Presentation to The Board of Regents, State of Iowa | November 2021

University of Iowa Health Care

PRESENTATION TO THE BOARD OF REGENTS, STATE OF IOWA
November 3, 2021

CHANGING MEDICINE.
CHANGING LIVES.®

Agenda

- Opening Remarks
- Operating and Financial Performance
- Faculty Presentation: Rural Emergency Care in Iowa

Opening Remarks

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Brooks Jackson, MD, MBA
Vice President for Medical Affairs
& Tyrone D. Artz, Dean, Carver College of Medicine

Operating and Financial Performance

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Suresh Gunasekaran, MBA
Associate Vice President, UI Health Care
& CEO, UI Hospitals & Clinics

Mark Henrichs, CPA, MHA
Interim Associate Vice President &
Chief Financial Officer, UI Health Care

Volume and Financial Highlights–FY22

THROUGH AUGUST 2021

Operating Margin
- Actual 8.0% vs goal of 3.7%

Key Volumes
- Inpatient Discharges
  - -4.8% vs budget | 0.6% vs prior year
- Acute Patient Days
  - -1.7% vs budget | +1.0% vs prior year
- Surgeries
  - -2.1% vs budget | -1.1% vs prior year
- Clinic Visits
  - +13.1% vs budget | -0.4% vs prior year (w/ ILI)

Acuity
- Case Mix Index 2.37

Length of Stay Index
- Adult at .98
- Pediatrics at 1.01

Revenues
- 4.7% above budget

Payer Mix
- Medicare below historical averages
- FY20: 38.0% | FY21: 37.2% | FY22 36.8%

Accounts Receivable
- Days in Net AR – 48.8 days

Salary Expenses
- 2.5% below budget

Non-Salary Expenses
- 2.0% above budget

Comparative Financial Results

FISCAL YEAR TO DATE: AUGUST 2021

NET REVENUES	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Patient Revenue	$381,907	$364,559	$350,364	$17,348	4.8%	$31,543	9.0%
Other Operating Revenue	8,440	8,133	12,248	307	3.8%	(3,808)	-31.1%
Total Revenue	**$390,347**	**$372,692**	**$362,612**	**$17,655**	**4.7%**	**$27,735**	**7.6%**
EXPENSES							
Salaries and Wages	$148,400	$152,165	$141,209	($3,765)	-2.5%	$7,191	5.1%
General Expenses	190,796	186,626	175,631	4,170	2.2%	15,165	8.6%
Operating Expense before Capital	$339,196	$338,791	$316,840	$405	0.1%	$22,356	7.1%
Cash Flow Operating Margin	**$51,151**	**$33,901**	**$45,772**	**$17,250**	**50.9%**	**$5,379**	**11.8%**
Capital- Depreciation and Amortization	20,102	20,112	17,007	(10)	0.0%	3,095	18.2%
Total Operating Expense	$359,298	$358,903	$333,847	$395	0.1%	$25,451	7.6%
Operating Income	**$31,049**	**$13,789**	**$28,765**	**$17,260**	**125.2%**	**$2,284**	**7.9%**
Operating Margin %	**8.0%**	**3.7%**	**7.9%**		**4.3%**		**0.1%**
Gain (Loss) on Investments	4,287	6,670	15,700	(2,383)	-35.7%	(11,413)	-72.7%
Other Non-Operating	(2,834)	(2,102)	(1,942)	(732)	-34.8%	(892)	-45.9%
Net Income	**$32,502**	**$18,357**	**$42,523**	**$14,145**	**77.1%**	**($10,021)**	**-23.6%**
Net Margin %	**8.3%**	**4.9%**	**11.3%**		**3.4%**		**-3.0%**

Key Metrics

	FY22 YTD Through Aug	Moody's Median
Financial Operations		
Operating Margin	7.3%	1.1%
Financial – Liquidity		
Days Cash on Hand	240	305
Financial – Leverage		
Debt to Capitalization	18.0%	21.4%

Improving Cardiology Patient Access

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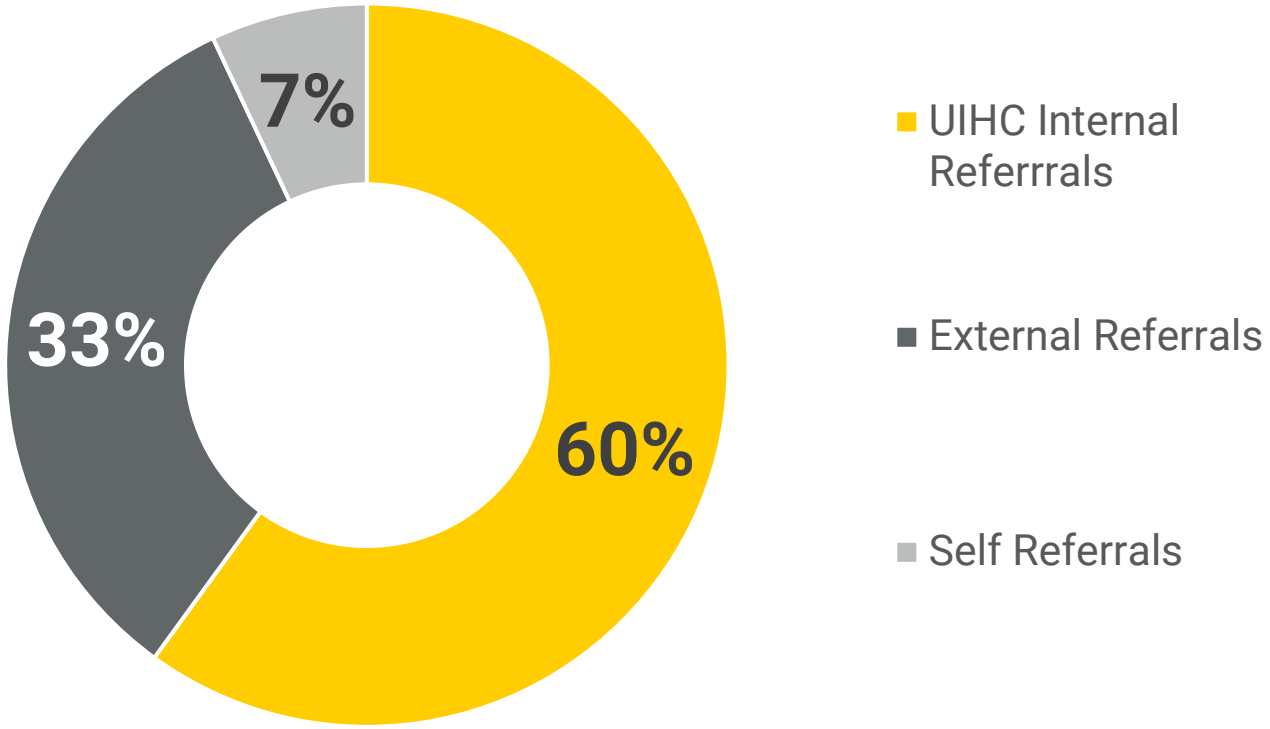
Serving Our Cardiology Patients

- 60% of referrals are established patients at UIHC referred by another UIHC provider
- 33% of referrals come from external providers
- 7% of referrals come directly from the patient themselves
- Goal to offer new evaluation appointments within 14 days



Cardiology Patient Access

Challenges

Experiencing appointment access challenges for referral and return Cardiology Patients

Testing Backlog

Experiencing a backlog of patients requiring diagnostic testing

New Patient Access

Only 41% of new patients able to be seen by a specialist within 14 days

GOAL: Increase available appointment slots for patients seeking New Referral or Follow-up Cardiology care

Cardiology Patient Access: Process

Formulated a Multidisciplinary Leadership Group

- Physicians, nurses, and other clinical team members
- Leadership and Scheduling Team

Performed Analytics

- Reviewed existing appointment availability
- Reviewed scheduling templates
- Evaluated scheduling practices for expansion opportunity

Implemented Strategies

(March 2021)

- Created additional appointments for acute patient needs
- Implemented direct scheduling from the Emergency Department to Cardiology Clinic
- Increased clinical support staff

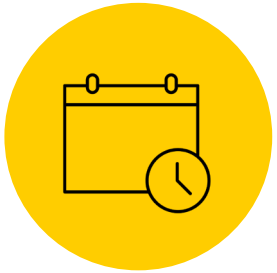
Cardiology Patient Access: Results

Increased visits

Cardiology clinic visit availability increased by **30%**

Increased testing

Diagnostic testing availability increased by **51%**



Increased access

New patients seen within 14 days increased to **52%**

Next Steps

Evaluating strategies for other populations within the Heart and Vascular Center to continue to increase patient access

Adult Discharge Lounge

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Adult Discharge Lounge: Background

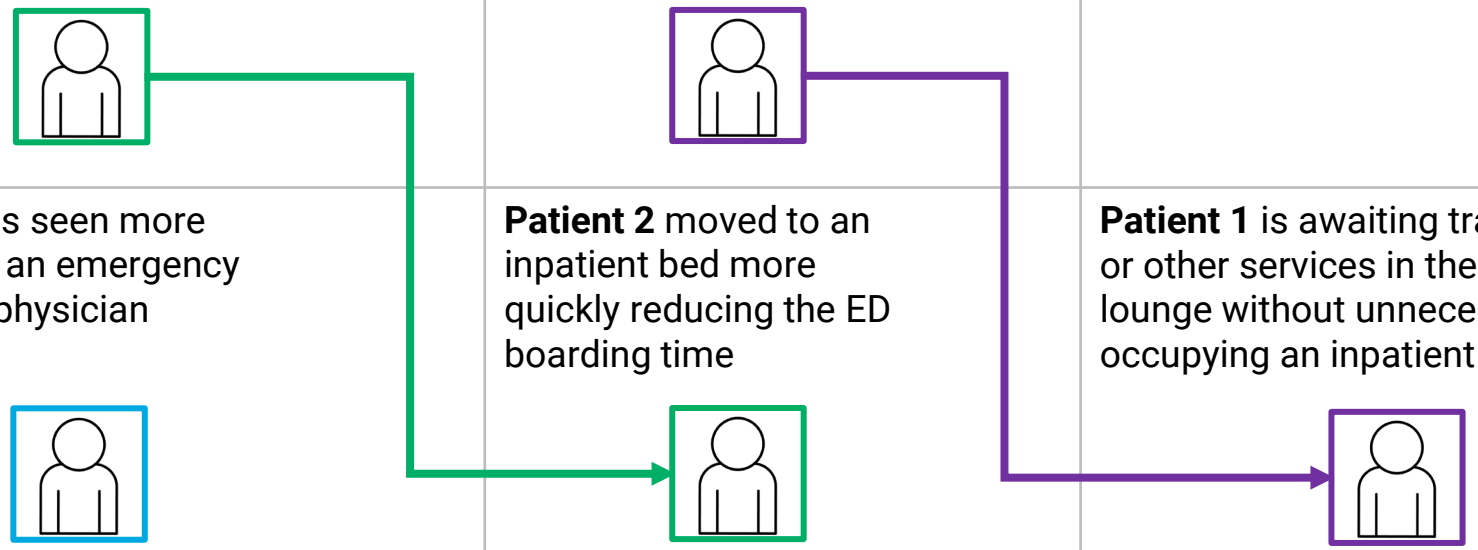
- Capacity-constrained hospitals often seek to expedite the inpatient discharge process to improve patient access.
- Due to the complexities of hospitals, there can often be a delay from when the patient is cleared to discharge and when the patient physically departs the hospital.
- As a countermeasure, some hospitals have implemented “Discharge Lounges” – designated areas where patients wait between the time their discharge orders are entered and when they are ready to leave the hospital.

Adult Discharge Lounge: UIHC Situation

- UI Hospitals & Clinics consistently operates at an adult occupancy above 90%.
- Patients are consistently waiting for bed availability to seek care from our specialists.
- Patients wait in the emergency department, clinic, community, etc.
- Implementing a discharge lounge is one of the many things UI Hospitals & Clinics is doing to improve access for patients needing our medical care.

Adult Discharge Lounge: Patient Flow

	Emergency Department Bed	Inpatient Bed	Discharge Lounge
Without Discharge Lounge	**Patient 2** is boarding in the ED while awaiting the inpatient bed occupied by patient 1	**Patient 1** is discharged, but occupying an inpatient bed while awaiting transportation or other services	
With Discharge Lounge	**Patient 3** is seen more quickly by an emergency medicine physician	**Patient 2** moved to an inpatient bed more quickly reducing the ED boarding time	**Patient 1** is awaiting transportation or other services in the discharge lounge without unnecessarily occupying an inpatient bed



Adult Discharge Lounge at UIHC

Discharge Lounge Facts and Figures

- 10 chairs in the Discharge Lounge
- Discharge Lounge open Monday-Friday 9 a.m. to 5 p.m.
- Dedicated staff member who answers questions and provides comfort and diversional activities
- Patients eligible when fully cleared for discharge and home going medications are picked up prior to the patient being taken to the Discharge Lounge
- Multidisciplinary collaboration between nursing, therapies, physician team to operationalize process

Adult Discharge Lounge: Patient Feedback

Average Patient Satisfaction Score

Patient Comments

“I was recently a patient in the ED and used your new discharge lounge while waiting for my ride. The staff was so kind and professional. It was nice to be right by the entrance when my ride arrived!”

“I was pleasantly surprised about how comfortable the discharge lounge was... I was given a warm blanket and didn’t have to wait in the noisy main lobby, which was great.”

Medical Training Expansion

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Medical Training Expansion

- UIHC currently provides training support for 821 total residents and fellows
- UIHC will be expanding trainee positions by 65 trainees in FY22
- The 65 additional positions will be fully funded by UI Health Care

Medical Training Expansion

Building the health care workforce of tomorrow is a critical mission of UIHC.

In FY23, 65 additional residency and fellowship programs will be added.

Residency Programs		Accredited Fellowship Programs		Non-Accredited Fellowship Programs	
Child Neurology	5	Clinical Cardiac Electrophysiology	1	Advanced Cardiac Imaging	1
Diagnostic Radiology	1	Hem Onc Blood & Marrow Transplant	6	Advanced Lung Disease and Transplant	1
Emergency Medicine	3	Infectious Disease	2	Body Imaging	2
Family Medicine	6	Medical Toxicology	2	Neuroimmunology	1
General Surgery	5	Nephrology – Critical Care	3	Thoracic and CV Imaging	1
Integrated Plastics	6	Neuropathology	1		
Neurosurgery	4	Psychiatry Addiction Med	1		
OB/GYN Rural Track	4				
Ophthalmology	4				
Orthopedics	5				

Rural Emergency Care in Iowa

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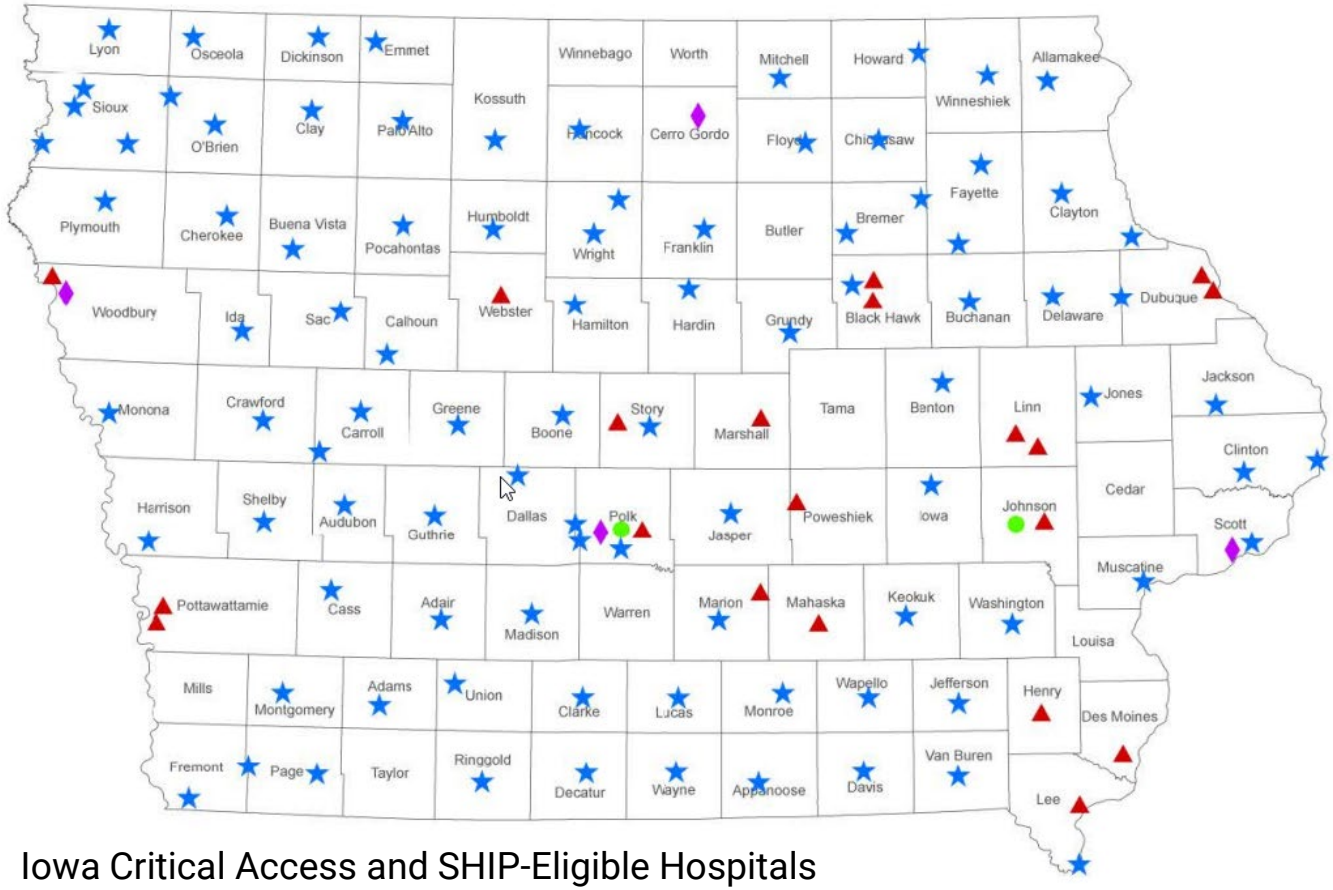
Nicholas M. Mohr, MD, MS
Professor of Emergency Medicine, Anesthesia, and Epidemiology
Vice Chair for Research, Department of Emergency Medicine

Emergency Care in Iowa



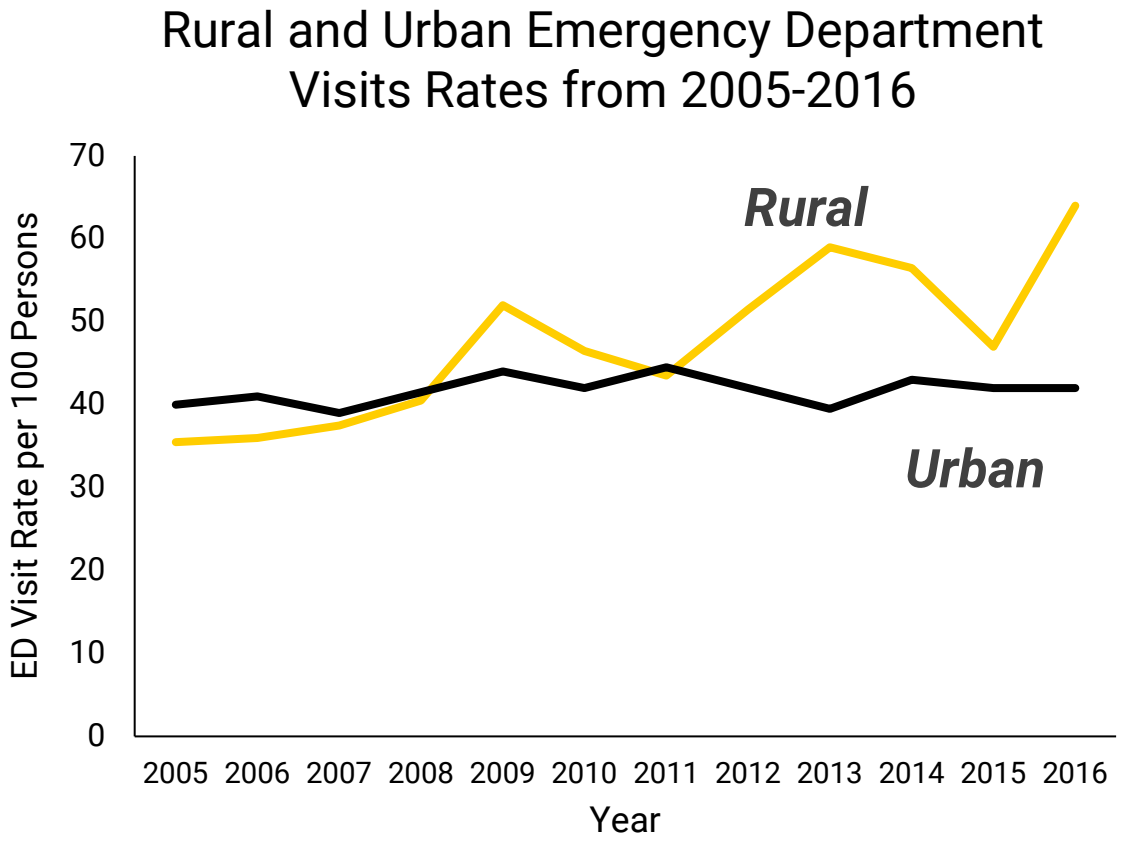
Iowa Critical Access and SHIP-Eligible Hospitals
Iowa Department of Public Health

- 120 hospitals in Iowa
- 82 critical access hospitals (most in U.S.)
  - 24-hour emergency care
- 60% of Iowa EDs staffed by advanced practice provider (40% in 2008)

Groth H, et al. West J Emerg Med 2013;14:186-90.

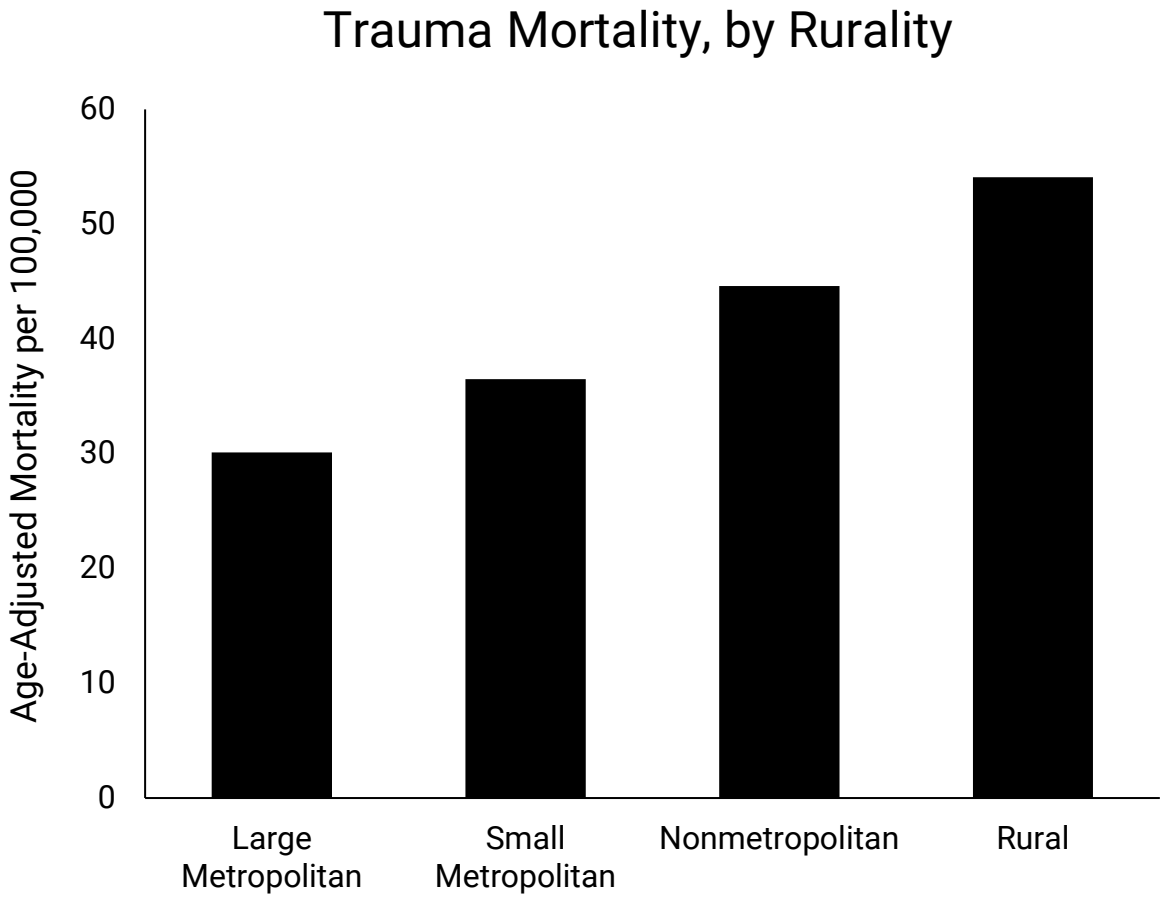
Rural ED Visits are Rising

- Rural emergency department visits (per capita) have increased by 50% over the past decade
- 48% of all ED visits in Iowa are in rural EDs (2019)



Greenwood-Ericksen M, et al. JAMA Network Open 2019;2:e191919.
Iowa Hospital Association

Rural Emergency Care is Important



- Rural trauma mortality is 79% higher than urban trauma
- Bypassing rural hospitals for sepsis (life-threatening infection) increases mortality by 5.6%
- Rural hospital closures are associated with 5% all-cause increased mortality

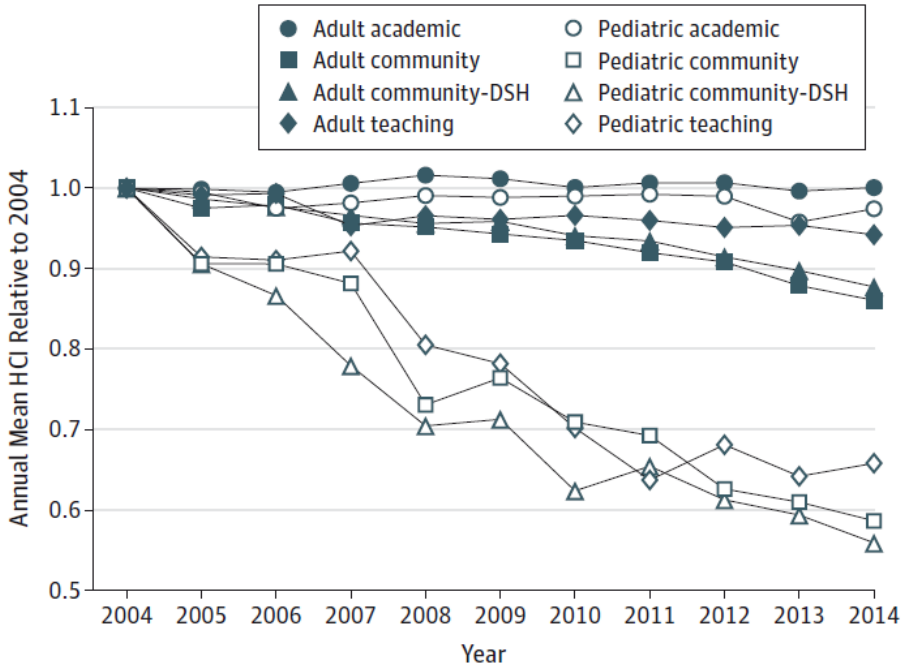
Peek-Asa C, et al. Am J Public Health 2004;94:1689-93.
Mohr NM, et al. Crit Care Med 2017;45:85-93.
Liu C, et al. Health Aff (Millwood). 2014;33:1323-9.

Rural Emergency Care is Unique

- Staffing challenges
- Specialist availability
- Low-volume centers and clinical outcomes
- Increasing regionalization
- Inter-hospital transfer
  - 59% of all Iowa sepsis patients are now transferred

Franca UL, et al. JAMA Ped. 2017;171:e171096.
Feazel LM, et al. Am J Emerg Med. 2015;33:1288-96.
Mohr NM, et al. J Crit Care. 2016;36:187-94.

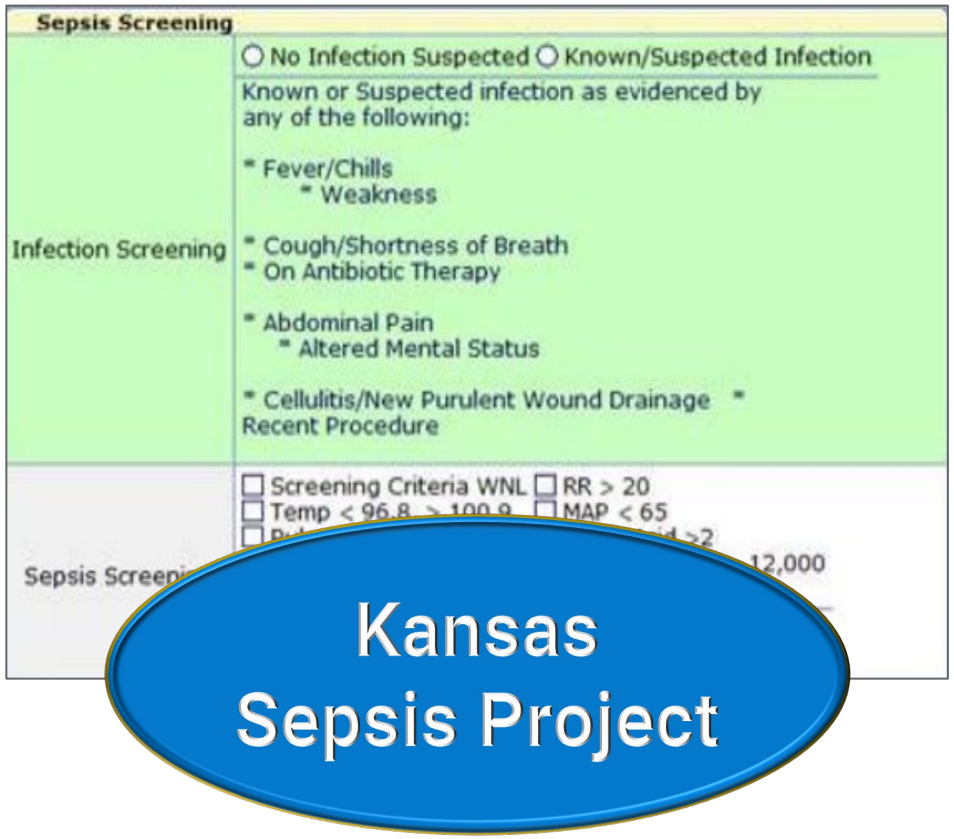
Figure 2. Annual Mean HCI for Different Hospital Cohorts and Populations Relative to 2004



DSH indicates disproportionate share hospital; HCI, Hospital Capability Index.

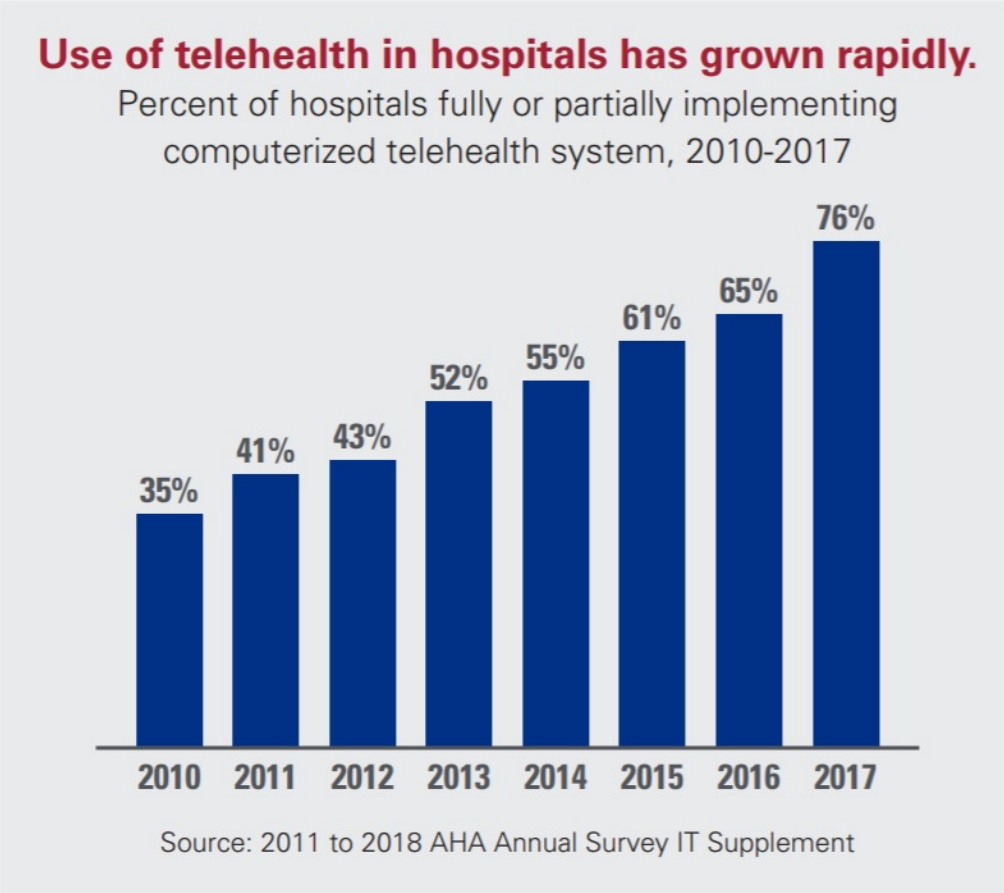
Building Knowledge for Rural Emergency Care System Development

- Standardizing rapid care for rural sepsis patients
  - University of Iowa, Avera eCARE (Sioux Falls, SD), Kansas Sepsis Project
- Developing protocols for ambulance personnel for sepsis care
  - Southeast Iowa
- Developing transfer guidelines for emergency surgical regionalization
  - University of Iowa, University of Utah, University of New Mexico (CTSA)



Mohr NM, et al. Res Pol Brief 2017;1-4.
Froehlich A, et al. J Crit Care. 2019;52:163-5.

Telehealth can Improve Care



American Hospital Association

- Rural Telehealth Research Center

RTRC Rural Telehealth RESEARCH CENTER

  - Home monitoring in VA hospitals
  - Sepsis in rural EDs
  - Behavioral health
  - Substance use
  - School nurse-based telehealth
  - Maternal direct-to-consumer telehealth

Telehealth can Improve Care

Telehealth can…

- Improve procedural outcomes
- Improve timeliness of transfer in trauma
- Improve education to front-line rural health workers
- Improve speed of radiography interpretation
- Improve guideline adherence
- Reduce burden of travel for specialty appointments

Lane S. AAPA News.
Van Oeveren L, et al. Telemed J E Health. 2017;23:290-7.
Mohr NM, et al. Acad Emerg Med. 2017;24:177-85.
Mohr NM, et al. Telemed J E Health. 2019;25:93-100.
Zhu X, et al. Telemed J E Health. 2021;27:441-7.

What does the future of rural emergency care look like?

- Rural Emergency Hospital (REH) model (2023)
- Flexible staffing
- Increasing use of telehealth (provider-to-provider, direct-to-consumer)
- Consolidated health systems
- “Systems of Care” approach

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Thank you

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