LTACHs. This database contained information from
many LTACHs, but we are no longer able to obtain this important information.

Accreditation

As a fully-accredited hospital, the TCH continues to focus on maintaining that accreditation status through "constant-readiness" educational sessions and conducting routine hospital environment of care rounds. We anticipate our Joint Commission unannounced triennial re-accreditation survey will occur between now and June 2014.

Community Outreach

The TCH Volunteer Program continues to grow in numbers and strength. Volunteers who have worked with us this past year have provided input and implemented actions to improve the program. The TCH had its very first robust summer program, and we are looking forward to the return of our Madison House Volunteers this fall. The hallway musician program has expanded, providing music to our patients, families, and staff four days per week. Using some of our community partners, we are increasing our flower donation-program, continuing to increase our music program, and anticipate developing distraction strategies for patients with dementia, using both internal expert resources (e.g., neuropsychology department) and community volunteers.