Transitional Care Unit

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Summary Presentation to County Commissioners
July 2, 2019

Situation

- Transition Care Units (TCUs) are a post-acute care setting that were designed for patients who may not have been ready to transition from a hospital acute-care stay directly to home.
  - In today's health care environment, Home Health Care is frequently the preferred method to transition patients from a hospital stay back to living at home.

- Over the years, our TCU has delivered high quality care with a passionate and exceptional staff.
  - Our Home Health Care is also delivering high quality care with exceptional staff right in the homes of our patients and is capable of meeting the increased demand for its services.

- Reimbursement no longer favors TCU utilization resulting in our TCU losing approximately $1.5M year.
  - Payers, including Medicare, are not reimbursing hospitals at a rate that allows the service to recoup its costs.
  - Payers are moving toward having patients return home for recovery and rehabilitation when there is a viable home care option.
  - TCUs are closing in regional hospitals all across the country due to these trends.

Background

- TCU is located on the fourth floor of our West campus and licensed for 16 beds. Our average daily census is 11.3 patients.
  - As the appropriateness of Home Health Care has increased, our TCU admissions have declined 9% this year and 29% just last month compared to June prior year.
  - For the most recent two calendar years at Cheyenne Regional, 37.1% of TCU admissions were due to simple pneumonia, sepsis, renal failure and pulmonary issues, and 24.5% were for major joint replacements: all Home Health Care eligible services.
  - TCU has 30 FTEs (i.e. RNs, CNAs and therapists) which are high-demand positions throughout CRMC.

- Financial trends for his unit have not turned around since 2015.
  - Projected FY 19 loss is $1.5 million
  - This is not predicted to change in the foreseeable future

Analysis

- Cheyenne Regional's healthcare redesign objective is to help patients meet their desire and their goals to heal in their homes.
  - Requires a strategic approach with an effective continuum of care, and transitions across the community, which has been a focus of our population health work.

- Best stewardship of hospital resources:
  - We are competing with qualified local providers with the same service as TCU, duplicating resources rather than collaborating.
  - Freeing up resources consumed by TCU will allow us the ability to grow and expand and improve services that Cheyenne Regional uniquely provides in our community, e.g. Intensive Care Unit services and the Mother Baby Unit.
  - Master facility plan: Space occupied by TCU is needed for other services; Keeping TCU will increase in construction costs by $4.8 million.

Request

- Closing TCU is in the overall best interest of the health system's resource stewardship.
  - Allows us to focus on services only we provide in our community.

- We are committed to supporting our patients in their transition from the hospital setting, through our home health service and through comparable skilled nursing facilities operating in our community.
  - Follow-up provided by RNs through out Transitions Across the Community Teams (TACT).
  - Cheyenne Regional Home Health offers skilled nursing, physical therapy, occupational therapy, speech therapy, social work and home health aide services.
  - Currently has the needed capacity to care for patients that required therapy or skill nursing whether they are transitioning to Laramie, Goshen or Platte counties.
  - e.g. Life Care is a Five Star facility with capacity in their 75 post-acute beds

- We are committed to our workforce and their transition to other departments within our hospital system that need their exceptional skills.

Frequently Asked Questions

- Why can skilled nursing facilities (SNFs) afford to provide this type care and Cheyenne Regional cannot?
  - They have other revenue sources and can spread costs for this population on a larger scale.

- What about patients that may need financial assistance for post-acute care?
  - Cheyenne Regional Home Health may be utilized, or we'll keep them longer in the hospital setting.

- Transitions from TCU to Comea?
  - Patients with a history of substance abuse that need antibiotic therapy can be admitted to TCU. It's very rare.
  - Options for these patients: home care, or if no payer source, patients will stay on the unit longer.
  - They are discharged back to Comea only with the shelter's approval.

  NOTE: How to transition homeless patients from BHS has been a community problem; stakeholder dialogue is needed regarding this population.

- If approved, when would the TCU close?
  - 2-3 months to ensure that CMS is notified, current patients complete their treatment, and staff are reassigned.

- Is this driven by our MSA with UCHealth?
  - No. This recommendation is the by-product of annual strategic planning and finance review.