AGENDA

BOARD OF REGENTS, STATE OF IOWA
UIHC COMMITTEE MEETING

January 17, 2007
8:30-11:30 a.m.
Clasen Memorial Board Room, UIHC
Iowa City, Iowa

I. Introductory Comments
   Regent Robert N. Downer, Chair
   Donna Katen-Bahensky, Director and Chief Executive Officer

II. Operations and Finance Report,
    Year to Date November 2006
   Donna Katen-Bahensky
   Dan Rieber, Interim Associate Director and Chief Financial Officer

III. Iowa Hospital Association PricePoint
     Donna Katen-Bahensky
     Dan Rieber

IV. IowaCare Update
    Donna Katen-Bahensky
    Stacey Cyphert, Special Advisor to the President,
    Special Advisor to the Dean of CCOM,
    Senior Assistant Hospital Director

V. EPIC Update
   Donna Katen-Bahensky
   Lee Carmen, Chief Information Officer, Director of Health Care Information Systems

VI. Ambulatory Care Standards
    Donna Katen-Bahensky
    Craig Syrop, MD, Chief Medical Officer of University of Iowa Physicians

VII. Community Benefit Survey
     Donna Katen-Bahensky

VIII. Baldrige Award
      Donna Katen-Bahensky
      Debbie Thoman, Senior Assistant Director, Joint Office of Compliance

IX. Director’s Remarks
    Donna Katen-Bahensky
Regent Downer called the meeting to order at 8:36 a.m.

<table>
<thead>
<tr>
<th>UIHC 1.</th>
<th>Discussion: Introductory Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Regent Downer gave opening comments.</td>
</tr>
<tr>
<td></td>
<td>The minutes were approved as distributed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UIHC 2.</th>
<th>Discussion: Fiscal Year FY 2006 in Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Donna Katen-Bahensky provided an overview of FY 2006.</td>
</tr>
<tr>
<td></td>
<td>Regents Downer and Arbisser requested the information on the economic impact of the hospital be put in a convenient pocket size or tri-fold handout.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Donna Katen-Bahensky and Dan Rieber reviewed the current fiscal year financials.</td>
</tr>
<tr>
<td></td>
<td>Regent Downer expressed that he feels it is terrific that ISU students also participated in the Dance Marathon this year.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UIHC 4.</th>
<th>Discussion: IowaCare Update</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stacey Cyphert provided a general overview of the program, including a brief discussion of how the program operated in its first year and gave an update on the new durable medical equipment and pharmaceutical programs for IowaCare patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UIHC 7.</th>
<th>Discussion: Director’s Report</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Donna Katen-Bahensky provided updates on recruitment of new department heads and updates on honors and awards received by UIHC.</td>
</tr>
</tbody>
</table>

Regent Downer adjourned the meeting at 10:35 a.m.
Operating and Financial Performance
Year-to-Date November 2006

Donna Katen-Bahensky
Director and Chief Executive Officer

Dan Rieber
Interim Associate Director and Chief Financial Officer
## Volume Indicators

### July 2006 through November 2006

<table>
<thead>
<tr>
<th>Operating Review (YTD)</th>
<th>Actual</th>
<th>Budget</th>
<th>Prior Year</th>
<th>Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions</td>
<td>11,494</td>
<td>10,862</td>
<td>10,656</td>
<td>632</td>
<td>5.8%</td>
<td>838</td>
</tr>
<tr>
<td>Patient Days</td>
<td>76,352</td>
<td>69,846</td>
<td>72,275</td>
<td>6,506</td>
<td>9.3%</td>
<td>4,077</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>6.64</td>
<td>6.43</td>
<td>6.78</td>
<td>0.21</td>
<td>3.2%</td>
<td>(0.14)</td>
</tr>
<tr>
<td>Average Daily Census</td>
<td>499.03</td>
<td>456.51</td>
<td>472.39</td>
<td>42.52</td>
<td>9.3%</td>
<td>26.65</td>
</tr>
<tr>
<td>Surgeries - Inpatient</td>
<td>4,502</td>
<td>4,383</td>
<td>4,297</td>
<td>119</td>
<td>2.7%</td>
<td>205</td>
</tr>
<tr>
<td>Surgeries - Outpatient</td>
<td>4,471</td>
<td>4,552</td>
<td>4,463</td>
<td>(81)</td>
<td>-1.8%</td>
<td>8</td>
</tr>
<tr>
<td>Emergency Treatment Center Visits</td>
<td>16,057</td>
<td>14,997</td>
<td>14,599</td>
<td>1,060</td>
<td>7.1%</td>
<td>1,458</td>
</tr>
<tr>
<td>Outpatient Clinic Visits</td>
<td>287,028</td>
<td>279,237</td>
<td>280,264</td>
<td>7,791</td>
<td>2.8%</td>
<td>6,764</td>
</tr>
</tbody>
</table>

| Case Mix                                    | 1.7370 | 1.7360 | 1.7366     | 0.0010             | 0.1%                   | 0.0004                 | 0.0%                   |
| Medicare Case Mix                           | 1.9185 | 1.8797 | 1.8453     | 0.0388             | 2.1%                   | 0.0732                 | 4.0%                   |

- Greater than 2.5% Favorable
- Neutral
- Greater than 2.5% Unfavorable
## Comparative Financial Results
### July 2006 through November 2006

### NET REVENUES:

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Prior Year</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Revenue</td>
<td>$305,664</td>
<td>$295,827</td>
<td>$274,073</td>
<td>$9,837</td>
<td>3.3%</td>
<td>$31,591</td>
<td>11.5%</td>
</tr>
<tr>
<td>Appropriations</td>
<td>5,586</td>
<td>5,586</td>
<td>5,586</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Operating</td>
<td>16,018</td>
<td>16,496</td>
<td>16,245</td>
<td>(478)</td>
<td>-2.9%</td>
<td>(227)</td>
<td>-1.4%</td>
</tr>
<tr>
<td>Total Revenue</td>
<td><strong>$327,268</strong></td>
<td><strong>$317,909</strong></td>
<td><strong>$295,043</strong></td>
<td><strong>$9,359</strong></td>
<td><strong>2.9%</strong></td>
<td><strong>$31,364</strong></td>
<td><strong>10.6%</strong></td>
</tr>
</tbody>
</table>

### EXPENSES:

<table>
<thead>
<tr>
<th>Category</th>
<th>Actual</th>
<th>Budget</th>
<th>Prior Year</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries and Wages</td>
<td>$165,412</td>
<td>$163,417</td>
<td>$150,953</td>
<td>$1,995</td>
<td>1.2%</td>
<td>$14,459</td>
<td>9.6%</td>
</tr>
<tr>
<td>General Expenses</td>
<td>122,619</td>
<td>121,531</td>
<td>114,390</td>
<td>1,088</td>
<td>0.9%</td>
<td>8,229</td>
<td>7.2%</td>
</tr>
<tr>
<td>Operating Expense before Capital</td>
<td>288,031</td>
<td>284,948</td>
<td>265,343</td>
<td>3,083</td>
<td>1.1%</td>
<td>22,688</td>
<td>8.6%</td>
</tr>
<tr>
<td>Earnings Before Depreciation,</td>
<td>39,237</td>
<td>32,961</td>
<td>30,561</td>
<td>6,276</td>
<td>19.0%</td>
<td>8,676</td>
<td>28.4%</td>
</tr>
<tr>
<td>Interest, and Amortization (EBDITA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital- Depreciation and</td>
<td>23,056</td>
<td>22,610</td>
<td>20,510</td>
<td>446</td>
<td>2.0%</td>
<td>2,546</td>
<td>12.4%</td>
</tr>
<tr>
<td>Amortization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating Expense</td>
<td><strong>$311,087</strong></td>
<td><strong>$307,558</strong></td>
<td><strong>$285,853</strong></td>
<td><strong>$3,529</strong></td>
<td><strong>1.2%</strong></td>
<td><strong>$25,234</strong></td>
<td><strong>8.8%</strong></td>
</tr>
</tbody>
</table>

### Operating Income

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>$16,181</strong></td>
<td><strong>$10,351</strong></td>
<td><strong>$5,830</strong></td>
<td>56.3%</td>
<td><strong>$6,130</strong></td>
<td>61.0%</td>
</tr>
</tbody>
</table>

### Operating Margin %

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4.9%</td>
<td>3.3%</td>
<td>3.4%</td>
<td>1.6%</td>
<td>48.5%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

### Gain (Loss) on Investments

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>10,065</td>
<td>4,085</td>
<td>4,101</td>
<td>5,980</td>
<td>146.4%</td>
<td>5,964</td>
</tr>
</tbody>
</table>

### Non-Recurring Items

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Net Income

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26,246</td>
<td>14,436</td>
<td>14,152</td>
<td>11,810</td>
<td>81.8%</td>
<td>12,094</td>
</tr>
</tbody>
</table>

### Net Margin %

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance to Budget</th>
<th>% Variance to Budget</th>
<th>Variance to Prior Year</th>
<th>% Variance to Prior Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8.0%</td>
<td>4.5%</td>
<td>4.8%</td>
<td>3.5%</td>
<td>77.8%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

**NOTE:** all dollar amounts are in thousands
Comparative Accounts Receivable at November 30, 2006

<table>
<thead>
<tr>
<th></th>
<th>June 30, 2005</th>
<th>June 30, 2006*</th>
<th>November 30, 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Accounts Receivable</td>
<td>$93,964,049</td>
<td>$95,976,921</td>
<td>$94,487,068</td>
</tr>
<tr>
<td>Net Days in AR</td>
<td>57</td>
<td>51</td>
<td>48</td>
</tr>
</tbody>
</table>

Days of Revenue in Net A/R

Bad Debts

MEDIAN (54) Moody's Aa Rating

* unaudited
# UIHC 2007 Scorecard

## INNOVATIVE CARE

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>Nov-07</th>
<th>FY2007 Target</th>
<th>FY '07 Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Market Share</td>
<td>6.9%</td>
<td>7.1%</td>
<td>[B]</td>
<td></td>
<td>% improvement over CY '06 [A]</td>
</tr>
<tr>
<td>Primary service area market share</td>
<td>22.7%</td>
<td>22.3%</td>
<td>[B]</td>
<td></td>
<td>% improvement over CY '06 [A]</td>
</tr>
<tr>
<td>Johnson County market share</td>
<td>52.8%</td>
<td>52.5%</td>
<td>[B]</td>
<td></td>
<td>% improvement over CY '06 [A]</td>
</tr>
<tr>
<td>Acute Admissions</td>
<td>25,063</td>
<td>26,030</td>
<td>27,166 [C]</td>
<td>26,011</td>
<td>UIHC Budget for 2.5 % growth</td>
</tr>
<tr>
<td>Clinic Visits (UIHC only)</td>
<td>668,456</td>
<td>673,947</td>
<td>683,034 [C]</td>
<td>671,477</td>
<td>UIHC Budget for 2% growth</td>
</tr>
<tr>
<td>Clinic visits (outreach and CMS)</td>
<td>182,764</td>
<td>182,901</td>
<td>178,282 [C]</td>
<td>186,957</td>
<td>UIHC Budget for 2% growth</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>6.99</td>
<td>6.71</td>
<td>6.64</td>
<td>6.40</td>
<td>UIHC Budget for 1/2 day reduction</td>
</tr>
</tbody>
</table>

## EXCELLENT SERVICE

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>Nov-07</th>
<th>FY2007 Target</th>
<th>FY '07 Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction - Adult</td>
<td>81.7</td>
<td>82.0</td>
<td>82.0</td>
<td>83.9</td>
<td>Current UHC 75th percentile</td>
</tr>
<tr>
<td>Patient Satisfaction - Adult ETC</td>
<td>81.7</td>
<td>82.9</td>
<td>83.5</td>
<td>85.0</td>
<td>Current UHC 90th percentile</td>
</tr>
<tr>
<td>Patient Satisfaction - Pediatric</td>
<td>80.2</td>
<td>81.2</td>
<td>85.3</td>
<td>82.9</td>
<td>Current UHC 75th percentile</td>
</tr>
<tr>
<td>Patient Satisfaction - Pediatric ETC</td>
<td>80.2</td>
<td>81.2</td>
<td>81.3</td>
<td>82.9</td>
<td>Current UHC 75th percentile</td>
</tr>
</tbody>
</table>

## EXCEPTIONAL OUTCOMES

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>Nov-07</th>
<th>FY2007 Target</th>
<th>FY '07 Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed/Expected Mortality Ratio</td>
<td>0.77</td>
<td>0.71</td>
<td>[D]</td>
<td>less than 1.0</td>
<td>UHC Benchmark Group</td>
</tr>
</tbody>
</table>

## STRATEGIC SUPPORT

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>FY2005 Actual</th>
<th>FY2006 Actual</th>
<th>Nov-07</th>
<th>FY2007 Target</th>
<th>FY '07 Benchmarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Per Adjusted Discharge</td>
<td>$8,941</td>
<td>$8,796</td>
<td>$8,822</td>
<td>$8,928</td>
<td>UIHC Budget</td>
</tr>
<tr>
<td>Operating Margin</td>
<td>3.03%</td>
<td>3.72%</td>
<td>4.90%</td>
<td>3.40%</td>
<td>UIHC Budget</td>
</tr>
<tr>
<td>Earnings Before Interest, Taxes, Depreciation and Amortization Margin</td>
<td>10.63%</td>
<td>11.08%</td>
<td>12%</td>
<td>11.40%</td>
<td>UIHC Budget</td>
</tr>
<tr>
<td>Employee Vacancy Rate</td>
<td>2.00%</td>
<td>2.32%</td>
<td>not yet available</td>
<td>3.00%</td>
<td>Internal</td>
</tr>
</tbody>
</table>

**CMI adjusted**

[A] FY '06 actual subject to change by IHA for missing data, CY 2005 Market share was 7.1%


[C] Trended Annual Projection from November 2006 fiscal YTD actuals: Acute admissions: 11,494; Clinic visits (UIHC only): 287,028; Clinic Visits (outreach and CMS): 74,284; EBITDA margin: 11.99%

[D] Due to data availability, mortality will not change until new quarter information is available
Iowa Hospital Association PricePoint

Donna Katen-Bahensky
Director and Chief Executive Officer

Dan Rieber
Interim Associate Director and Chief Financial Officer
Iowa Hospital PricePoint

- Iowa hospitals are voluntarily publicizing hospital charge information via the Iowa Hospital Association website through an internet based program entitled PricePoint

- Data is customized for IHA & Iowa hospitals utilizing data from:
  - IHA Hospital Statewide Inpatient Discharge Data Base
  - Audited financial data reported by Iowa hospitals on the AHA Annual Survey of Hospitals
  - Inpatient discharges for hospitals from July, 2005 to June, 2006

- Goal of Pricing Transparency
  - To provide consumers with useful information about hospital and other health care prices on a comparative basis across the various service provided

- Access to Information
  - Launched publicly on January 10, 2007
  - Located on the Iowa Hospital Association website (www.ihaonline.org) – under Iowa Hospital PricePoint banner
  - Data is updated quarterly in order to represent a rolling 12 months
  - Data displayed will have been severity of illness adjusted utilizing the 3M All Patient Refined DRGs (APR-DRGs) methodology
Iowa Hospital PricePoint

• Who will use PricePoint?
  – Access to PricePoint information is available to anyone at no cost
  – Initial audience
    • Public policy makers
    • Journalists
    • Employers/payors
    • Individuals for whom a hospital's actual charge factors into the amount they must pay
  – IHA expects that as the health insurance market evolves, hospital charges will be increasingly relevant to consumers
Iowa Hospital PricePoint

• What is a “Charge”?
  – “Charge” is the amount the facility bills for a patient’s care; this is not the same thing as “expected payment”, the amount paid, or the actual cost
  – The hospital charge does not include professional fees such as those for the physician’s or surgeon’s services
  – In the majority of cases, hospitals are paid considerably less than the billed amount

• Examples of why hospitals do not receive billed charges:
  – Government programs such as Medicare, Medicaid, and Hawk-I determine the amount programs will pay and hospitals have no ability to negotiate reimbursement for government-paid services
  – Commercial insurers and other purchasers usually negotiate discounts on behalf of the patients they represent
  – Hospitals have policies that allow low-income persons to receive reduced-charge or free care
Iowa Hospital PricePoint (cont’d)

• What Consumers will find on PricePoint:
  – Pricing and Utilization
    • Discharges
    • Average length of stay
    • Average charge per day
    • Median charge
    • Comparison with all Iowa hospitals in a particular Medicare payment classification
    • Comparison with all Iowa hospitals with similar net patient revenue
    • Comparison with up to 4 personally selected hospitals

• What Consumers will NOT find on PricePoint:
  – Charge data indicative to the prices consumers will actually pay for services – Consumers need to contact insurers or individual hospitals regarding specifics of healthcare coverage
  – Quality and safety data - Although a link will be provided to Iowa Healthcare Collaborative (www.ihconline.org) for those who would like to review quality and safety data
  – A perfect system – Enhancements will be made over the next year including the addition of selected charge data for ambulatory surgeries
Iowa Hospital PricePoint (cont’d)

Caveats for pricing are necessary because issues surrounding hospital pricing remain complex and difficult for many consumers to understand. Prices vary based on several factors including:

- Payor mix
- Facility cost structures
- New technology
- Staffing costs
- Intensity of care
- Range of services provided
- Documentation
- Capital expenses
- Cost of charity care and community benefit provided
- Payments mandated by different insurance companies, health plans, and government payors
Iowa Hospital PricePoint (cont’d)

IHA has identified several indicators that need to be explored before the complete spectrum of pressures influencing prices can be fully evaluated by the public including:

• State and Federal underpayment for services
  – nearly 60% of patient care delivered in Iowa hospitals falls under either Medicare or Medicaid and Iowa receives one of the lowest reimbursement rates in the nation

• Role of payor community
  – consumers are more interested in out-of-pocket costs because traditional insurance usually covers most of the cost for hospital care

• Role of other healthcare providers
  – hospitals want to respond to the needs of individuals beyond those of traditional insurance coverage

• Transparency in the vendor community
  – many costs related to hospital pricing are beyond the hospitals control – i.e. pharmaceuticals & medical devices
IowaCare Update

Donna Katen-Bahensky
Director and Chief Executive Officer

Stacey Cyphert
Special Advisor to the President,
Special Advisor to the Dean of CCOM,
Senior Assistant Hospital Director
IowaCare & Chronic Care Enrollment (net of disenrollments)

YTD FY 07 average enrollment per month = 16,512
FY 06 average enrollment per month = 12,994
Even with declining trend in FY 07, enrollment remains 3,518 greater per month on average than FY 06.
These patients account for 26,404 visits.

21 counties already ≥ 100% of FY 06 unique patients:
- 7 90-99%
- 22 80-89%
- 22 70-79%
- 11 60-69%
- 7 50-59%
- 5 40-49%
- 3 30-39%
- 1 20-29%

Total includes patients whose residence appears to be outside Iowa. It also includes patients for whom a claim has not yet been submitted to DHS.

BOR UIHC COMM 011707
FY 07 IowaCare Volume at UI Hospitals and Clinics Remains Brisk

- Nearly 7,900 unique patients were seen at the UI Hospitals and Clinics in all of FY 06 so the roughly 6,300 seen YTD means have already seen 80% of the FY 06 unique patient volume in the first 6 months of FY 07.

- FY 07 funding for IowaCare at the UI Hospitals and Clinics is the same as was originally set for FY 06 (and this amount proved insufficient).

- UI Hospitals and Clinic staff have had informal discussions with Department of Human Services staff regarding UIHC’s projected FY 07 IowaCare reimbursement needs at Medicaid reimbursement rates given current trends. Even with the carryover from FY 06, it appears current FY 07 funding will be insufficient for the entire year so adjustments to the funding, eligibility, and/or benefit package will need to be made.
IowaCare is NOT an Entitlement

441--92.14(249A,81GA,ch167) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). **When funds are expected be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited** to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) Suspension of enrollment. To ensure equitable treatment, **applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year.** “First-come, first-served” status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) Enrollment for limited services. **Eligibility or payment for services received cannot be approved beyond the amount of funds available.** Because funds are limited, applications may be approved for a reduced scope of services.
Medical Assistance Projections & Assessment Council in Limbo

- **Charge:** Make quarterly cost projections for the Medicaid Program and the expansion population authorized pursuant to 2005 Iowa Acts, HF 841; review quarterly reports on all initiatives under Code chapter 249J, including those provisions in the design, development, and implementation phases, and make additional recommendations for Medicaid Program and expansion population reform on an annual basis; review annual audited financial statements relating to the expansion population submitted by the providers included in the expansion population provider network; review quarterly reports on the success of the Iowa Medicaid Enterprise based upon the contractual performance measures for each Iowa Medicaid Enterprise partner; and **assure that the expansion population is managed at all times within funding limitations.** In assuring such compliance, the council shall assume that supplemental funding will not be available for coverage of services provided to the expansion population.

- New leadership and membership have not yet been determined (Co-Chairs Senator Maggie Tinsman and Representative Danny Carroll were both defeated in the recent election).

- No future meetings are currently scheduled.
UI Hospitals and Clinics’ Pilot Pharmaceutical and Durable Medical Equipment Programs Are Serving Patients

- August 14, 2006, the UIHC implemented pilot programs sans reimbursement to facilitate IowaCare beneficiary access to pharmaceuticals and durable medical equipment.
- Through the end of December, 2006:
  - Over 36,000 prescriptions have been filled at a cost for drugs, labor and shipping of approximately $1.24 M.
  - Over 3,000 DME items have been provided at a cost in excess of $122,000.
- The pilot programs have been committed to for FY 07 – a decision regarding what is to happen beginning FY 08 needs to be made in the near future so that sufficient time remains for affected parties to be informed and plan accordingly.
IowaCare Now Covers Certain Prescription & Non-Prescription Smoking Cessation Drugs

- Nicotine replacement product coverage includes:
  - Generic bupropion sustained-release products that are FDA-indicated for smoking cessation.
  - Over-the-counter nicotine replacement patches and gum, with prior authorization.
    - Nicotine gum 2 mg, 4 mg
    - Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day

- Funding is to come from the health care transformation account.

- UI Hospitals and Clinics is still awaiting details from DHS regarding exactly how this coverage will work.

Source: ARC 5284B, ARC 5536B and various communications with Jennifer Vermeer, Assistant Medicaid Director in Iowa.
DHS Has Submitted a Request to Amend the IowaCare Waiver to Permit Comprehensive Medical Exams

- Seeking permission to pay at Medicaid rates for an annual physical exam provided to an IowaCare beneficiary by a network or non-network provider.

- One of the six codes (see below) has been proposed to be used along with a V70 (General Medical Exam) diagnosis code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient: <strong>expanded</strong> history/physical</td>
</tr>
<tr>
<td>99203</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient: <strong>detailed</strong> history/physical</td>
</tr>
<tr>
<td>99204</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient: <strong>comprehensive</strong> history/physical</td>
</tr>
<tr>
<td>99212</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient: <strong>problem-focused</strong> history/physical</td>
</tr>
<tr>
<td>99213</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient: <strong>expanded</strong> history/physical</td>
</tr>
<tr>
<td>99214</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient: <strong>detailed</strong> history/physical</td>
</tr>
</tbody>
</table>
Proposing providers may also bill for the lab tests below, payable at Medicaid rates.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>81000</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy.</td>
</tr>
<tr>
<td>81001</td>
<td>Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, with microscopy.</td>
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<tr>
<td>82465</td>
<td>Cholesterol, serum or whole blood, total.</td>
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<tr>
<td>82947</td>
<td>Glucose; quantitative, blood (except reagent strip).</td>
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<tr>
<td>85004</td>
<td>Blood count; automated differential WBC count.</td>
</tr>
<tr>
<td>85025</td>
<td>Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC counts.</td>
</tr>
<tr>
<td>85027</td>
<td>Complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count).</td>
</tr>
</tbody>
</table>
DHS Has Submitted a Request to Amend the IowaCare Waiver to Permit Comprehensive Medical Exams (cont.)

- Proposing providers that develop a personal health action plan -- a written, individualized plan of care for the IowaCare patient -- may bill for it using the code below and will be reimbursed $20.
- It is unknown when coverage will actually start.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>99402</td>
<td>Counseling and/or risk factor reduction intervention, approximately 30 minutes.</td>
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</table>

Source: December 7, 2006 letter to James Scott and Lane Terwillager in the Centers for Medicare and Medicaid Services from Kevin Concannon, Director of the Iowa Department of Human Services.
State Institution Patients
The Cost of Providing Free Care to Residents of State Institutions is Significant

- The UI Hospitals and Clinics provided $5.1 M in services to state institution patients in FY 06 at Medicaid reimbursement rates.
- The CCOM provided $1.4 M in services to state institution patients in FY 06 at Medicaid reimbursement rates.
- Combined, the UIHC & CCOM provided $6.5 M in services to state institution patients in FY 06 at Medicaid reimbursement rates. None of this expense was reimbursed from state sources.
- YTD FY 07 experience appears consistent with FY 06. Through December 31, 2006 the UIHC has provided approximately $2.5 M in services to state institution patients at Medicaid reimbursement rates and CCOM physicians have provided $716,000.
Total Inmates: Actual & Forecast

Growth in the prison population may lead to an increased care burden on the UIHC & CCOM.

Efforts Are Being Made to Address Costs Associated with Care of State Institution Patients

- This Fall an unprecedented contract was negotiated with the Department of Corrections (DOC) for payment at Medicaid rates for treatment of a specific prisoner.

- UIHC & CCOM staff have initiated discussions with DOC Medical Director Ed O’Brien and Iowa Medical and Classification Center Warden Lowell Brandt regarding ways to increase efficiency and cut costs of providing care to prisoners. Additional meetings are planned.
EPIC Update

Donna Katen-Bahensky
Director and Chief Executive Officer

Lee Carmen
Chief Information Officer, Director of Health Care Information Systems
Project Objective

The Epic Project is the delivery of a fully functional, comprehensive and integrated Clinical Information System that meets the complex clinical needs of UIHC across the continuum of care. The scope of this effort includes:

- Electronic Medication Record (EMR)
- Computerized Provider Order Entry (CPOE)
- Pharmacy, Prescription and MAR Management
- Radiology Management
- OR/Anesthesia Management
## High-Level Scope and Timeline

<table>
<thead>
<tr>
<th>Year 4</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
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**Legend**

- **Go-Live**
  - Big Bang
  - Specialty Add-Ons
  - Web Ap
  - Due Diligence to Follow

- **Shaded Section of Timeline Confirmed after 1st Quarter of Project**
Epic’s Design & Application Team
Team of experts dedicated to a successful implementation on time and within budget

Epic’s Implementation Coordinator
Client’s Project Director

Client’s Project Team
Dedicated individuals composed of experts from the following areas: clinical staff, business analysts and information systems
Methodology Overview

**Phase 0**
- Executive Education & Project Groundwork
- Groundwork Phone Call
- Project Planning & Analysis
- Project Team Defined

**Phase 1**
- Analysis Questionnaires completed
- Scope Defined
- Site Visits Completed
- Model System Variances Determined & Documented
- Customer Team attends training at Epic

**Phase 2**
- Building Model
- System Variances
- Workflow Validation Session
- Stoplight Evaluations
- Customer Completes Certification

**Phase 3**
- Red light Validation Points resolved
- Usability Labs conducted
- System Built Out

**Phase 4**
- End users trained and prepared for Go-Live
- Finalized and Tested System

**Phase 5**
- System is Live & Optimized
- Post Live Visits by Epic Design Team
- Evaluation of Platinum Scope

**Phase 6**
- Preparation for Roll-out
Business Metrics

Purpose: Measure Impact of Implementation

• 304 Metrics

• Measure
  – Pre-kick-off
  – Quarterly where possible during system build
  – On-going post implementation
Business Metrics Categories

- UIHC Report Card Parameters
- JCAHO/CMS Core Measures
- AHRQ Adult and Pediatric Patient Safety and Quality Indicators
- IHI 5 Million Lives Campaign Metrics (incorporates 100K Lives project initiatives)
- CMS PVRP (Physician Voluntary Reporting Program) Quality Ambulatory Metrics
Guiding Principles

• Patient-Centered
• Standardize Where Possible
• Use Best Practice Models When Possible
• Avoid Paralysis by Analysis
• Minimize Customization as Much as Possible
• Perfect is the Enemy of Good Enough
• Go-live is not the Final Step
• Hit Every Milestone: *De-scope before moving target deadlines*
• Be Positive and Creative
• Soon is not a Time
• Hope is not a Plan
Key Success Factors

• Go live on time,  
  even if it means simplifying scope

• Stay focused on project scope,  
  go-live is not the final step

• When less is more

• Clinical Validation =  
  accurate order sets and content

• Have fun and celebrate successes
Accomplishments to Date

- Refinement of Project Plan
- Design/Ordering Phase 1 System Hardware $8.6M
- Complete Third Party Licensing
- Licensing of Data Extraction / Loading Tools, Data Query Tools for Clinical Data Warehouse
- 9 Epic Sessions on Site
- 48 Staff Have Attended 108 Epic Courses
Community Benefit Survey

Donna Katen-Bahensky
Director and Chief Executive Officer
Background of Community Benefit

• Some nonprofit hospitals receive various tax exemptions from federal, state, and local governments with the expectation that, in return, they will provide benefits to the community

• The tax exemptions nonprofit hospitals receive allow them to use funds that would have been paid in taxes for patient care or other purposes

• Nonprofit hospitals tend to:
  – Provide more uncompensated care
  – Provide care to a greater percentage of Medicaid patients
    • Government hospitals have a 27% Medicaid share vs. the 17% Medicaid share found in other nonprofit organizations
  – Provide services and care that are unprofitable
Community Benefit Survey

• IHA Hospital Community Benefit Survey and Report is a voluntary effort taken by IHA to collect information about the benefits Iowa hospitals return to their communities.

• Community Benefits are programs and services that address identified community health needs, regardless of source or availability of payment, and provide measurable improvement in health care access, health status, and the use of health care resources.

• Community Benefits go beyond direct, mission-driven patient care activities and support one or more of the following:
  – Community-based mission
  – Problems of the poor or medically underserved
  – Health status of the identified community
  – Community health costs
  – Entire target community regardless of ability to pay
  – Partnerships within the community
Community Benefit Criteria

Community benefits are not provided for marketing or promotional purposes and must meet at least one of the following criteria to be considered:

- Generates a low or negative margin
- Responds to needs of special populations
- Supplies services/programs that would likely be discontinued, or provided by another not-for-profit organization, if the decision made was purely financial
- Responds to public health needs
- Involves education or research that improves overall community health
Community Benefit Categories

• Charity Care
• Government-Sponsored Health Care
• Community Benefit Services
  – Community Health Improvement Services
    • Education
    • Clinical Services
    • Support Services
  – Health Professions Education
    • Physicians/Medical Students
    • Nurses/Nursing Students
    • Scholarships/Funding for Professional Education
  – Subsidized Health Services
  – Financial and In-Kind Contributions
  – Community-Building Activities
  – Community Benefit Operations

*** Research and Teaching – Academic Teaching Hospitals have not included the education and research contributions they make when compiling information on community benefit but are looking for methods to accurately reflect that data for future surveys
Ambulatory Care Standards

Donna Katen-Bahensky
Director and Chief Executive Officer

Craig Syrop, MD
Chief Medical Officer of the University of Iowa Physicians
Driving Force

• Common Strategic Goal
  – UIHC
    • Innovative Care
      – Goal #1, Strategy 1.1, tactic a
  – CCOM
    • Inpatient and Ambulatory Care Delivery
      – Strategy #1, C, ii
Standards of Excellence Steering Committee

Co-Chairs
Linda Everett, PhD
Associate Director and Chief Nursing Officer
Craig Syrop, MD
Chief Medical Officer of the University of Iowa Physicians

- Physicians
  Teresa Brennan, MD
  Keith Carter, MD
  Janet Schlechte, MD
  Mike Shasby, MD
  Steve Wolfe, MD
  Eric Dickson, MD
  Mark Iannettoni, MD
  Ellen Lind, MD

- Staff
  Kim Chamberlain
  Joelle Jensen
  Jody Kurtt
  Sabi Singh
  John Swenning
Committee Charge and Process

• Develop New Standards of Excellence with the following components:
  – Long term and short term goals
  – Specific objectives
  – Measurable criteria for success
  – Mapped on a score card dashboard

• Process
  – Interviewed patients, faculty, staff
    • Patient Family Advisory Councils of CHI and UIHC
  – Iterations of drafts to individual Clinic Leadership Teams for feedback, 100% response rate
  – Many debates in steering committee
  – Benchmarking with other institutions, MGMA, ACHE, AAACN, UHC and a very thorough literature review
  – All led to a set of standards divided into 3 categories
Ambulatory Standards of Excellence

1. Pre-Clinic visit
   • Patients will have access to the service of their choice at the date and time of their choosing.
   • Clinic telephone will be answered within 20 seconds.
   • All new patients will be provided a standardized and comprehensive instructional letter.
   • Clinic cancellation will follow policy set forth by the University of Iowa Physicians.
Ambulatory Standards of Excellence

2. Clinic Visit

- Check in will occur within 5 minutes after patient’s arrival in the clinic.
- The UIHC, UIP and CCOM do not expect clinic delays, however all unexpected clinic delays will be explained to patients at check-in, and an estimate of anticipated wait time will be given. Patient will have the option of rescheduling the appointment. Patients who choose to wait will be given a specific time to return to the clinic or provided a beeper to notify them when to return to the clinic.
- Patient with multiple appointments scheduled for the same days will be provided a print-out of their schedule for the day at their first visit.
- Patient will not wait more than a total of 15 minutes after scheduled appointment time to be escorted to the exam room.
- Patient will not wait more than a total of 15 minutes for the care provider to present in the exam room.
- All health care providers and staff will apply customer-focused communication and interpersonal skills to exceed the expectations of patients.
Ambulatory Standards of Excellence

3. **Post-Clinic Visit**
   - Communication of lab, test or procedure results to patient will occur in an appropriate and timely fashion.
   - Clinics will return patient phone calls within a timely fashion.
   - The UIHC, CCOM, and UIP will establish and maintain excellent communications with referring physicians.
   - 95% of all Electronic Medical Record documentation will be completed in 7 days.
   - Patient will understand health care choices and instructions for treatment.
Measuring Results

• Press-Ganey for Ambulatory Clinics
  – Currently in first round of data collection; first set of results available in February, 2007 for the 2nd quarter of FY07
  – Benchmark against similar institutions in order to compare UIHC scores to the mean and best practice performances
  – Example: ER current usage of Patient Satisfaction scores to assist in driving changes in processes, procedures and incentive plans

• Internal Reports
  – Most of the metrics set forth are based on existing reports
<table>
<thead>
<tr>
<th>Standards of Excellence Dashboard</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Visits</strong></td>
</tr>
<tr>
<td><strong>Total Encounters</strong></td>
</tr>
<tr>
<td><strong>Total Billing Visits</strong></td>
</tr>
<tr>
<td><strong>New Visits</strong></td>
</tr>
<tr>
<td><strong>Return Visits</strong></td>
</tr>
<tr>
<td><strong>No Shows</strong></td>
</tr>
<tr>
<td><strong>No Shows %</strong></td>
</tr>
<tr>
<td><strong>Appointment Availability</strong></td>
</tr>
<tr>
<td><strong># of Bumped Patients</strong></td>
</tr>
<tr>
<td><strong># of Bumped Clinic Sessions</strong></td>
</tr>
<tr>
<td><strong>Provider Schedule Availability</strong></td>
</tr>
<tr>
<td><strong>Average Lead Time (days)</strong></td>
</tr>
<tr>
<td><strong>Telephone Management</strong></td>
</tr>
<tr>
<td><strong>Call Abandonment Rate</strong></td>
</tr>
<tr>
<td><strong>Average Answer Time (seconds)</strong></td>
</tr>
<tr>
<td><strong>EMR Documentation</strong></td>
</tr>
<tr>
<td><strong>H&amp;P Signed</strong></td>
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<tr>
<td><strong>Clinical Note Dictated</strong></td>
</tr>
<tr>
<td><strong>Clinical Notes Delinquent 30-65 days</strong></td>
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<tr>
<td><strong>Clinical Notes Delinquent 60-90 days</strong></td>
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<tr>
<td><strong>RN Documentation</strong></td>
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<td><strong>Phone Documentation</strong></td>
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<tr>
<td><strong>Patient Satisfaction</strong></td>
</tr>
<tr>
<td><strong>Ability to access care provider of choice</strong></td>
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<tr>
<td><strong>Wait Time Check-in</strong></td>
</tr>
<tr>
<td><strong>Explanation of Delay</strong></td>
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<tr>
<td><strong>Schedule Provided for Multiple Apprs.</strong></td>
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<tr>
<td><strong>Wait Time Reception</strong></td>
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<tr>
<td><strong>Wait Time Exam Room</strong></td>
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<tr>
<td><strong>Explanation care provider gave about problem or condition</strong></td>
</tr>
<tr>
<td><strong>Overall rating of care received</strong></td>
</tr>
<tr>
<td><strong>Amount of time care provider spent with you</strong></td>
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<tr>
<td><strong>Concern care provider showed for your questions or worries</strong></td>
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<tr>
<td><strong>Information care provider gave you about medications</strong></td>
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<tr>
<td><strong>Instructions for follow-up care</strong></td>
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<tr>
<td><strong>Ease of getting lab results</strong></td>
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<tr>
<td><strong>Promptness in returning phone calls</strong></td>
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Implementation

• Provide initial data
  – Start quarterly

• Incorporate data with results from Navigant Ambulatory Care Consultation
  Approximately 100 Expected Recommendations pertaining to:
  – Operations efficiency
  – Governance
  – Funds flow
  – Staffing models

• Provide regular updates

• Request implementation of standards become minimum performance expectation of respective Clinical Leadership Teams
  – Identify individual areas not keeping pace, review reasons for not keeping pace and expect an action plan
Next Steps

• Endorsement from various UIHC/CCOM advisory groups
  – Director’s Staff, UIP, etc.

• Establish the RACI for each standard
  – Responsible
  – Accountable
  – Consult
  – Inform

• Establish actual timelines and report back
• Roll out the new standards in ambulatory care areas
Baldrige Award

Donna Katen-Bahensky
Director and Chief Executive Officer

Debbie Thoman
Senior Assistant Director, Joint Office of Compliance
Baldrige National Quality Award

- An award to recognize quality in U.S. manufacturing and service industries, healthcare and education by focusing on improved customer value and organizational performance
- Highest level of recognition for performance excellence
- Based on 11 core values and concepts
- By developing a Baldrige mentality UIHC may gain:
  - An outside perspective that identifies strengths and opportunities for improvement; every organization is measured against the same set of criteria
  - Aligned leaders because the criteria create a single shared focus
  - Focus on highest organizational priorities due to an integrated management system that aligns excellence efforts throughout
Baldrige Criteria Purposes

Criteria are the basis for conduction of organizational self-assessments, making awards, and for giving feedback. The Healthcare Criteria have 3 roles in strengthening U.S. competitiveness

1. To help improve organizational performance practices, capabilities, and results

2. To facilitate communication and sharing of best practices information among health care organizations and among U.S. organizations of all types

3. To serve as a working tool for understanding and managing performance and for guiding organizational planning and opportunities for learning
Baldrige Core Values and Concepts

- Visionary Leadership
- Patient-Focused Excellence
- Organizational and Personal Learning
- Valuing Staff and Partners
- Agility
- Focus on the Future
- Managing for Innovation
- Management by Fact
- Social Responsibility and Community Health
- Focus on Results and Creating Value
- Systems Perspective
Baldrige Health Care Criteria for Performance Excellence Framework: 
A Systems Perspective

Organizational Profile: 
Environment, Relationships, and Challenges

1. Leadership
2. Strategic Planning
3. Focus on Patients, Customers, & Markets
4. Measurement, Analysis, and Knowledge Management
5. Human Resource Focus
6. Process Management
7. Results
Baldrige Workplan

- Basic Training for Senior Leaders
- Advanced Training for Senior Leaders
- Quarterly Visits
- Mid-Level Training
- Medical Staff Orientation
- Organization Profile
- Cultural Assessment
- Creation of Criteria Champions
- UIHC Self Assessment
- Benchmarking Visits
- Assemble First Submission
Director’s Remarks

Donna Katen-Bahensky
Director and Chief Executive Officer
Director’s Remarks

I. Child Magazine

II. Epic Implementation

III. Recruitment

IV. Site Visits
   I. JCAHO Survey for Primary Stroke Center – Feb. 2, 2007
   II. ACGME Institutional Accreditation – Continued for 5 years

V. NICU/OB Bed Additions

VI. OR Case Volume

VII. Centers of Excellence

VIII. CTSA Update
Child Magazine

• Child Magazine announced January 4th, their selection of top children’s hospitals in the nation, ranking CHI 20th

• This is the first year that Children’s Hospital of Iowa has been eligible to participate in the review

• Rankings are based on:
  – Survival rates
  – Number of complex procedures and intricate surgeries
  – Volume of research studies
  – Efforts to reduce medical errors
  – Quality and training of doctors and nurses
  – Child-friendliness
  – Support for families
  – Community involvement

• Congratulations to Dr. Michael Artman, John Brandecker, Jody Kurtt, and the faculty and staff of Children’s Hospital of Iowa!
JCAHO Surveys

• Primary Stroke Center Certification
  – February 2 (one day, one surveyor)

• Laboratory Survey
  – Unannounced
    – Point of Care and Special Functions Lab (one day, one surveyor)

• Hospital Survey
  – Unannounced
    – All programs (5 days, 6-7 surveyors)
ACGME Survey

The Accreditation Council for Graduate Medical Education

- granted UIHC “Continued Accreditation”
- Effective 10/18/2006
- Accredited for a period of 5 years
- Intervals between site visits range from 1-5 years, with the longer period indicating greater confidence in the program’s ability to provide quality education
- The Review Committee commended UIHC for demonstrated substantial compliance with requirements
NICU/OB Capacity Expansion

- **3 John Pappajohn Pavilion East**
  - Utilize two bays to provide 8 beds
  - Create a Mother/Baby Unit appearance with same level of security now present in unit

- **7 Roy Carver Pavilion North**
  - Provide 15 additional NICU beds (single patient rooms)
    - Twins could be placed in the double rooms to increase capacity
  - Create ability to have additional rooms for patient use and office functions, storage and support

- **Timeline**
  - Renovation of two bays while majority of rooms are used for patient care (Nov ’06 to May ’07)
  - Relocation of Pediatric patients to 3 JCP (May/June ’07)
  - Open short-term NICU satellite unit on 7 RCP (July ’07)
OR Increased Volumes

- OR Procedure Volume has exceeded budget with record volumes in November and December

Main and ASC Volumes Combined

<table>
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<th>2005</th>
<th>2006</th>
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<tr>
<td>November</td>
<td>1,702</td>
<td>1,742</td>
</tr>
<tr>
<td>December</td>
<td>1,613</td>
<td>1,722</td>
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- Eight days since November 20th have exceeded 90 cases, with only three days in the same time period for 2005
- November 21, 2006 set a record with 101 procedures

Thank you to the OR surgeons, faculty, and staff for their hard work and dedication!