

# AGENDA

## BOARD OF REGENTS, STATE OF IOWA UIHC COMMITTEE MEETING

September 6, 2006  
8:30-11:30 a.m.  
Nursing Clinical Education Center  
W421 GH  
Iowa City, Iowa

- |   |   |
|---|---|
| I. Introductory Comments                  | Regent Robert N. Downer, Chair<br>Donna Katen-Bahensky, Director and Chief Executive Officer                              |
| II. Old Business                          | Donna Katen-Bahensky  |
| a. UIHC Business Plan Template            | Anthony DeFurio, Chief Financial Officer  |
| b. IowaCare Update                        | Stacey Cyphert; Special Advisor to the President, Special Advisor to the Dean of CCOM, Senior Assistant Hospital Director |
| c. Department of Corrections Update       |   |
| III. New Business                         | Donna Katen-Bahensky  |
| a. 5-Year Capital Plan                    | John H. Staley, Senior Associate Director   |
| b. Operations and Finance Report          | Anthony DeFurio, Chief Financial Officer  |
| c. Strategic Plan Discussion              |   |
| IV. Director's Remarks                    | Donna Katen-Bahensky  |
| V. Nursing Clinical Education Center Tour |   |

**UIHC COMMITTEE**  
**BOARD OF REGENTS, STATE OF IOWA**  
**MINUTES**  
**JULY 19, 2006**  
**IOWA CITY**

Members: Robert Downer, Chair  
 Amir Arbisser  
 Tom Bedell - absent  
 Rose Vasquez

Regent Downer called the meeting to order at 8:30a.m.	
<b>UIHC 1.</b>	<b>Introductory Comments, Committee Structure, Future Agendas</b>
<u>Discussion:</u>	Regent Downer gave opening comments and provided a general overview and direction for the committee. The committee discussed the responsibilities and various relationships the committee hopes to achieve.
<u>Action:</u>	The committee unanimously approved the minutes from the May committee meeting.
<b>UIHC 2.</b>	<b>Governance Structure Discussion</b>
<u>Discussion:</u>	Donna Katen-Bahensky discussed the issue of how quality fits into the Board of Regents Agenda.
<u>Action:</u>	Regent Downer would like this discussion to be on the agenda for a future committee meeting.
<b>UIHC 3.</b>	<b>Information Technology Update</b>
<u>Discussion:</u>	Lee Carmen provided an overview of the current review and process for replacement of the UIHC IT system.
<b>UIHC 4.</b>	<b>Strategic Planning Discussion</b>
<u>Discussion:</u>	Donna Katen-Bahensky reviewed the process the UIHC utilized in reviewing its strategic plan.
<b>UIHC 5.</b>	<b>Operating and Financial Performance Report</b>
<u>Discussion:</u>	Anthony DeFurio provided a review of the volume indicators, accounts receivable, case mix index, and the comparative financial results.
<b>UIHC 6.</b>	<b>IowaCare Update</b>
<u>Discussion:</u>	Stacey Cyphert provided an update on the IowaCare program. The committee also discussed UIHC's plan to provide limited pharmaceuticals and durable medical equipment to the IowaCare population on a trial basis during FY 2007.
<u>Follow-up:</u>	Regent Downer requested IowaCare improvements be part of the legislative agenda.
<b>UIHC 7.</b>	<b>Director's Report</b>
<u>Discussion:</u>	Donna Katen-Bahensky discussed awards and recognition, recruitments, market share, the smoke free campus, disaster preparedness, facility access, and the task force on physician workforce.
Regent Downer adjourned the meeting at 11:28 a.m.	

**UIHC COMMITTEE**  
**BOARD OF REGENTS, STATE OF IOWA**  
**MINUTES**  
**AUGUST 2, 2006**  
**IOWA CITY**

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Members: Robert Downer, Chair  
Amir Arbisser  
Tom Bedell - absent  
Rose Vasquez

Regent Downer called the meeting to order at 8:38a.m.

**UIHC 1.**

**Introductory Comments**

Discussion:

Regent Downer gave opening comments. Regent Wahlert joined the meeting by phone.

**UIHC 2.**

**Governance Structure Discussion**

Discussion:

Regent Downer discussed a proposed governing board he had provided to other members of the committee.

Action:

Regents Vasquez and Wahlert requested the memo be provided to all Regents.

**UIHC 3.**

**Strategic Planning Discussion**

Discussion:

Donna Katen-Bahensky and Alan Zuckerman reviewed the process the UIHC utilized in revamping its strategic plan.

**UIHC 4.**

**FY 2006 Volume Review**

Discussion:

Anthony DeFurio provided a review of the FY 2006 volume indicators.

**UIHC 5.**

**Director's Report**

Discussion:

Donna Katen-Bahensky discussed awards and recognition, recruitments, market share, the smoke free campus, disaster preparedness, facility access, and the task force on physician workforce.

Regent Downer adjourned the meeting at 11:08 a.m.

# UIHC Business Plan Template

**Anthony DeFurio**

Chief Financial Officer

# Business Plan Components

## 1. EXECUTIVE SUMMARY

- General Description and Overview
- Stakeholders
- Scope of Services
- Implementation Management Team
- Implementation Timeframe
- Keys to Success

## 2. SERVICE LINE OVERVIEW

- Service Line Definition
- Profitability and Collections
- Payor Mix
- Charges by Payor
- Historical Information (Previous 2 Years)

## 3. MARKET ASSESSMENT

- Narrative Service Definition
- Scope of Services
- Target Populations
- Key Relationships
  - Patient Profile
  - Referral Profile
- Market Profile
- Environmental Assessment
- Competitor Assessment
- Marketing SWOT
- Marketing Recommendations

## Business Plan Components (cont'd)

### 4. QUALITY ASSESSMENT

- Quality Measure Scorecard
- JCAHO/CMS Core Measures Scorecard (if applicable)
- Quality SWOT
- Priority Recommendations

### 5. OPPORTUNITIES

- Overall SWOT
- Competitor Pricing
- Access and Service
- Outreach
- Public Health Initiatives
- Community Partnership

### 6. FEASIBILITY AND OPERATIONAL ANALYSIS

- Physician Profile
- Human Resources
  - Non-physician Staffing
  - Nursing
  - Physician Extenders
- Research
- Space, Equipment, and Capital
- Facility Requirements
- Capacity Requirements
- Technology Requirements
- Philanthropy
- Legal and Regulatory Requirements
- Overall SWOT

## Business Plan Components (cont'd)

### 7. FINANCIAL PLANNING

- Revenue Forecast

### 8. IMPLEMENTATION PLAN

- Leadership and Staff
  - Hierarchy of Reporting – Org Chart
  - Management Reporting Procedures
- Communication Plan
- Timeline and Project Schedule

# IowaCare Update

## Stacey Cyphert

Special Advisor to the President,  
Special Advisor to the Dean of CCOM,  
Senior Assistant Hospital Director

## Legislators Praise UIHC for IowaCare

On behalf of the Iowa House of Representatives, we want to thank you for your efforts during the past year for the IowaCare program.

Many states spend years working to revise or develop new health care programs. Iowa was able to create and implement IowaCare in less than 4 months. While many people can rightfully claim a share of the credit, this change would never have occurred without the commitment and effort of the physicians and staff of the University of Iowa Hospitals and Clinics.

Thanks to your willingness to adapt, our state has been able to provide healthcare services to more Iowans. We also have been able to preserve critical federal matching funds for the Iowa's Medicaid program.

After one year of the program, IowaCare has experienced its ups and downs. As policy-makers, we are always looking for ways to improve this vital program. We have worked with administration and the department to respond to physician concerns surrounding medications and DME. As the people most connected to IowaCare, we would certainly like to continue to hear your thoughts on this program and what the state can do to implement positive change. Please feel free to contact us:

[Danny.Carroll@legis.state.ia.us](mailto:Danny.Carroll@legis.state.ia.us)

[Dave.Heaton@legis.state.ia.us](mailto:Dave.Heaton@legis.state.ia.us)

[Linda.Upmeyer@legis.state.ia.us](mailto:Linda.Upmeyer@legis.state.ia.us)

Thank you again for all you do for the citizens of Iowa. We, as a state, are very appreciative of the physicians and staff of the University of Iowa Hospitals and Clinics and your dedication to improving the lives of all Iowans!

Source: August 18, 2006 e-mail message to Stacey Cyphert from Representative Linda Upmeyer.

## Legislators Praise UIHC for IowaCare (cont'd)

Donna and Stacey,

I want to thank the staff at the University of Iowa Hospitals and Clinics for your commitment and service to the citizens of Iowa. Your investment in our health care is exemplary, and I realize the funding falls short of the level of service you provide. I am proud to call the Hospital and Clinic professionals my friends and neighbors, and I will continue to work to bring the funding levels up to the award winning level of service you provide.

Not a week goes by without someone in Iowa relating their story about their care at our hospital, and their stories always contain two themes: the extremely high level of expertise and the deep caring for the patients you serve.

Thank you again for your service.

Dave Jacoby  
State Representative

## Clinicians Advisory Panel\*

Sec. 19. NEW SECTION. 249J.17 CLINICIANS ADVISORY PANEL CLINICAL MANAGEMENT.

1. Beginning July 1, 2005, the medical director of the Iowa Medicaid enterprise, with the approval of the administrator of the division of medical services of the department, shall assemble and act as chairperson for a clinicians advisory panel to recommend to the department clinically appropriate health care utilization management and coverage decisions for the medical assistance program and the expansion population which are not otherwise addressed by the Iowa medical assistance drug utilization review commission created pursuant to section 249A.24 or the medical assistance pharmaceutical and therapeutics committee established pursuant to section 249A.20A. The meetings shall be conducted in accordance with chapter 21 and shall be open to the public except to the extent necessary to prevent the disclosure of confidential medical information.
2. The medical director of the Iowa Medicaid enterprise shall report on a quarterly basis to the medical assistance projections and assessment council established pursuant to section 249J.19 and the council created pursuant to section 249A.4, subsection 8, any recommendations made by the panel and adopted by rule of the department pursuant to chapter 17A regarding clinically appropriate health care utilization management and coverage under the medical assistance program and the expansion population.
3. The medical director of the Iowa Medicaid enterprise shall prepare an annual report summarizing the recommendations made by the panel and adopted by rule of the department regarding clinically appropriate health care utilization management and coverage under the medical assistance program and the expansion population.

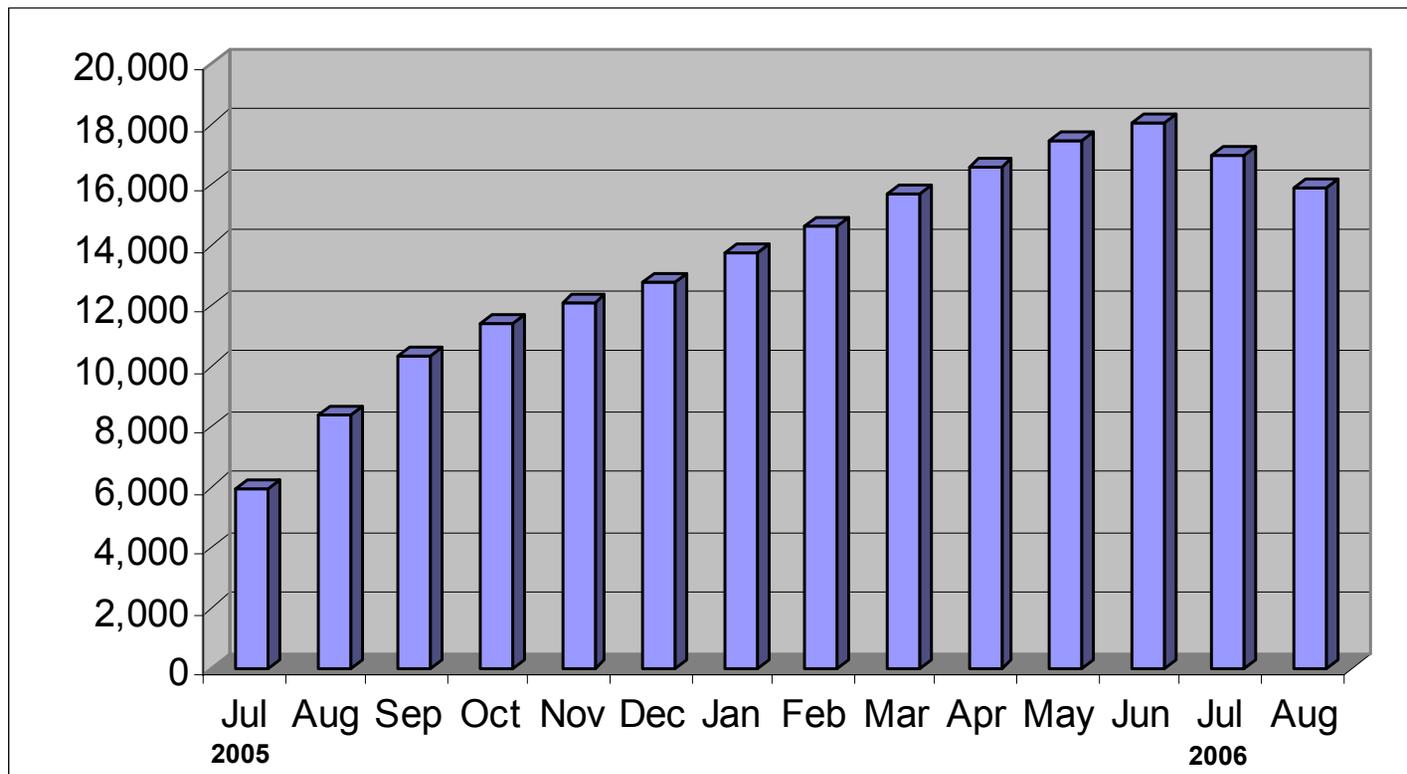
\*Per Laws of the 81<sup>st</sup> Iowa General Assembly, 2005 Session, Ch. 167 (HF 841)

## Clinicians Advisory Panel Membership

- Dr. David Cranston, MD
- Ms. Linda Gehrke, ARNP
- Dr. Kirk Peterson, MD
- Ms. Jean Lunde, PA-C
- **Dr. Janet Schlechte, MD** – Professor, UI Carver College of Medicine
- Dr. Roger Skierka, MD
- Dr. James Whalen, MD

NOTE: First meeting is Friday, September 15, 1:00 p.m. – 4:00 p.m., at IME Headquarters in Des Moines.

## IowaCare & Chronic Care Enrollment Net of Disenrollments



\*Data shown for August 2006 only goes through August 28 and does not yet reflect any disenrollments that may occur for failure to pay premiums.

## IowaCare Update

- As of August 28, 2006, net enrollment in IowaCare and Chronic Care has declined by 2,196 from a peak of 18,075 at the end of June 2006.
- Nearly half of the enrollment decline (1,047 people or 47.7%) has occurred in Polk County.
- The decline may be due in part to beneficiary documentation requirements associated with the Deficit Reduction Act of 2005 (P.L. 109-171).
- It is unknown at this time the extent to which this decline will continue or the extent to which it will impact on patient care volume at the UIHC
  - Not everyone who enrolls in IowaCare utilizes services at the UIHC.
  - Of the 27,377 people enrolled in IowaCare or Chronic Care at some point in FY 06, only 7,875 unique patients (28.8%) were treated at the UIHC.

## IowaCare Update (cont'd)

- The UIHC continues to provide transportation in excess of 150 roundtrips per month for IowaCare patients, with each trip averaging approximately four people.
- FY 07 data through August 24, 2006 shows the UIHC has seen 2,977 unique IowaCare or Chronic Care patients who have made 6,958 visits.
- August 14, 2006, the UIHC implemented pilot programs to facilitate IowaCare beneficiary access to pharmaceuticals and durable medical equipment.
  - Over 3,300 prescriptions have already been filled at a cost in excess of \$80,000.
  - DME has been provided to approximately a dozen patients at a cost in excess of \$5,000.

## Questions & Answers Regarding the UIHC's Pharmaceutical and Durable Medical Equipment Pilot Programs for IowaCare

### How does the pharmacy pilot program work?

- Beginning August 14, 2006, UI Hospitals and Clinics started providing generic pharmaceuticals on its formulary to IowaCare patients free of charge for use at home. Only prescriptions written by licensed UI Hospitals and Clinics practitioners and filled at UI Hospitals and Clinics pharmacies are covered. Patients receive no more than a 30-day supply of prescription drugs at any one time.

### What isn't covered in the pharmacy pilot program?

- Over-the-counter medications are not provided under the IowaCare pilot pharmaceutical program, except for certain forms of insulin. In general, brand name medications are not included. However, for IowaCare patients not using generic medications, UI Hospitals and Clinics will provide a one-time, 30-day supply of brand-name pharmaceuticals. The IowaCare patients will then be assisted in contacting pharmaceutical assistance programs, as they are now, if desired. Home infusion medications are also not covered under the pilot program, although the UIHC Ambulatory Care Pharmacy will dispense directly to IowaCare patients covered oral or self-injectable medications pursuant to a prescription.

## **Questions & Answers Regarding the UIHC's Pharmaceutical and Durable Medical Equipment Pilot Programs for IowaCare (cont.)**

### **What if a patient needs a prescription refilled?**

- For IowaCare enrollees living outside of Johnson County, prescription refills of 30 days or less may be mailed to the patient. Patients living in Johnson County may pick up refills of 30 days or less by visiting UI Hospitals and Clinics. Prescriptions will generally not be mailed to P.O. boxes. No prescriptions will be mailed to an out-of-state address under any circumstances.

### **Can IowaCare patients use an Emergency Treatment Center visit to get their regular medications?**

- No. Routine medications not directly related to the acute reason for the ETC visit will NOT be prescribed by ETC medical staff. IowaCare or Chronic Care patients will be instructed to contact UI Hospitals and Clinics' IowaCare Assistance Center at (319) 356-1000 to request assistance in receiving their routine medications.

## Questions & Answers Regarding the UIHC's Pharmaceutical and Durable Medical Equipment Pilot Programs for IowaCare (cont.)

### How does the durable medical equipment pilot program work?

- UI Hospitals and Clinics will provide select DME items to IowaCare enrollees free of charge during the pilot period. Common DME items that may be provided under the program include:
  - Orthopedic braces/supports/prosthetics
  - Feeding tubes/pumps
  - IV pumps
  - Oxygen and supplies
  - Ostomy supplies
  - Diabetic supplies (test strips, glucometers, syringes)
  - Dressing supplies
  - Wound evacuators
- Only DME authorized by licensed providers at UI Hospitals and Clinics are included in the pilot, and patients must obtain the equipment directly from the hospital or a provider authorized by UI Hospitals and Clinics. Quantities may be limited on an individual basis. If DME is available through county relief agencies, Department of Human Services offices, and/or local lending programs, it will not be provided at hospital expense.

## Questions & Answers Regarding the UIHC's Pharmaceutical and Durable Medical Equipment Pilot Programs for IowaCare (cont.)

### Who is eligible for the pharmacy and DME pilot programs?

- Patients who are enrolled in IowaCare in each month for which services are desired are generally eligible for the pilot programs. To receive medications and/or DME IowaCare enrollees must have been seen at UI Hospitals and Clinics during a scheduled visit since the inception of IowaCare. Some patients may be required to be seen again before prescriptions will be filled.
- Also eligible are individuals with incomes greater than 200 percent of the federal poverty level who were part of the Chronic Care program in Fiscal Year 2006 and continue to be enrolled. These people will receive only pharmaceuticals or DME free of charge for their authorized chronic condition.

### Are there any exceptions to eligibility?

- IowaCare patients residing in Polk County are not eligible to receive on-going supplies of medications, but may receive a 10-day supply of medications at discharge from UI Hospitals and Clinics. They may be eligible to receive medications and DME through the Community Care program offered by Broadlawns Medical Center.

## **Questions & Answers Regarding the UIHC's Pharmaceutical and Durable Medical Equipment Pilot Programs for IowaCare (cont.)**

### **How are IowaCare patients being notified of the pilot programs?**

- The Department of Human Services sent letters on August 10, 2006 to individuals currently enrolled in IowaCare or Chronic Care. Patients were instructed to contact UI Hospitals and Clinics' IowaCare Assistance Center at (319) 356-1000 to request assistance. The Iowa Department of Human Services may choose to make potential new enrollees aware of these pilot programs. UI Hospitals and Clinics will also inform new IowaCare and Chronic Care patients about these pilot programs as they contact us.
- If an IowaCare patient is eligible for pharmaceutical or DME coverage under Medicare, the Veterans' Administration, or any other third-party payer, he or she will not be eligible to receive benefits under the pilot programs.

### **Can changes be made in the pilot programs?**

- Yes, modifications may be made to the pilot programs by the UI Hospitals and Clinics throughout the year as deemed necessary or appropriate.

## **Questions & Answers Regarding the UIHC's Pharmaceutical and Durable Medical Equipment Pilot Programs for IowaCare (cont.)**

### **How long will the pilot programs last?**

- The pilot programs will operate concurrently with the IowaCare program at the UIHC during FY 07.

### **Then what?**

- UI Hospitals and Clinics will keep the Board of Regents, State of Iowa, and legislative leaders apprised of the utilization and cost of the pilot programs. Discussions will occur regarding the on-going need for these pilot programs and, if so determined, regarding available sources of support.

### **Is there an estimate of how much it will cost UI Hospitals and Clinics to cover the free medications and DME through June 30, 2007?**

- It is impossible to know with certainty what IowaCare enrollment and utilization will be. The current estimate of the cost to UI Hospitals and Clinics in Fiscal Year 2007 for these two pilot programs is in excess of \$6 million. The UIHC receives no federal or state financial support for these pilot programs.

### **How can patients or providers learn more about the pilot programs?**

- Contact UI Hospitals and Clinics IowaCare Assistance Center at (319) 356-1000.

# Department of Corrections Update

## **Stacey Cyphert**

Special Advisor to the President,  
Special Advisor to the Dean of CCOM,  
Senior Assistant Hospital Director

## Preliminary Review of Prison Healthcare Practices in Select States

- Colorado
  - The Department of Corrections hires management companies to contract and perform utilization management service for prisoners. There are agreements in place for the DOC patients that the University of Colorado Hospital sees at a discount from billed charges.
- Idaho
  - State Board of Corrections pays the provider of medical service an amount no greater than the Idaho Medicaid reimbursement rate. For services where a Medicaid reimbursement rate is not applicable, the state pays the usual and customary rates for such services.
- Illinois
  - Northwestern Memorial Hospital, for the most part, bills for and is paid at full charges.
- New Jersey
  - An audit found that one provider had negotiated a per diem rate for inpatient services, while other providers billed the prison based on itemized costs.

## Preliminary Review of Prison Healthcare Practices in Select States (cont'd)

- New York
  - State correctional facilities are entitled to the Medicaid reimbursement rate for inpatient services, but outpatient services are eligible for negotiation and are typically paid at a percent of charge.
- Ohio
  - University Hospitals Health System in Cleveland, has a Department of Corrections contract with one of their smaller community hospitals and are reimbursed at percentage (80-90%) of charge.
- Wisconsin
  - Payment is provided as a percentage of charge, with the exception of transplant, which is reimbursed at the Medicaid rate (50% of charge). Wisconsin previously used a rate per visit on outpatient services and a rate per discharge on inpatient services. Pursuant to 2001, Wisconsin Department of Corrections patients had a co-payment of \$2.50, effective 9/02 the legislative requirement is \$7.50.

## Iowa Department of Corrections Update

- UIHC remains committed to working with Department of Corrections (DOC) officials to ensure that prisoners receive medically necessary and appropriate care in a cost-effective manner.
- UIHC sent DOC a 28E agreement on August 8, 2006 to facilitate a mutually-beneficial resolution to a concern involving care needs of a specific prisoner and is awaiting a response.

# 5-Year Capital Plan

**John H. Staley, Ph.D.**

Senior Associate Director

## **FIVE-YEAR, FY 2008-2012 CAPITAL PLAN**

- Developed in accord with Board Office guidelines applicable to all Universities/Special Schools
- Includes projects estimated to cost \$250,000 or more that UIHC plans to initiate during five-year, FY 2008-2012 period
- Excludes:
  - projects with previously approved budgets for which expenditures will be made during the FY 2008-2012 period
  - projects included in the UIHC's FY 2007 Capital Plan
  - projected equipment expenditures during the FY 2008-2012 period

- Initiation of each project is contingent on:
  - availability of self-generated UIHC funding and/or UIHC Bond Revenue
  - approval through UIHC's annual capital budget process
  - conclusions/recommendations adopted in finalizing UIHC's Strategic Facilities Master Plan for FY 2006-2035
  - approval by Board of Regents, State of Iowa
- Projects are prioritized as:
  - **Priority 1** – Projects needed to comply with Life-Safety, Building Codes or Regulatory Standards and/or develop patient care and support facilities to meet new patient needs or anticipated growth in patient volume while enhancing revenues/decreasing expenses
  - **Priority 2** – Projects essential to meeting commitments related to UIHC's mission or specific Strategic Plan strategies, but, not expected to yield significant revenue or cost reductions
- Total anticipated expenditures for Capital Plan projects - \$88 million

**Five-Year, FY 2008-2012 Capital Plan**  
**Summary of Estimated Project Costs by Project Category \***  
(\$ in Thousands)

<b>Project Category</b>	<b>FY 2008</b>	<b>FY 2009</b>	<b>FY 2010</b>	<b>FY 2011</b>	<b>FY 2012</b>	<b>Five-Year Total</b>
Fire & Environmental Safety Resolution	\$ 670	\$ 670	\$ 670	\$ 550	\$ 550	\$ 3,110
New Construction	---**	---**	---**	---**	---**	---**
Remodeling/Renovation/ Rehabilitation	\$ 10,369	\$ 13,649	\$ 19,354	\$ 20,113	\$ 21,464	\$ 84,949
Grand Total	\$ 11,039	\$ 14,319	\$ 20,024	\$ 20,663	\$ 22,014	\$ 88,059

\* Expenditures on projects included in the FY 2008-2012 Capital Plan that are ultimately approved will be incurred over several years. The annual estimated project costs are not projections of total capital expenditures for the respective years.

\* \* It is anticipated that conclusions and recommendations of the UIHC's Strategic Facilities Master Plan for FY 2006-2035 will identify new construction needs for the FY 2008-2012 period. These will be fully documented for consideration and approval by the Board of Regents, State of Iowa

# Operating and Financial Performance

**Anthony DeFurio**

Chief Financial Officer

# Volume Indicators

## July 2006 through July 2006

	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
<b>Operating Review (YTD)</b>							
Admissions	2,203	2,149	2,102	54	2.5% ●	101	4.8% ●
Patient Days	15,115	14,183	14,983	932	6.6% ●	132	0.9% ○
Length of Stay	6.86	6.60	7.13	.26	4.0% ●	(0.27)	-3.7% ●
Average Daily Census	487.58	457.52	483.32	30.06	6.6% ●	4.26	0.9% ○
Surgeries - Inpatient	845	836	820	9	1.0% ○	25	3.0% ●
Surgeries - Outpatient	893	861	844	32	3.7% ●	49	5.8% ●
Emergency Treatment Center Visits	3,244	2,908	2,831	336	11.5% ●	413	14.6% ●
Outpatient Clinic Visits	51,769	50,573	50,759	1,196	2.4% ○	1,010	2.0% ○

●	○	●
Greater than 2.5% Favorable	Neutral	Greater than 2.5% Unfavorable

# Comparative Financial Results

## July 2006 through July 2006



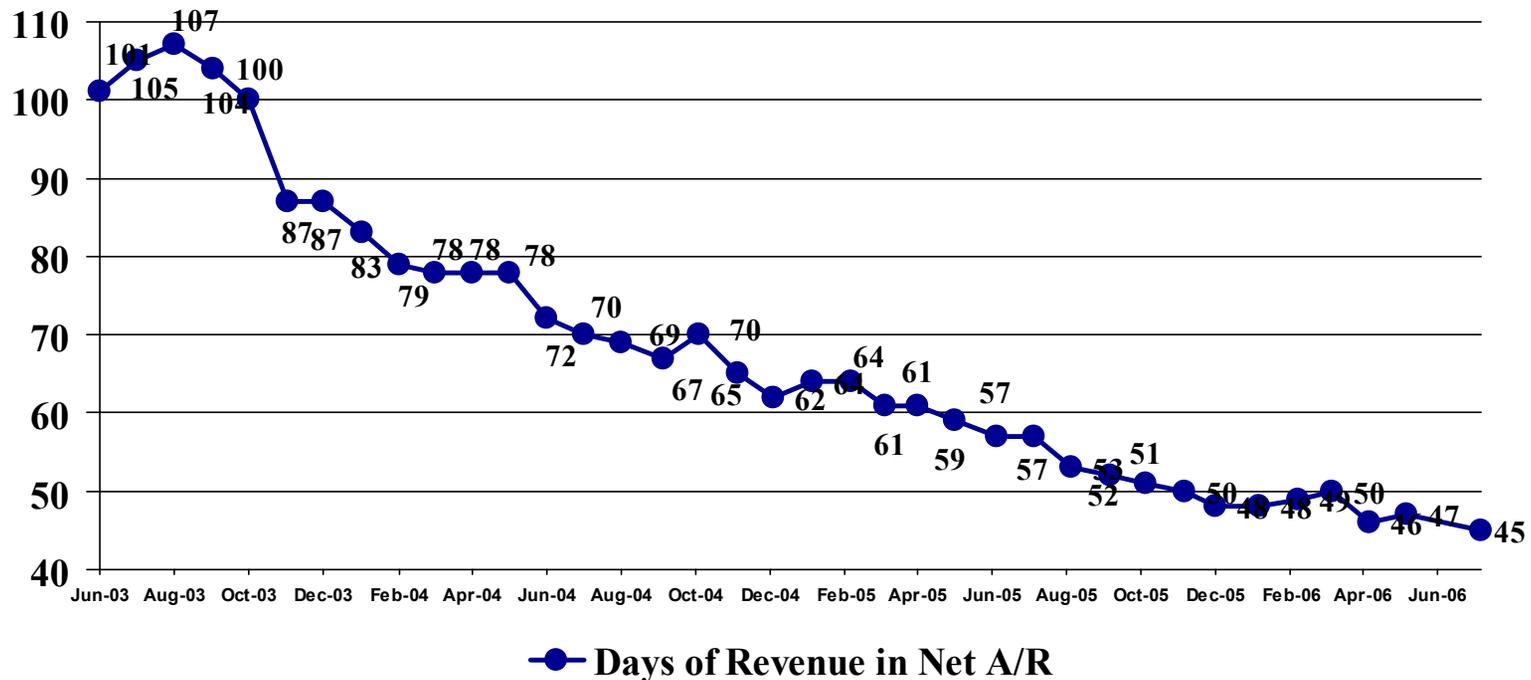
	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
<b>NET REVENUES:</b>							
Patient Revenue.	\$58,926	\$58,657	\$52,143	\$269	0.5%	\$6,783	13.0%
Appropriations	1,117	1,117	1,117	0	0.0%	0	0.0%
Other Operating Revenue	3,261	3,283	3,566	(22)	-0.7%	(305)	-8.6%
<b>Total Revenue</b>	<b>\$63,304</b>	<b>\$63,057</b>	<b>\$56,826</b>	<b>\$247</b>	<b>0.4%</b>	<b>\$6,478</b>	<b>11.4%</b>
<b>EXPENSES:</b>							
Salaries and Wages	\$32,865	\$32,504	\$29,647	\$361	1.1%	\$3,218	10.9%
General Expenses	22,882	24,134	20,997	(1,252)	-5.2%	1,885	9.0%
Operating Expense before Capital	55,747	56,638	50,644	(891)	-1.6%	5,103	10.1%
Earnings Before Depreciation, Interest, and Amortization (EBDITA)	7,557	6,419	6,182	1,138	17.7%	1,375	22.2%
Capital- Depreciation and Amortization	4,446	4,522	4,381	(76)	-1.7%	65	1.5%
<b>Total Operating Expense</b>	<b>\$60,193</b>	<b>\$61,160</b>	<b>\$55,025</b>	<b>(\$967)</b>	<b>-1.6%</b>	<b>\$5,168</b>	<b>9.4%</b>
<b>Operating Income</b>	<b>\$3,111</b>	<b>\$1,897</b>	<b>\$1,801</b>	<b>\$1,214</b>	<b>64.0%</b>	<b>\$1,310</b>	<b>72.7%</b>
<b>Operating Margin %</b>	<b>4.9%</b>	<b>3.0%</b>	<b>3.2%</b>	<b>1.9%</b>	<b>63.3%</b>	<b>1.7%</b>	<b>53.1%</b>
Gain (Loss) on Investments	293	817	731	(524)	-64.1%	(438)	-59.9%
Non-Recurring Items	0	0	0	0	0.0%	0	0.0%
<b>Net Income</b>	<b>3,404</b>	<b>2,714</b>	<b>2,532</b>	<b>690</b>	<b>25.4%</b>	<b>872</b>	<b>34.4%</b>
<b>Net Margin %</b>	<b>5.4%</b>	<b>4.2%</b>	<b>4.4%</b>	<b>1.2%</b>	<b>28.6%</b>	<b>1.0%</b>	<b>22.7%</b>

**NOTE:** all dollar amounts are in thousands

## University of Iowa Hospitals and Clinics

# Comparative Accounts Receivable as of July 31, 2006

	June 30, 2004	June 30, 2005	July 31, 2006	Median Moody's Aa Rating
<b>Net Accounts Receivable</b>	<b>\$110,344,338</b>	<b>\$93,964,049</b>	<b>\$85,459,490</b>	<b>na</b>
<b>Net Days in AR</b>	<b>72</b>	<b>57</b>	<b>45</b>	<b>54</b>



# Strategic Plan Discussion

**Donna Katen-Bahensky**

Director and Chief Executive Officer

## UIHC Strategic Plan

- **Innovative Care**
  - Care Delivery
  - Clinical Programs
- **Excellent Service**
  - Patient Satisfaction
  - Referring Physician Satisfaction
  - Staff, Faculty, and Volunteer Engagement
- **Exceptional Outcomes**
  - Safety
  - Clinical Outcomes

## Innovative Care

- **Care Delivery**

- UI Hospitals and Clinics will be recognized as a state and national leader in developing and implementing new and more efficient health care delivery models that emphasize a quality-driven patient experience.

- **Clinical Programs**

- Select UI Hospitals and Clinics clinical services will be leaders in the state and national market by offering cutting edge clinical services, robust clinical research, and strong training opportunities.

## Excellent Service

- **Patient Satisfaction**
  - Patients and families will be highly satisfied with their entire UI Hospitals and Clinics experience in all settings.
- **Referring Physician Satisfaction**
  - UI Hospitals and Clinics will be recognized by referring physicians for its efficient and effective support of their patients.
- **Staff, Faculty, and Volunteer Engagement**
  - Staff, faculty, and volunteers are valued and engaged in the pursuit of UI Hospitals and Clinics' vision.

## Exceptional Outcomes

- **Safety**
  - UI Hospitals and Clinics will provide a continuously improving, safe environment for all patients and staff at all times.
- **Clinical Outcomes**
  - UI Hospitals and Clinics will use a continuous improvement process to achieve exceptional clinical outcomes.

## Discussion Questions

- Has anything in the external/internal environment changed that might support revisiting our current goals or tactics?
- As a Board, are there additional strategies, goals, or tactics that you would like to see included?

## **Director's Remarks**

**Donna Katen-Bahensky**

Director and Chief Executive Officer

## Director's Remarks

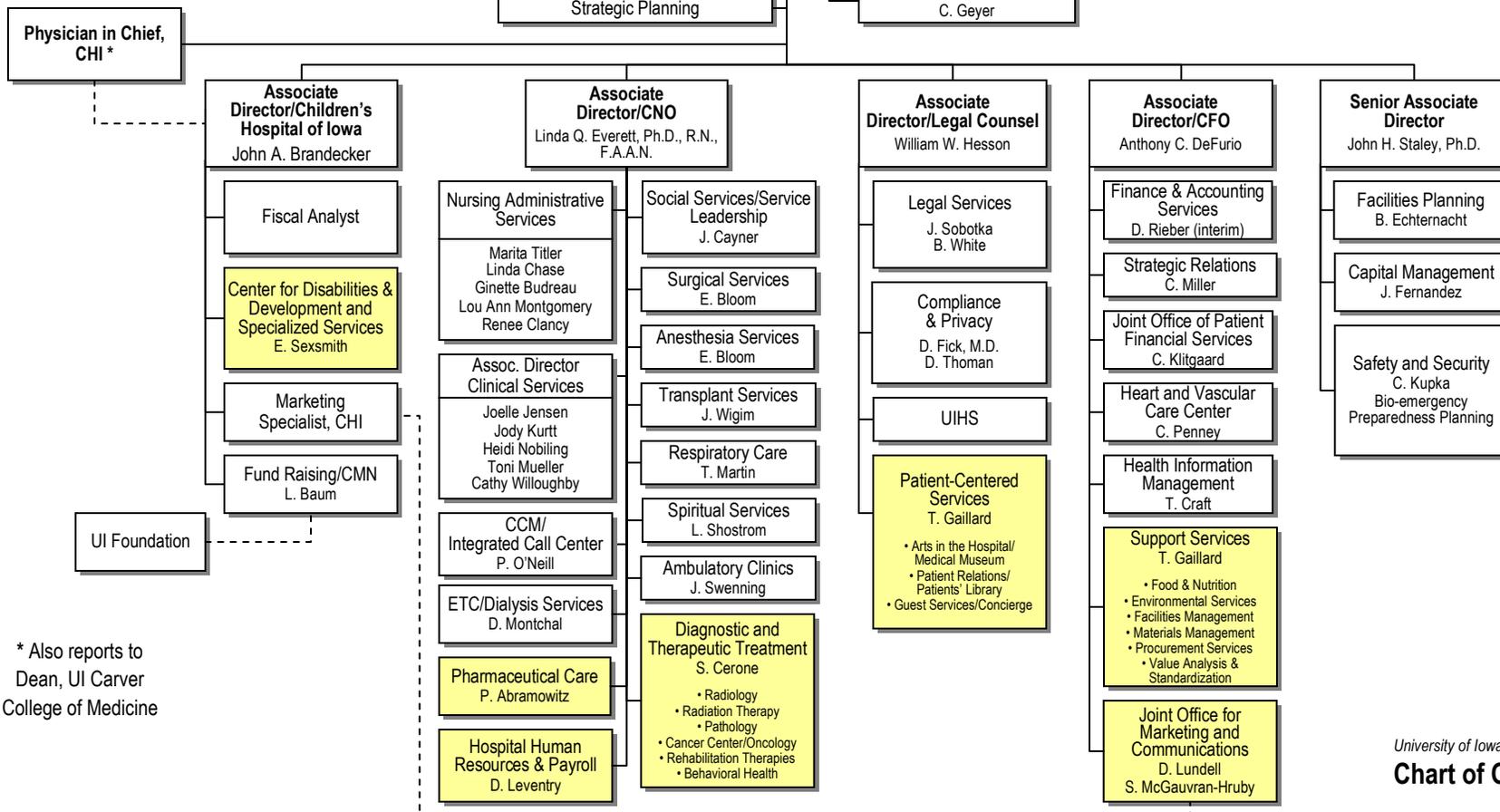
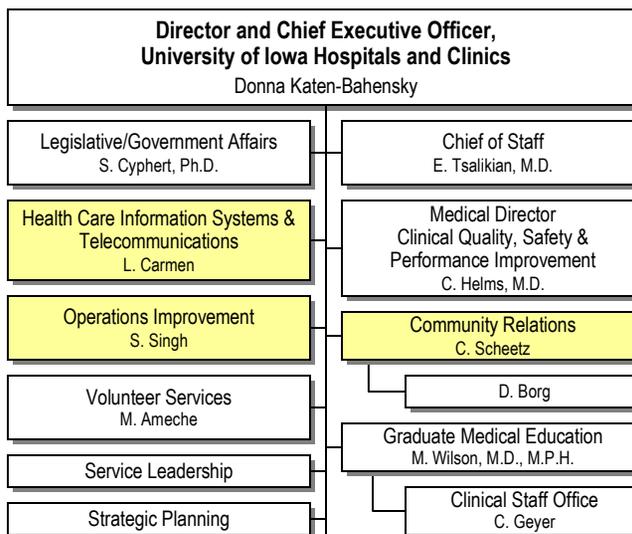
- I. Organizational Structure Changes
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- VI. Other

# Organizational Structure

## Phased Approach

- Phase I
  - Temporary reassignment of COO's direct reports to remaining Associate Directors
- Phase II
  - Ambulatory Care Consultation complete
  - Children's Hospital of Iowa Administrator orientation complete
  - Recruitment of Chief Medical Officer
  - Review structure for all departments
  - Services lines and centers organized
  - Look at potential for adding other leadership position(s)
- Phase III
  - Make decision about COO position
  - Potential for other decisions about structure

# Phase I (6-9 months)



\* Also reports to  
Dean, UI Carver  
College of Medicine

# Employee Engagement Survey

## UIHC Strategic Plan – The Iowa Difference

- Excellent Service Goal #3:
  - Staff, faculty and volunteers are valued and **engaged** in the pursuit of UI Hospitals and Clinics' vision
- Enable staff to accomplish work, contribute to staff learning and motivation, contribute to staff well-being and grow staff satisfaction
- Baldrige Criteria – Human Resources Focus

## Morehead Associates

- Based in Charlotte, North Carolina
- Over 25 years of workplace research experience
- Nearly 4 million individual employees surveyed
- Clients throughout the United States and abroad
- Employee populations ranging from 100 to over 50,000

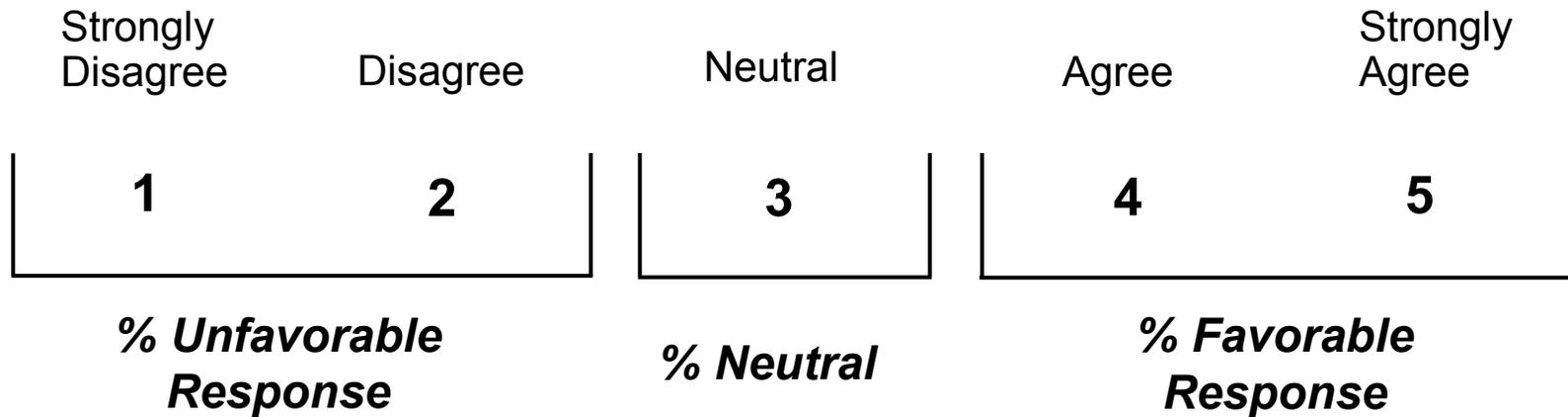
# Employee Engagement

- Morehead and Associates defines employee engagement as:
  - emotional attachment to,
  - identification with, and
  - involvement in the organization.
- Goals of Employee Engagement Research
  - Evaluate employees' perceptions on workplace issues linked to high performance
  - Guide action planning efforts at the work-unit level
  - Strengthen organization-wide communication
  - Measure improvement
- Why is Engagement Important to a High Performing Organization?
  - Research indicates that Engagement is a blend of commitment, loyalty, productivity and ownership. It is the illusive force that motivates employees to higher levels of performance.\*

## Format and Administration of Survey

- 30 closed-ended items
- All items categorized into domains
  - Organization
  - Manager
  - Employee
- Open-ended item:
  - What one thing could your work unit do to improve the patient experience?
- Method: Web-based
- Timeframe: April 2006
- Response Rate
  - April 2006: 5,500 (85%)

## Performance Scale



## Importance Scale



## Most Important Items

Q#	Item	Domain	2006 Imp. Score
6	The person I report to treats me with respect.	M	4.48
16	This organization makes every effort to deliver safe, error-free care to patients.	O	4.46
7	This organization provides high-quality care and service.	O	4.41
12	My work unit provides high-quality care and service.	E	4.35
30	Overall, I am a satisfied employee.	E	4.35
28	This organization treats employees with respect	O	4.35

## Most Important Items (cont'd)

Q#	Item	Domain	2006 Imp. Score
9	My work unit works well together.	E	<b>4.30</b>
1	I like the work I do.	E	<b>4.29</b>
18	The person I report to is a good communicator.	M	<b>4.29</b>
27	This organization supports me in balancing my work life and personal life.	O	<b>4.28</b>
17	My work unit is adequately staffed.	O	<b>4.28</b>

## Highest Scoring Items that are Very Important\*

Q#	Item	Domain	Section	2006 Perf. Score
1	I like the work I do.	E	Job-Person Match	<b>4.31</b>
12	My work unit provides high-quality care and service.	E	Quality/ Customer Focus	<b>4.22</b>
10	I would recommend this organization to family and friends who need care.	O	Commitment Indicator	<b>4.13</b>
16	This organization makes every effort to deliver safe, error-free care to patients.	O	Quality/ Customer Focus	<b>4.12</b>
7	This organization provides high-quality care and service.	O	Quality/ Customer Focus	<b>4.11</b>

\* Importance score is 4.0 or above

## Highest Scoring Items that are Very Important\* (cont'd)

Q#	Item	Domain	Section	2006 Perf. Score
4	When appropriate, I can act on my own without asking for approval.	M	Employee Involvement	<b>4.11</b>
6	The person I report to treats me with respect.	M	Leadership	<b>4.10</b>
14	I respect the abilities of the person to whom I report.	M	Leadership	<b>4.04</b>
2	My job makes good use of my skills and abilities.	E	Job-Person Match	<b>4.01</b>
6	This organization shows its commitment to employee safety.	O	Regard for Employees	<b>3.97</b>
5	The person I report to encourages teamwork	M	Leadership	<b>3.97</b>

\* Importance score is 4.0 or above

## Lowest Scoring Items that are Very Important\*

Q#	Item	Domain	Section	2006 Perf. Score
17	My work unit is adequately staffed.	O	Work-Personal Life Balance	3.21
26	I am satisfied with the recognition I receive for doing a good job.	M	Employee Involvement	3.27
20	Different work units work well together in this organization.	O	Unity	3.31
19	Physicians and hospital staff respect each other.	O	Regard for Employees	3.44
21	I am involved in decisions that affect my work.	M	Employee Involvement	3.46

\* Importance score is 4.0 or above

## Lowest Scoring Items that are Very Important\* (cont'd)

Q#	Item	Domain	Section	2006 Perf. Score
24	This organization treats employees with respect.	O	Regard for Employees	<b>3.51</b>
27	This organization supports me in balancing my work and personal life.	O	Work-Personal Life Balance	<b>3.59</b>
18	The person I report to is a good communicator.	M	Leadership	<b>3.67</b>
25	I get the tools and resources I need to do my job.	O	Regard for Employees	<b>3.75</b>
9	My work unit works well together.	E	Coworker Relations	<b>3.79</b>

\* Importance score is 4.0 or above

## UIHC Survey Results: Key Observations

- Areas of strength include:
  - Confidence in the care provided – quality, service and safety
  - Employees feel empowered to make decisions
  - Organization values employees from different backgrounds
- Opportunities for improvement include:
  - Teamwork within and between work units
  - Recognition
  - How employees feel they are treated by the organization
  - Manager/employee relations
  - Staffing
  - Physician/staff relations
- Results vary by work unit

## Comment Analysis: Top Themes

- Open-ended Item: *What one thing could your work unit do to improve the patient experience?*
  1. Address staffing issues
  2. Update the facility and equipment
  3. Focus on quality patient care and customer service
  4. Increase respect, and improve communication with the patients
  5. Encourage teamwork and communication among staff members

*Note: A total of 3,737 responses were given for this item.*

## Next Steps

- INSIGHT for staff sharing the overall results and next steps as noted here
- Management Staff meeting with Morehead to learn how to interpret and use the results for their area
- Management Staff to meet with their Senior Leader to discuss their results and prepare for sharing with staff
- Share results with staff and listen to their ideas for improvement
- Create an action plan for 2 items and define a measurement tool for tracking progress
- Work action plans, assess if improving through use of measurement tool

## Anticipated Outcomes

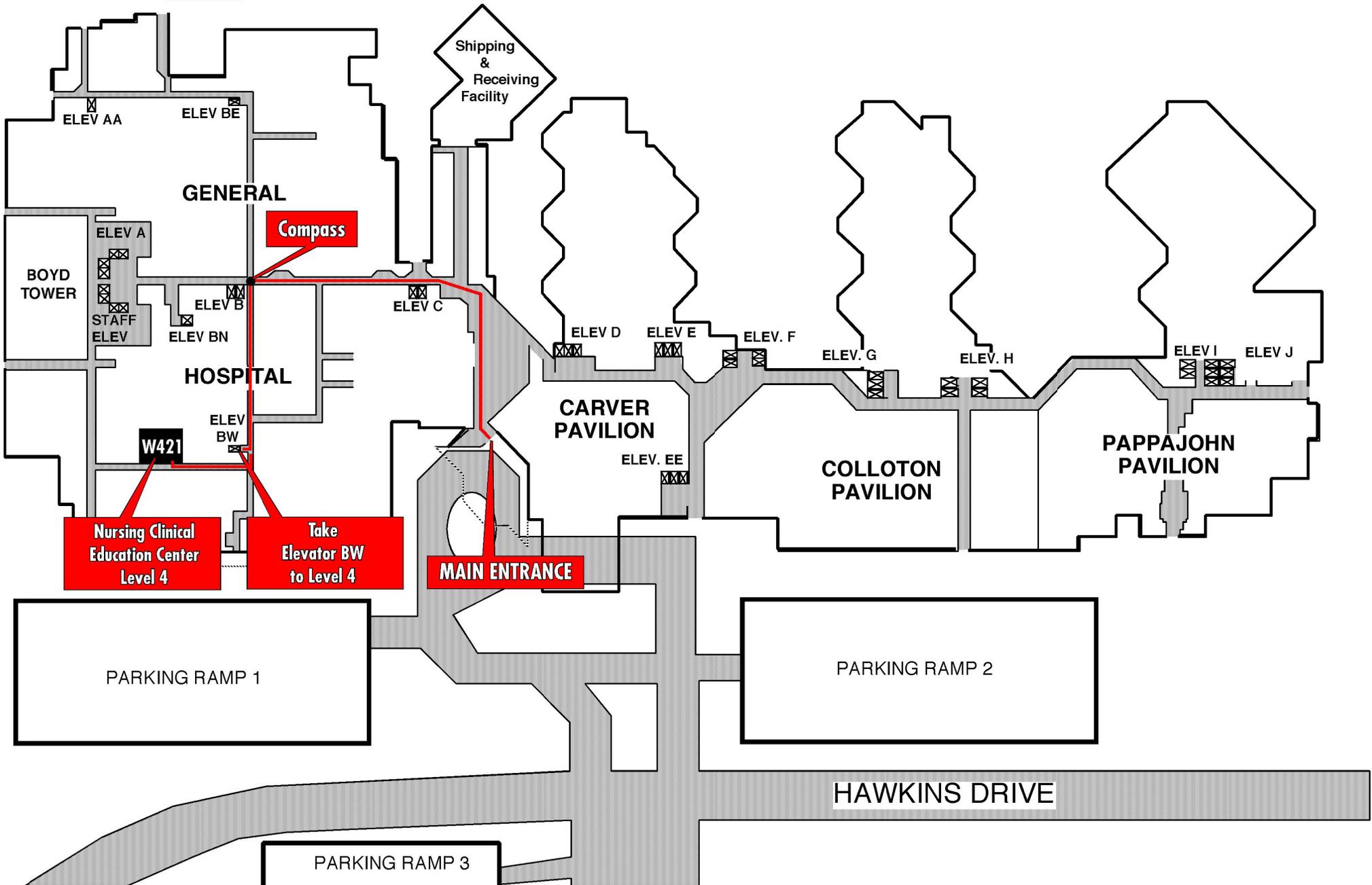
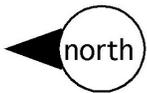
- Employees understand survey results
- Employees participate in celebrating strengths and developing action plans to address opportunities for improvement
- Accountability for change is established and acted upon
- Changes occur that lead to a better workplace which facilitates excellent service, exceptional outcomes and innovative care

## Director's Remarks

- I. Organizational Structure Changes
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- VI. Other

# THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS

Please follow directional signs to Conference Room W421,  
located in the Nursing Clinical Education Center, Fourth Level, General Hospital.



**NEWS**

To print this page [click here](#), or select "Print" from the "File" menu of your browser.

Aug. 2006

**5 Intersections**

*From pay for performance to the rise of the uninsured, healthcare is eyeing a convergence that could transform the industry.*

Healthcare is approaching a hopeful turning point in 2006—perhaps stemming from many leaders' realization that no one solution can cure the industry's ills. Though consumer-driven healthcare may come the closest, even that trend is not one movement, but the intersection of extreme cost pressures with improving technology. At close range, the high cost and poor quality in much of the healthcare industry is unsustainable, but optimism in some quarters comes from the idea that a combination of rising influences are headed for a meeting in the next few years.

The hope, for example, is that providers will look at pay for performance as an incentive to improve their information technology. Maybe in that same P4P process they will adopt evidence-based medicine as a way to improve their clinical processes. In the form of the Centers for Medicare & Medicaid Services, the federal government is showing growing interest in things like P4P. Why? Because pressure is growing on Washington to demand more value for its healthcare expenditures. The government eventually will have to devise a way to help the approximately **45 million Americans** who roll the dice every day without health coverage.

Ultimately, the biggest efficiency gains may come as pressures on the industry force its formerly isolated stakeholders into new alliances—or at minimum, into discussions about mutual self-interest. Although the future can always bring unexpected events that make crossing paths diverge, the next five years could see many propitious intersections.

"Combined, we are going to get to an intersection that could be good," says Janet Marchibroda, CEO of the eHealth Initiative and Foundation, a Washington, D.C.-based organization that strives to improve healthcare quality, safety and efficiency through information technology. "We have demands from consumers, including all of us who are getting older, more educated and used to the Web. We are used to banging folks over the head when we don't get what we want. Combine that with IT becoming more interoperable, and add transparency and accountability and rising costs, and they could push us over the edge to our country's vision—a navigable healthcare system."

**P4P will explode, one way or another**

In the past five years, pay for performance has moved out of theory and into practice. But even the approximately 110 pay-for-performance programs in place nationwide usually carry the tag "demonstration" or "initiative." In the next five years, the question will be whether pay for performance will achieve the critical mass necessary for it to be evaluated as a reliable change agent.

CMS' affection for P4P shows no signs of waning. Even with a relatively small **\$8.85 million pot of money** in its Premier Hospital Quality Incentive Demonstration, CMS announced in November 2005 that the project had demonstrated 4 percent improvement in patients with acute myocardial infarction, 9 percent improvement in patients with heart failure, 10 percent improvement in pneumonia, 5 percent improvement in coronary artery bypass grafts and 5 percent improvement in total hip and knee replacements. CMS administrator Mark B. McClellan, M.D., Ph.D., gushed that such results were "exactly what we should be paying for in Medicare." Hospitals in the top 10 percent for a given condition were awarded a 2 percent bonus in Medicare payments.

The Deficit Reduction Act of 2005 requires CMS to develop a value-based plan in the 2009 fiscal year, which will include processes for choosing quality measures, processes for validation of those measures, and a system of payment adjustments. "So it is not a question on whether the marketplace will really take it on or not," says Suzanne Delbanco, CEO of The Leapfrog Group, "because now the biggest purchaser of healthcare will."

The public reporting of quality information and pay for performance are inexorably tied. Paul Keckley, executive director of the Vanderbilt Center for Evidence-based Medicine in Nashville, Tenn., says that while the two had been on parallel paths, those paths may soon converge.

"More and more of the clinical processes—for example, how diagnoses are done and what interventions are prescribed—will be under the spotlight," Keckley says. "There will be much more payor attention on adherence to the evidence, on things like inappropriate variation, or the overuse or underuse of diagnoses and interventions. That will be linked directly to the various ways we can pay or withhold payment from providers."

The bigger question that will need an answer in the next two or three years is what types of payments or incentives actually change behavior, Keckley says. “The early P4P projects have threshold bonuses and some tiered bonuses, but what do you do about an organization that hits a threshold and can’t move any higher? Do you suspend any payments?”

Mechanical challenges in P4P are numerous. Much debate has led to little consensus on the incentives necessary to get a physician’s attention. And P4P initiatives often rely on new money to fund them—a self-limiting flaw that could doom many efforts to a short lifespan when the new money runs out. Others worry that P4P is not a comprehensive solution that survives in any context, and that a more systematic look at aligning incentives is necessary—including the removal of so-called “perverse incentives,” where doctors get paid more to do more tests and procedures.

“Back in Washington, you hear senators talking about it as if we just sprinkle a few performance measures on top of fee-for-service medicine and think that is going to do any good,” says Alain Enthoven, emeritus professor of management at Stanford University. “You are talking about doctors who don’t have basic underlying incentives to manage resources wisely. For P4P, it all depends on which kind of doctors you are talking about. Are they in medical groups that accept responsibility for managing the cost of a population?”

At this point, P4P is like a drug that has wowed creators with its results from initial clinical trials. So one concern becomes not about effectiveness in the baseline results, but whether the whole idea is getting a true test.

“One danger we face is that a few years from now—once the **100 experiments** we have going across the country for pay for performance have had the test of time—we may find that our efforts have been far too wimpy,” Delbanco says. “We are going to be standing there having conversations maybe about how pay for performance doesn’t work, but in fact what we will be discussing is that our mild attempts at pay for performance didn’t work. That will lead to a whole new round of discussion on payment reform and how to align incentives.”

### All about the quality

Elizabeth McGlynn, Ph.D., associate director of Santa Monica, Calif.-based RAND Health, published a 2003 study, “The Quality of Care Delivered to Adults in the United States,” that found only **55 percent of American** patients receive recommended care—and the level of quality varied substantially for certain medical conditions. The poor overall healthcare quality error rate often compares unfavorably with superior mistake ratios, such as the percentage of IRS phone-in tax advice that is accurate and the percentage of luggage lost by airlines.

In practice, “recommended care,” or evidence-based medicine, has made inroads into the care of discreet populations with single conditions. But while there is ever more reliable data on treatment of diabetics, for example, the formula becomes more complicated by comorbid conditions like heart disease and depression, or even by factors like age, says Keckley.

“What EBM has done in its first wave of activity is probably grabbed a lot of the low-hanging fruit,” Keckley says, adding that better informatics tools are allowing for more distinct profiles of single-disease populations. “Now we have to create the evidence around which approaches work best. So there is some catch-up.”

Big players dominate quality improvement programs. Large multispecialty groups tend to pursue evidence, adopt guidelines and manage variation aggressively, but those groups only represent some **9 percent of physicians nationwide**, Keckley says. Two high-cost variables—computers and people—hold back widespread adoption of quality improvement in most medical offices, says Francois de Brantes, national coordinator of Bridges to Excellence, a Washington, D.C.-based quality improvement organization.

“Larger practices can hire a specialized nurse who can go from practice site to practice site,” de Brantes says. “That type of effort is very difficult to get done in a traditional small practice. There are no SWAT teams out there to help the docs change, apart from the quality improvement organizations, and they don’t have the staff to change **150,000 small practices** across the country.”

The tools of the trade for quality improvement are electronic medical records, yet a recent survey by The Commonwealth Fund, a New York-based private foundation, found that only **23 percent of primary-care physicians** use EMRs. But the next few years could see propulsion of EMR use and the data that goes along with them as more regional health information organizations form. With more RHIOs come more, and better, data to build the case for evidence-based medicine.

“With RHIOs and other common repositories of data, we have standardizable data tools that we can mine,” Keckley says. “At that point, we can associate various interventions with various characteristics of the population retrospectively, instead of having to go out and spend nine or 10 years testing and publishing.”

What pushes quality is often the public reporting of outcomes, yet adoption of public reporting is in pockets. Payors are certain to keep the pressure up, but that chorus may soon be joined by more employers—and even consumers. “There are far more levers at work in the marketplace that are pushing physicians to adhere to guidelines,” Delbanco says.

### ‘Mess-information’ era will wither

Google takes about **0.12 seconds** to return **184 million pages** on diabetes. The search engine takes one hundredth of a second longer to offer **163 million results** for heart disease. There is a comparative dearth of information on foot pain, with a mere **38.6 million pages**.

Like a parched traveler offered a drink from a fire hose, consumers face a flood of healthcare information that has morphed into “mess-information” in the past five years. Payors and physicians are among the groups that have started winnowing that information down for consumer use, driven by the advent of consumer-driven healthcare. But the next five years could see healthcare information move farther beyond the virtual reference desk.

“People don’t know how to navigate it,” Keckley says. “We did 16 focus groups in February with consumers trying to really drill into how they get information and how they sort through quality and evidence. There is a whole lot of stuff out there, but does it really change the behavior of the consumer? Is it specific to their profile? That is where the next five years becomes an exponential explosion of this mass personalization.”

Two advancing technologies outside of IT could drive better information, Keckley says. One is an improvement in biometric data equipment that can report data—from blood pressure to heart rates and blood sugar—back to the physician or caregiver. The second major change is the advancing ability to match risk and genomic factors to personal information. On the IT side, major players like IBM Corp. and Revolution Health, a Washington, D.C.-based company that is launching an array of consumer-directed healthcare offerings, are staking ground for helping consumers navigate the care matrix. “You are going to see the market peppered with consumer-facing applications, sort of like our dot-com boom days,” Marchibroda says. “Maybe it will actually take hold this time because it will have the ability to hook into real information.”

The next five years will see growing connections between what today exists separately: the personal healthcare records held by your physician or health plan and the information systems those providers and payors use to administer care. Pamela Pure, president of McKesson Provider Technologies in Alpharetta, Ga., says the pieces are in place for more convergence.

“We are just starting to invent the future right now,” Pure says. “For the first time, the technologies are affordable, the technologies are ready, and the access points are much more available and accessible, not only for physicians, but to the payors and to the patients.”

So are the days when consumers ask, “What is diabetes?” in the past? Have they been replaced by, “What are my test results and trends?” Marchibroda says no one has been able to make those connections yet, but that time is almost here. “He who is able to link those exchanges will win,” she says. “It will be a fun time to watch.”

### The uninsured will become a force

Aren’t 45.8 million Americans without adequate health insurance already a force? The ranks of the uninsured outnumber the **35-million-member AARP** and its lobbying clout. But despite fervent advocacy by many well-meaning groups and political organizations, the uninsured do not have nearly the force to influence healthcare policy in Washington that their numbers would suggest.

The uninsured’s influence could change in the next few years, however. In the past, as the number of uninsured grew, they remained largely within the bottom quintile of American income. But new statistics indicate a lack of health insurance is now staring the middle class in the face, as well. A 2004 U.S. Census Bureau report showed that between 2003 and 2004, the percentage of uninsured with incomes between **\$50,000 and \$75,000** grew from **12.5 percent to 13.3 percent**, while the uninsured percentage of those making less grew only a tenth of 1 percent. Unlike their fellow Americans who may not have the political organization to support them—or the time and resources to make a stink about it—the middle class is not likely to take medically induced bankruptcy well at all, says Arnold Milstein, M.D., medical director of the Pacific Business Group on Health in San Francisco. The middle class does vote, and it has assets to protect, he says.

“When someone in their family gets sick, they will lose everything—and they will get mad,” Milstein says. “Those are the seeds for a tipping point. I am not a political expert, but I am telling you it is going to happen. There is something fundamentally wrong in this country if a person’s whole life savings can vanish as a result of not making enough money

to buy health insurance.”

States are certainly trying to force Washington’s hand when it comes to the uninsured. Whether it is Massachusetts mandating universal coverage, Maryland pressuring large employers or Tennessee dismantling its TennCare program, states are working to keep the uninsured manageable while hoping Washington will come to their aid. While the plight of the uninsured received a percentage of sound bites from President Bush and Sen. John Kerry in the 2004 presidential race, the issue was a blip to voters worried about the economy and the war on terror. In 2008, the economy and war may still dominate, but expect more attention to be paid to the **45.8 million people** who don’t have an insurance card. “It will be impossible for the next presidential campaign not to address healthcare. And I mean coverage—not quality, not IT—but coverage,” Delbanco says.

### Stakeholders will become mutually self-interested

Chances are that today, somewhere in a hotel meeting room, over chicken salad and iced tea, a healthcare leader is giving the “call to action” speech. It is likely based on a passionate, sincere belief that the stakeholders in the audience—be they medical group practice administrators, nurse managers, CIOs or health plan presidents—hold the keys to fixing healthcare. These stakeholder pep rallies serve a purpose, but everyone who listens knows that the healthcare industry is like a lifeboat: When only one side is rowing, the boat goes in circles.

An encouraging sign is that disparate groups are talking. RHIOs have encouraged competing providers to come together. Pay-for-performance programs link health plans and health systems in something other than the contentious annual contract renewal. Hospital CEOs are crossing town to talk about health improvement programs with large employers.

If nothing else, by 2011, maybe the healthcare industry will be farther along in tearing down the walls.

“We still are in silos,” Marchibroda says. “I do think the quality indicator conversation is happening apart from the electronic health record conversation. If this loose group of leaders in each of these areas comes together, we have the opportunity to make something happen, but it is not happening yet. They are beginning to. It doesn’t just happen overnight.”

*Jim Molpus is editor of HealthLeaders magazine and HealthLeaders Online News. He may be reached at [jmolpus@healthleadersmedia.com](mailto:jmolpus@healthleadersmedia.com)*

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