UNIVERSITY OF VIRGINIA
BOARD OF VISITORS
MEETING OF THE
MEDICAL CENTER
OPERATING BOARD
FOR THE UNIVERSITY
OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
May 20, 2013
UNIVERSITY OF VIRGINIA
MEDICAL CENTER OPERATING BOARD FOR THE UNIVERSITY OF VIRGINIA
TRANSITIONAL CARE HOSPITAL
Monday, May 20, 2013
8:15 am – 8:30 am
4th Floor, Emily Couric Clinical Cancer Center

Committee Members:
Edward D. Miller, M.D., Chair
Vincent J. Mastracco Jr., Vice Chair
Helen E. Dragas
Victoria D. Harker
Andrew K. Hodson, MB.Ch.B
William P. Kanto Jr., M.D.
Stephen P. Long, M.D.
Constance R. Kincheloe
Charles W. Moorman
The Hon. Lewis F. Payne

Ex Officio Members:
Teresa A. Sullivan
Steven T. DeKosky, M.D.
Dorrie K. Fontaine
Robert S. Gibson, M.D.
Patrick D. Hogan
R. Edward Howell
John D. Simon

AGENDA

I. ACTION ITEM

- Fiscal Year 2014 Operating and Capital Budget

II. 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)

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.
AGENDA ITEM: I. Fiscal Year 2014 Operating and Capital Budgets

BACKGROUND: The Transitional Care Hospital's (TCH’s) operating and capital budgets are consolidated with the Medical Center’s overall budget. At its May meeting, the Board of Visitors acts on the proposed budget based on a recommendation from the Medical Center Operating Board.

DISCUSSION: The TCH’s 2014 fiscal plan has been developed while considering the challenge of providing a new patient care service in a new environment, developing a new workforce, and introducing teaching and training of clinical providers. The cost 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. In addition, on December 29, 2012, Center for Medicare and Medicaid Services (CMS) lifted the statutory moratorium on designing new long term care hospitals or satellites. For 2014, MedPAC recommends the Long Term Care Hospital standard amount would be reduced by 2%. The TCH’s fiscal year 2014 budget reflects the 2% reduction in reimbursement for Medicare cases. For fiscal year 2014, the TCH expects to continue its volume growth of this very high acuity patient population.

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 provides a cumulative operating and capital budget that contains service demand forecasts, required full-time equivalent (FTE) personnel, and non-labor expenses.
BUDGET AND OPERATING ASSUMPTIONS

Market conditions: For fiscal year 2014, discharges are budgeted to grow in excess of 25% from fiscal year 2013 projected levels. The growth will be facilitated by increased registered nurses and hospitalist recruitment and additional referrals from outside facilities. The following table includes historical and projected patient volumes:

<table>
<thead>
<tr>
<th></th>
<th>Actual FY 2012</th>
<th>Projected FY 2013</th>
<th>Budget FY 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>211</td>
<td>300</td>
<td>398</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>28</td>
<td>28</td>
<td>28</td>
</tr>
<tr>
<td>Patient Days</td>
<td>5,821</td>
<td>8,400</td>
<td>11,144</td>
</tr>
</tbody>
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Revenues: The TCH’s fiscal year 2014 budgeted payor mix reflects an increase in Medicaid and Medicaid Health Maintenance Organization cases from prior years. One of the TCH’s greatest challenges is the unwillingness of government payors to increase payments commensurate with the increases in medical delivery costs. Growth in revenues will result from the impact of increasing volume and negotiated contracts with rate increases.

Rate changes: The TCH Medicare base rate for fiscal year 2014 is $38,346 per case. With a Medicare case mix index (CMI) of 1.28, this will result in a total Medicare reimbursement rate of $48,100 per case (including the 2% anticipated reduction).

Expenses: Expenses from operations are projected to increase by 15% from the fiscal year 2013 projections. This increase is attributed to an increase in volume, hospitalist’s salaries and expenses, and staff salaries.

Staffing: The TCH’s paid FTEs are planned at 136, an increase of 12 FTEs from current fiscal year projection of 124 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 School of Medicine faculty on documentation of clinical care and its coding.
- The continuation of the collaborative effort between the TCH and the School of Medicine faculty on supply cost.
- 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 effort to enhance care delivery and integrate information technology services through the Electronic Medical Record project.

The major risk factors that may 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.
- The continuing impact of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.
- Increases in the cost of medical equipment and pharmaceutical goods that exceed the budget assumptions.

A summary of TCH projected financial operating results is provided as follows:
(Millions) Projected FY13 Budget FY14
Total Operating Revenue $18.0 $21.1
Operating Expense 16.8 19.8
Operating Income 1.2 1.3
Total Margin 6.70% 6.25%

**Capital Plan:** Funds available to meet capital requirements are derived from operating cash flows, funded depreciation reserves, philanthropy, and interest income. The TCH faces many challenges regarding capital funding as continued pressures on the operating margin affect cash flow, while demand for capital will increase significantly due to the need to expand. Subject to funds availability, the TCH management recommends $600,000 be authorized for capital requirements.

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

**APPROVAL OF THE 2013-2014 OPERATING AND CAPITAL BUDGETS FOR THE UNIVERSITY OF VIRGINIA TRANSITIONAL CARE HOSPITAL**

RESOLVED, the 2013-2014 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 Executive Vice President and Chief Operating Officer, and the Medical Center Operating Board.
UNIVERSITY OF VIRGINIA
BOARD OF VISITORS AGENDA ITEM SUMMARY

BOARD MEETING:   May 20, 2013

COMMITTEE:       Medical Center Operating Board

AGENDA ITEM:     II.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 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 of recent events that
do not require formal action.
UNIVERSITY OF VIRGINIA
BOARD OF VISITORS AGENDA ITEM SUMMARY

BOARD MEETING: May 20, 2013

COMMITTEE: Medical Center Operating Board

AGENDA ITEM: II.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 Transitional Care Hospital (TCH) ended the period of July 1, 2012 through February 28, 2013 with a net operating income figure of $474,353, compared to the budgeted operating income figure of $485,180. The variance of $10,827 is directly related to volume. The TCH projected an average daily census of 28 versus an actual average daily census of 26 for the first eight months of fiscal year 2013. The operating margin for the TCH was 4.1% as of February 28, 2013.

During this same period, inpatient discharges were 193 compared to the budget of 232. Average length of stay was 27.1 days, which is less than the budget of 29.0. The all payor Case Mix Index (CMI) of 1.27 was higher than the budgeted CMI of 1.25. The difference is attributable to 35% of cases being a vent wean DRG, which carries a CMI weight of 1.95. As of October 1, 2012, CMS reduced the CMI for the vent weaning DRG to 1.95 from 2.02.
The TCH has experienced an increase in complex wound care cases. Year to date through February 28, 2013, the TCH reported that 27% of its cases were wound care related. This is a 6% increase over the prior quarter. These cases are care-intensive and require additional resources.

Total FTEs were 113, below the budget of 122 FTEs. The TCH continues to report no contract labor.

For the period from July 1, 2012 through February 28, 2013, the TCH received 594 referrals which resulted in 204 admissions. One hundred and fifty-two of those admissions (74%) were from the Medical Center. The 152 Medical Center admissions represent 4,125 patient days or approximately 17 Medical Center beds per day which would not have been available to the Medical Center without the TCH. In addition, the 4,125 patient days reduced the Medical Center’s average length of stay by 0.17 days.

**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.

**Clinical Operations**

Clinical services at the TCH are provided by physicians, registered nurses, registered respiratory therapists, wound care nurse practitioner, 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, multidisciplinary rounding provides an opportunity to communicate a plan and recent changes in patient status.

During the third quarter of this fiscal year, the TCH implemented a lightweight voice-activated device which allows individuals or groups to communicate with each other using a wireless network. The badge works anywhere that is covered by the network. The badge weighs about two ounces, is 4.2 inches
long by 1.4 inch wide, and is worn around the neck with a lanyard, clipped to a jacket lapel, or in a shirt pocket. The badges are voice activated and recognize speech patterns. This communication system also easily adapts to accented speech patterns.

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. For the third quarter of fiscal year 2013, 451 vent days were recorded. Twenty-five patients were admitted for vent weaning, although two of those patients changed their status to palliative care and ventilator support was suspended. Sixteen patients were successfully weaned, resulting in a wean rate of 69.6%, exceeding the 60.1% national benchmark. The respiratory department is continuing its work to develop an instrument which can be used to train tracheostomy patients and their caregivers.

Wound Management

The wound management program successfully recruited a Wound, Ostomy & Continence Advanced Practice Nurse during the first quarter of fiscal year 2013 and added Dr. David Drake as the Medical Director in the second quarter. These roles provide the TCH the opportunity to continue to increase the patient population we serve by expanding the scope and complexity of wounds for which we provide care. Additionally, both roles are responsible for further leading our efforts towards Joint Commission certification in Wound Care Management.

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 TCH has merged 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 patient admission through discharge.

Clinical Liaison

The referral base continues to broaden significantly. Patient referrals for fiscal year 2013 are on pace to increase by 50% compared to fiscal year 2012. Areas of focus for present and future business development include expanding beyond the current markets identified previously. The TCH continues to strengthen internal system referrals via a dedicated liaison as well as ongoing collaboration and communication with the Medical Center Care Management team. This will facilitate and improve safe and appropriate patient flow within the Health System.

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. The goal is 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 March 31, 2013, the average Medicare length of stay was 26.32 days, and the overall length of stay for all payors was 26.55 days. The reported average length of stay is below the budgeted figure of 29.0 days, a direct result of discharge planning which is initiated prior to admission, ongoing coordination of care throughout the patient’s stay, and effective communication with our community partners.

Human Resources

As of March 31, 2013, the TCH reported 113 FTEs with no contracted Registered Nurses or Respiratory Therapists.

Recruitment and Retention

For the period from January 1, 2013 through March 31, 2013, the TCH successfully recruited seven permanent staff: three Registered Nurses, one Pharmacy Supervisor, one Physical Therapist, and two Patient Care Assistants.

During the above period, TCH participated in various employee engagement activities including hosting a quarterly
Town Hall Meeting, holding monthly Employee Engagement Committee meetings, honoring staff accomplishments, recognizing STAR employees (Employee of the Month), participating in Hoos Well events, establishing an Outtakes focus group, and celebrating holidays with patients and visitors.

In the first quarter of this fiscal year, the TCH implemented a focused professional development education program based on input from employees. This program, titled “Top 5,” was implemented to encourage employees to contribute to a quarterly selection of five educational offerings, thereby providing the opportunity to learn about topics and practices which are pertinent to their daily activities. The program continued into the 3rd quarter with five new topics offered including Code 12, Emergency Situations, Enteral Feedings, Challenging Situations, and End of Life Care.

Quality and Performance Improvement

The TCH Quality Improvement Plan Dashboard is utilized to track approved metrics for improvement. We established internal targets for many of our metrics based on historical data. We expected external benchmarks to be established and published in January 2013, but these targets have not yet been released. We are meeting and exceeding 12 of our 16 metrics year-to-date for fiscal year 2013. Plans are being developed to improve performance in the areas where we have not met our targets.

Patient Satisfaction

We continue to provide our patients with the Press Ganey Patient Satisfaction Survey prior to their discharge. While our response rate is still lower than our target, it has increased from the previous year. Additionally, we mailed approximately 50 surveys to the patients who took a survey home with them rather than complete it prior to discharge in case the survey was lost once they left the TCH. Our scores indicate that we are exceeding expectations in three of our five targeted areas and falling just short of our targets in the other two areas.

External Benchmarking

The TCH has submitted data through December 31, 2012 to meet The Joint Commission ORYX Non-Core Measures requirements. Effective January 1, 2013, The Joint Commission will temporarily suspend the requirement for LTACHs to submit data for ORYX Non-Core Measures in deference to the new CMS Quality Reporting
Program. This temporary suspension will allow time for The Joint Commission and CMS to come to agreement on metrics and definitions for Quality Reporting for LTACHs. However, the TCH will continue to utilize the same process and vendor and submit data quarterly in order to obtain external quality benchmarks within the LTACH industry.

The TCH has completed the required data abstraction, data entry and data submission for the first quarter of the new CMS LTACH Quality Reporting Program. Maintaining compliance will be important to avoid the 2% reduction in Medicare reimbursement for failure to comply. Thus far it appears that all of the records we have submitted have been accepted, but this is a new and complex program and there may be adjustments, refinements, or other changes in the future.

Accreditation

As a Joint Commission accredited facility, the TCH continues to focus on maintaining its status through "constant-readiness" educational sessions and regular hospital environment of care rounds. We are currently four months into the 18-month window for an unannounced Joint Commission Survey.

Regulatory

The TCH continues to monitor the impact of the implementation of the 25% rule. In Government Fiscal Year 2005, CMS issued a rule allowing Long Term Care Hospitals (LTCHs) to admit no more than 25% of their patients from any single referring hospital. UVA is allowed 50% due to its market dominance, but the rule may impact the TCH as our volumes grow. Originally, the rule was intended to prevent inappropriate admissions, but the 25% limit was arbitrarily imposed without distinguishing between patients who need the type of care that LTCHs provide and those who do not. Congress suspended the final phase-in of the 25% rule in 2007. In 2010, the 25% rule was again suspended through July 1, 2012.

As part of the fiscal year 2013 Medicare inpatient payment update rule, CMS could have started enforcing the 25% rule. Instead, CMS continued the stay of full implementation through fiscal year 2013. CMS is in the process of revising LTCH payment policies, which they believe will make full implementation of the 25% rule unnecessary. The TCH continues to monitor the status of this rule.
Community Outreach

The TCH is committed to the donation of time and resources to benefit the communities of which we serve.

We continue to work very closely with the Health System Volunteer Program. The TCH program now consists of two trained volunteers and 20 Madison House volunteers. We joined the health system in celebrating our Auxiliary volunteers on February 13 and hosted an on-site celebration for all of our volunteers during the week of April 26. While our current Madison House Volunteers will be taking the summer off, we will have 10 additional volunteers to work with us during the summer months.

Five members of the TCH (including two physician partners) were privileged to present one of our case studies at the Schwartz Rounds in January 2013. This was a well-attended event and the presentation appeared to be well-received.

Selected members of our staff have also had the honor of participating in several Chamber of Commerce events this quarter.

Awards & Recognition

National Association of Long Term Hospitals (NALTH)

The TCH received the National Association of Long Term Hospital’s (NALTH) 2013 Goldberg Award. The Goldberg award originated in 2006 and is named after a founding member of the NALTH organization. It is awarded to one hospital every year in recognition of an innovative process or technology that supports LTCHs. The overarching principle is innovation, and the TCH was awarded for its submission of "Weighing the Significance of Urinary Catheter Reduction". This submission focused on accurately obtaining intake and output measurements in the acutely ill patient via the adoption of a practice used in neonatal intensive care units. This innovative adaptation of practice resulted in a reduction in urinary catheter usage and a reduction in the overall Catheter Associated Urinary Tract Infections (CAUTI) rate while also improving the accuracy of urinary output data to facilitate medical decision-making in our acutely ill population.

The award was presented at NALTH’s 24th Annual Meeting in Washington, DC on April 25.
American Association for Respiratory Care (AARC)

The TCH earned Quality Respiratory Care Recognition (QRCR) under a national program aimed at helping patient and families make informed decisions about the quality of the respiratory care services available in hospitals. The QRCR program was started by the American Association for Respiratory Care (AARC) in 2003 to help consumers identify those facilities using qualified respiratory therapists to provide respiratory care. Hospitals earning the QRCR designation ensure patient safety by agreeing to adhere to a strict set of criteria governing their respiratory care services. Approximately 700 hospitals, or 15% of hospitals in the United States, have applied for and received this award.