



University of Iowa Health Care

*Presentation to
The Board of Regents, State of Iowa
October 26-27, 2011*

- Opening Remarks (Robillard)
- Impact of Medicare and GME Cuts (Robillard, Rothman)
- Operational and Financial Performance (Kates, Fisher)
- UIHC Salary & Benefit Costs—Benchmark Performance (Kates)
- Faculty Presentation: The Treatment of Children with Spinal Deformity (Weinstein)



Opening Remarks

Jean Robillard, MD
Vice President for Medical Affairs



Impact of Medicare and GME Cuts

Jean Robillard, MD
Vice President for Medical Affairs

Paul Rothman, MD
Dean, Carver College of Medicine

- A committee has been created to develop and pass a package of \$1.5 trillion in additional federal spending cuts over 10 years. Failure by Congress to enact further spending reductions at the end of this year will trigger a series of automatic cuts of as much as \$1.2 trillion.
 - If the super committee’s plan fails to become law, a 2% across-the-board spending cut will go into effect for 10 years.
- Timetable:
 - **Nov. 23:** Deadline for the committee to vote on a plan with \$1.5 trillion in deficit reduction.
 - **Dec. 2:** Deadline for the committee to submit report and legislative language to the president and Congress.
 - **Dec. 23:** Deadline for both houses to vote on the committee bill.
 - **Jan. 15, 2012:** Date that the "trigger" leading to \$1.2 trillion of future spending cuts goes into effect, if the committee's legislation has not been enacted.

- If the Sustainable Growth Rate (SGR) problem with Medicare physician payments is not fixed, and it is estimated to require \$300 B to fix, physicians across the country, including those at UI Health Care, will experience a 29.4% Medicare payment rate cut (\$9.5 M per year) starting January 1, 2012.
- If a 2% across-the-board cut comes to be, UI Health Care would experience a negative \$5.3 M annual impact just related to Medicare, exclusive of the SGR issue.

	Impact of 2% Medicare Cut
UIHC	\$4,528,000
UI Physicians	\$780,000
TOTAL IMPACT	\$5,308,000

- Since 2002, Congress has passed a series of short-term bills annually to block significant cuts to Medicare physician reimbursement.
 - The current fix is scheduled to expire on January 1, 2012.
- Absent another fix, physicians across the country will experience a 29.4% Medicare payment rate cut.
 - UI physicians will experience an annual loss of \$9.5 M in Medicare payments if this cut is implemented.
 - Few believe a cut of this magnitude will actually occur, but the solutions are not without consequences.

MedPac Plan for Repeal of the Sustainable Growth Rate

- Institutes a 10-year payment rate freeze for primary care physicians.
- \$235 billion in offsets from cuts to Medicare Part D drug plans (32%), post-acute care facilities (21%), Medicare benefits to senior citizens (14%), and hospitals (11%), among other areas (22%), to help pay for the plan.
- MedPAC's plan also calls for specialists to receive reduced payments of 5.9 percent for three straight years, followed by a 7-year payment freeze.
- Notwithstanding the hospital cuts noted above, UI Health Care modeling shows over the course of the next 10 years that about \$12 million would be lost.

2% Medicare Cut Details

Estimated Impact of Proposed Medicare Changes

Based upon FY 2011 Activity

An across-the-board 2% Medicare cut

FY 2011 (per PS&R or interim cost rpt for H, and MPV for P data)	amounts in 000's									
	Part A	Part B	Total Hospital	<2%>	UIP	UICMS	Total Physician	<2%>	Grand Total	<2%>
Physician Payments					34,275	3,292	37,567	(751)	37,567	(751)
Physician Extender Payments (PA's, NP's, etc)					1,105	344	1,449	(29)	1,449	(29)
IP MS-DRG Payments	76,123		76,123	(1,522)			-	-	76,123	(1,522)
IP Capital Payments	9,053		9,053	(181)			-	-	9,053	(181)
IP Psychiatric Unit payments	5,564		5,564	(111)			-	-	5,564	(111)
OP APC and other payments		70,662	70,662	(1,413)			-	-	70,662	(1,413)
OP renal dialysis payments		3,320	3,320	(66)			-	-	3,320	(66)
OP Psychiatric Unit payments		982	982	(20)			-	-	982	(20)
IP DSH Payments	19,383		19,383	(388)			-	-	19,383	(388)
IP IME Payments	25,036		25,036	(501)			-	-	25,036	(501)
Direct GME	5,040	2,422	7,462	(149)			-	-	7,462	(149)
Bad Debts	123	83	206	(4)			-	-	206	(4)
Organ Acquisition	7,812		7,812	(156)			-	-	7,812	(156)
Other pass thru - para med ed	468	328	796	(16)			-	-	796	(16)
Grand Total FY 2011 Medicare Pmts	148,602	77,797	226,399	(4,528)	35,380	3,636	39,016	(780)	265,415	(5,308)

Direct Graduate Medical Education (DGME) Payments

- DGME payments help compensate teaching hospitals for costs directly related to resident physicians' education, such as trainee stipends, supervising physicians' costs and benefits, and administrative costs associated with running GME programs.
- Medicare pays for its share of teaching hospitals' direct costs; the remaining DGME expenses are financed by other sources, such as commercial payors, Veterans Affairs Medical Centers, state Medicaid programs, philanthropies, and hospital and faculty practice plan revenues.
- DGME payments are based on a "per-resident amount" (PRA), which reflects a hospital's direct GME costs. This amount is then multiplied by the number of residents (up to a cap determined by the Centers for Medicare & Medicaid Services) and the hospital's ratio of Medicare inpatient days to the number of total inpatient days for all patients in the hospital.

- Shortage of physicians exists
 - Iowa has one of the lowest physician per 100,000 population ratios in the nation.
- UI Health Care already substantially subsidizes resident physician education and will be challenged to maintain current training levels if the limited support is reduced further
- Enhanced likelihood that physicians will practice in Iowa if they perform resident/fellow training in Iowa

UI Health Care Incurs Expenses for Operating Accredited Residency Programs above its Cap*

	FY 11 Amount
Revenues:	
Medicare Direct GME	\$7,462,162
Medicaid Direct GME	\$6,075,544
IowaCare Direct GME	\$0
Commercial Insurance GME	\$11,611,312
Iowa City VA Rotations - Residents	\$2,523,690
Other Rotations/Grants - Residents	\$631,335
Iowa City VA Rotations - Fellows	\$743,621
Other Rotations/Grants - Fellows	\$2,481,037
TOTAL Revenues	\$31,528,701
Expenses:	
Salaries & Fringe Benefits	\$44,155,847
Other Direct and Indirect Expenses	\$17,197,218
TOTAL Expenses	\$61,353,065
Net Profit/(Loss)**	(\$29,824,364)

*83.08 FTEs above cap.

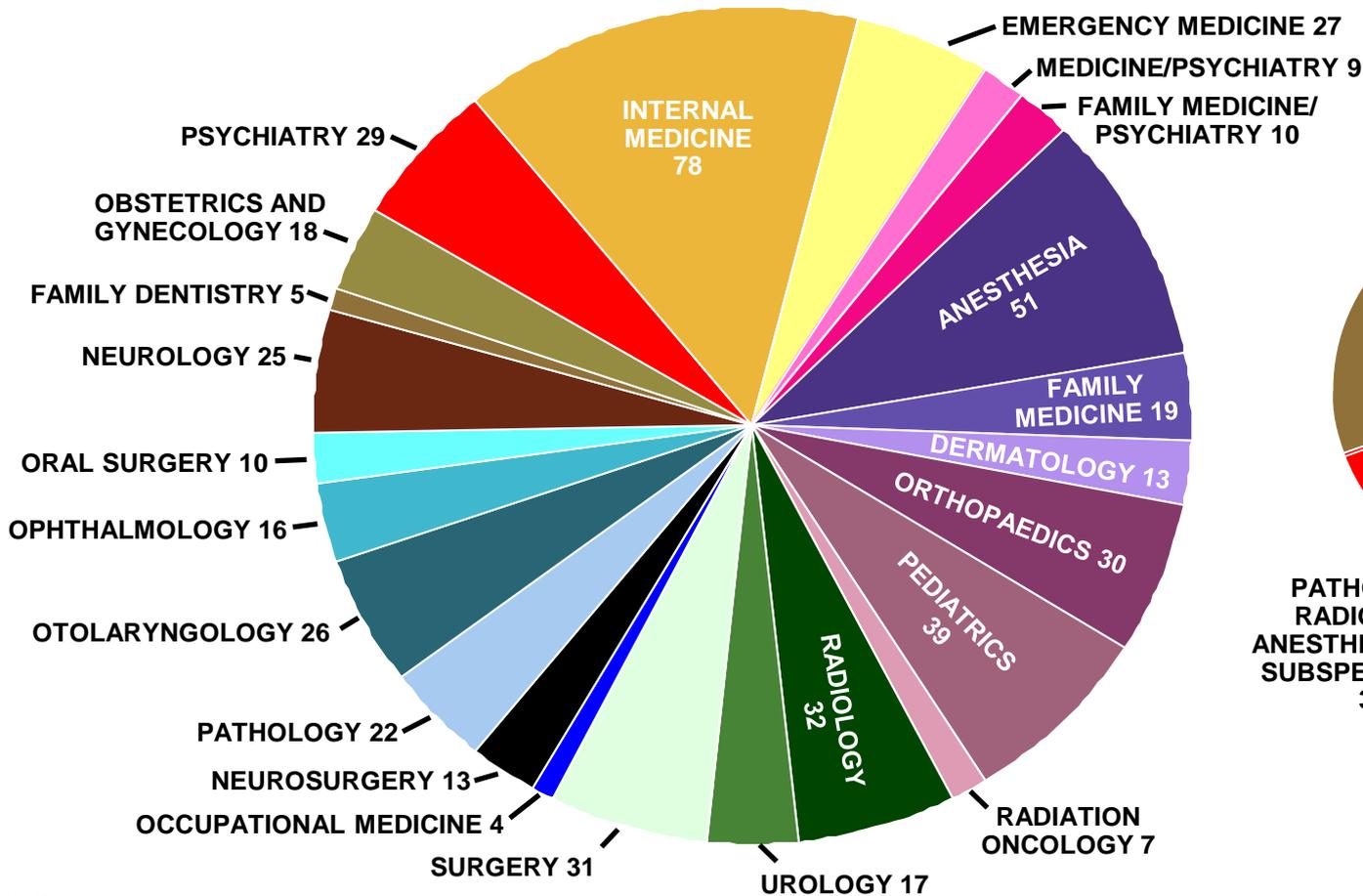
**There are inefficiencies associated with resident education but the costs, while real, are difficult to quantify and are not included here.

Sponsorship	Number	Total
UI Programs		106
Residencies	24	
Fellowships	82	
Accredited (39)		
Non-Accredited (43)		
UI-Affiliated Programs		13
Residencies	12	
Fellowships	1	
Independent Programs		4
Residencies	3	
Fellowships	1	
TOTAL		123

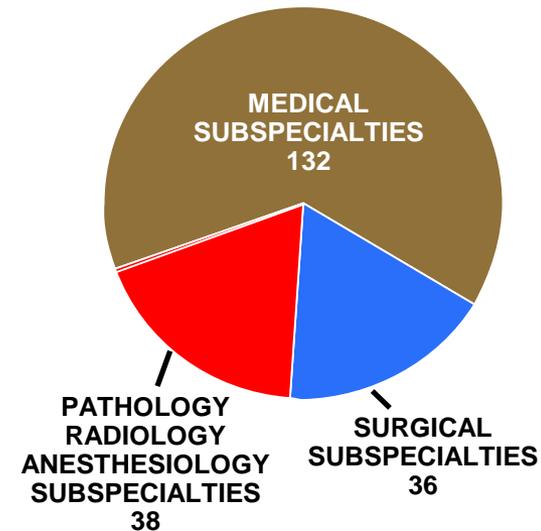
UI Health Care is directly involved with 76 of Iowa's 80 accredited training programs.

737 RESIDENT AND FELLOW DOCTORS* IN TRAINING

531 RESIDENT DOCTORS



206 FELLOW DOCTORS



*Count as of July 1, 2010



Operating and Financial Performance Update

Ken Kates, Chief Executive Officer
UI Hospitals & Clinics

Ken Fisher, Associate Vice President for Finance
and Chief Financial Officer

Volume Indicators

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Discharges	5,256	5,122	5,116	134	2.6% ●	140	2.7% ●
Patient Days	32,770	31,776	33,422	994	3.1% ●	(652)	-2.0% ○
Length of Stay	6.24	6.23	6.29	0.01	0.1% ○	(0.05)	-0.8% ○
Average Daily Census	528.55	512.52	539.06	16.03	3.1% ●	(10.51)	-2.0% ○
Surgeries – Inpatient	1,945	1,937	1,930	8	0.4% ○	15	0.8% ○
Surgeries – Outpatient	2,685	2,555	2,640	130	5.1% ●	45	1.7% ○
ED Visits	10,494	9,741	9,512	753	7.7% ●	982	10.3% ●
Outpatient Clinic Visits	149,152	148,257	141,679	895	0.6% ○	7,473	5.3% ●
Case Mix	1.7849	1.7780	1.7500	0.0069	0.4%	0.0349	2.0%
Medicare Case Mix	1.9474	1.9900	1.9714	(0.0426)	-2.1%	(0.0240)	-1.2%

 Greater than 2.5% Favorable
  Neutral
  Greater than 2.5% Unfavorable

Discharges by Type

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Adult Medical	1,770	1,759	1,762	11	0.6% ○	8	0.5% ○
Adult Surgical	2,410	2,338	2,328	72	3.1% ●	82	3.5% ●
Adult Psych	275	260	261	15	5.7% ●	14	5.4% ●
<i>Subtotal – Adult</i>	<i>4,455</i>	<i>4,357</i>	<i>4,351</i>	<i>98</i>	<i>2.3% ○</i>	<i>104</i>	<i>2.4% ○</i>
Pediatric Medical	562	520	521	42	8.1% ●	41	7.9% ●
Pediatric Surgical	12	39	38	(27)	-69.0% ●	(26)	-68.4% ●
Pediatric Critical Care	134	133	133	1	0.7% ○	1	0.7% ○
Pediatric Psych	93	73	73	20	26.7% ●	20	27.4% ●
<i>Subtotal – Pediatrics w/o newborn</i>	<i>801</i>	<i>765</i>	<i>765</i>	<i>36</i>	<i>4.7% ●</i>	<i>36</i>	<i>4.7% ●</i>
Newborn	264	254	236	10	4.0% ●	28	11.9% ●
TOTAL w/o Newborn	5,256	5,122	5,116	134	2.6% ●	140	2.7% ●

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Greater than 2.5% Favorable	Neutral	Greater than 2.5% Unfavorable

Discharge Days by Type

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Adult Medical	10,155	10,028	10,112	127	1.3% ○	43	0.4% ○
Adult Surgical	12,400	11,822	11,891	578	4.9% ●	509	4.3% ●
Adult Psych	3,050	3,064	3,099	(14)	-0.4% ○	(49)	-1.6% ○
<i>Subtotal – Adult</i>	<i>25,605</i>	<i>24,913</i>	<i>25,102</i>	<i>692</i>	<i>2.8% ●</i>	<i>503</i>	<i>2.0% ○</i>
Pediatric Medical	2,665	2,989	3,026	(324)	-10.8% ●	(361)	-11.9% ●
Pediatric Surgical	319	177	177	142	80.0% ●	16	22.5% ●
Pediatric Critical Care	3,451	3,291	3,321	160	4.9% ●	130	3.9% ●
Pediatric Psych	735	543	547	192	35.3% ●	188	34.4% ●
<i>Subtotal – Pediatrics w/o newborn</i>	<i>7,170</i>	<i>7,000</i>	<i>7,071</i>	<i>170</i>	<i>2.4% ○</i>	<i>99</i>	<i>1.4% ○</i>
Newborn	583	606	527	(23)	-3.7% ●	56	10.6% ●
TOTAL w/o Newborn	32,775	31,913	32,173	862	2.7% ●	658	2.0% ○

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Greater than 2.5% Favorable	Neutral	Greater than 2.5% Unfavorable

Average Length of Stay by Type

August 2011

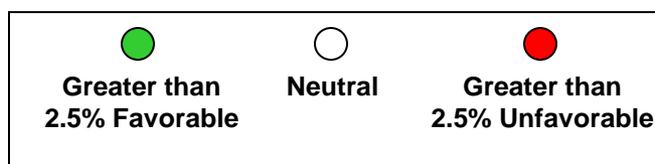
Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Adult Medical	5.74	5.70	5.74	0.04	0.6% ○	0.00	0.0% ○
Adult Surgical	5.15	5.06	5.11	0.09	1.8% ○	0.04	0.7% ○
Adult Psych	11.09	11.77	11.87	(0.68)	-5.8% ●	(0.78)	-6.6% ●
Subtotal – Adult	5.75	5.72	5.77	0.03	0.5% ○	(0.02)	-0.4% ○
Pediatric Medical	4.74	5.75	5.81	(1.00)	-17.4% ●	(1.06)	-18.3% ●
Pediatric Surgical	26.58	4.58	4.66	22.00	480.1% ●	21.93	470.7% ●
Pediatric Critical Care	25.76	24.73	24.97	1.03	4.2% ●	0.79	3.2% ●
Pediatric Psych	7.91	7.40	7.49	0.52	7.0% ●	0.42	5.6% ●
Subtotal – Pediatrics w/o newborn	8.96	9.15	9.24	(0.19)	-2.1% ○	(0.29)	-3.1% ●
Newborn	2.21	2.39	2.23	(0.18)	-7.4% ●	(0.02)	-1.1% ○
TOTAL w/o Newborn	6.24	6.23	6.29	0.01	0.1% ○	(0.05)	-0.8% ○

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Outpatient Surgeries – by Clinical Department

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Cardiothoracic	7	11	14	(4)	-38.3% ●	(7)	-50.0% ●
Dentistry	122	97	99	25	26.1% ●	23	23.2% ●
Dermatology	7	7	7	-	0.0% ○	-	0.0% ○
General Surgery	404	423	447	(19)	-4.6% ●	(43)	-9.6% ●
Gynecology	137	129	142	8	5.8% ●	(5)	-3.5% ●
Internal Medicine	3	1	0	2	498.3% ●	3	-
Neurosurgery	72	77	97	(5)	-7.1% ●	(25)	-25.8% ●
Ophthalmology	591	545	609	46	8.4% ●	(18)	-3.0% ●
Orthopedics	651	631	587	20	3.1% ●	64	10.9% ●
Otolaryngology	427	404	406	23	5.8% ●	21	5.2% ●
Radiology – Interventional	5	5	5	-	0.0% ○	-	0.0% ○
Urology w/ Procedure Ste.	259	223	227	36	16.0% ●	32	14.1% ●
Total	2,685	2,555	2,640	130	5.1% ●	45	1.7% ○



Inpatient Surgeries – by Clinical Department

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Cardiothoracic	213	191	199	22	11.5% 	14	7.0% 
Dentistry	24	21	25	3	13.0% 	(1)	-4.0% 
General Surgery	585	550	525	35	6.4% 	60	11.4% 
Gynecology	119	132	129	(13)	-10.1% 	(10)	-7.8% 
Neurosurgery	299	283	283	16	5.5% 	16	5.7% 
Ophthalmology	20	27	30	(7)	-25.8% 	(10)	-33.3% 
Orthopedics	423	465	491	(42)	-9.1% 	(68)	-13.8% 
Otolaryngology	124	128	126	(4)	-3.4% 	(2)	-1.6% 
Radiology – Interventional	18	19	19	(1)	-5.2% 	(1)	-5.3% 
Urology w/ Procedure Ste.	120	119	103	1	0.9% 	17	16.5% 
Total	1,945	1,937	1,930	8	0.4% 	15	0.8% 

Solid Organ Transplants	51	55	65	(4)	-7.3% 	(14)	-21.5% 
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Greater than 2.5% Favorable	Neutral	Greater than 2.5% Unfavorable

Emergency Department

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
ED Visits	10,494	9,741	9,512	753	7.7% ●	982	10.3% ●
ED Admits	2,818	2,640	2,548	178	6.7% ●	270	10.6% ●
ED Conversion Factor	26.9%	27.1%	26.8%		-0.9% ○		0.2% ○
ED Admits / Total Admits	54.2%	51.9%	49.7%		4.3% ●		9.0% ●

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Greater than 2.5% Favorable	Neutral	Greater than 2.5% Unfavorable

Clinic Visits by Clinical Department

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget		Variance to Prior Year	% Variance to Prior Year	
Anesthesia	2,334	2,492	2,611	(158)	-6.4%	●	(277)	-10.6%	●
CDD	1,374	1,322	1,405	52	3.9%	●	(31)	-2.2%	○
Clinical Research	1,780	1,738	2,011	42	2.4%	○	(231)	-11.5%	●
Dermatology	4,207	5,250	3,914	(1,043)	-19.9%	●	293	7.5%	●
Emergency Department	10,494	9,741	9,512	753	7.7%	●	982	10.3%	●
General Surgery	4,191	3,928	3,950	263	6.7%	●	241	6.1%	●
Heart and Vascular	6,422	6,163	6,181	259	4.2%	●	241	3.9%	●
Hospital Dentistry	2,633	2,172	2,138	461	21.2%	●	495	23.2%	●
Internal Medicine	18,311	17,566	16,242	745	4.2%	●	2,069	12.7%	●
Neurology	2,850	2,792	2,598	58	2.1%	○	252	9.7%	●
Neurosurgery	1,522	1,488	1,554	34	2.3%	○	(32)	-2.1%	○
Obstetrics/Gynecology	12,694	12,509	12,055	185	1.5%	○	639	5.3%	●
Ophthalmology	11,827	11,830	11,045	(3)	0.0%	○	782	7.1%	●
Orthopedics	10,261	9,896	9,712	365	3.7%	●	549	5.7%	●
Otolaryngology	4,956	4,651	4,568	305	6.6%	●	388	8.5%	●
Pediatrics	7,611	7,253	7,334	358	4.9%	●	277	3.8%	●
Primary Care	36,296	37,728	35,659	(1,432)	-3.8%	●	637	1.8%	○
Psychiatry	6,349	6,972	6,597	(623)	-8.9%	●	(248)	-3.8%	●
Urology	2,783	2,675	2,399	108	4.0%	●	384	16.0%	●
Other	257	93	194	164	176.8%	●	63	32.5%	●
Total	149,152	148,257	141,679	895	0.6%	○	7,473	5.3%	●

● Greater than 2.5% Favorable

○ Neutral

● Greater than 2.5% Unfavorable

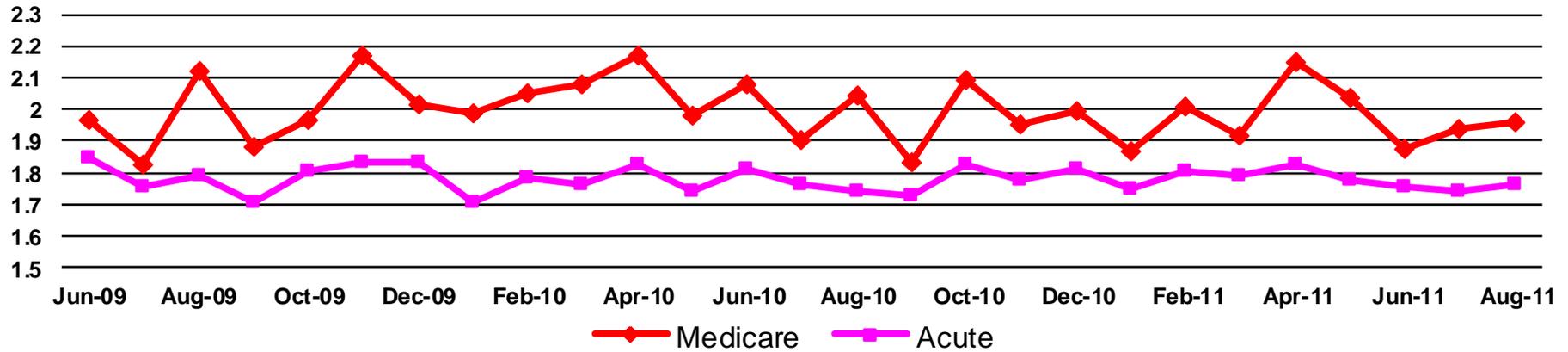
Primary Care Visits

August 2011

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Employee Health Clinic	3,127	2,775	2,744	352	12.7% ●	383	14.0% ●
Family Care Center	14,102	17,062	13,507	(2,960)	-17.4% ●	595	4.4% ●
Offsite Clinics	12,034	10,394	12,805	1,640	15.8% ●	(771)	-6.0% ●
QuickCare Clinics	3,737	3,909	3,210	(172)	-4.4% ●	527	16.4% ●
Primary Care Clinic North	3,296	3,587	3,393	(291)	-8.1% ●	(97)	-2.9% ●
TOTAL	36,296	37,728	35,659	(1,432)	-3.8% ●	637	1.8% ○

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Greater than 2.5% Favorable	Neutral	Greater than 2.5% Unfavorable

Case Mix Index



UIHC Comparative Financial Results

August 2011



Dollars in Thousands

NET REVENUES:	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Patient Revenue	\$86,858	\$87,028	\$83,367	(\$170)	-0.2%	\$3,491	4.2%
Other Operating Revenue	4,303	4,003	3,683	300	7.5%	620	16.8%
Total Revenue	\$91,161	\$91,031	\$87,050	\$130	0.1%	\$4,111	4.7%

EXPENSES:

Salaries and Wages	\$45,280	\$46,936	\$40,289	(\$1,657)	-3.5%	\$4,991	12.4%
General Expenses	37,587	35,479	35,273	2,108	5.9%	2,314	6.6%
Operating Expense before Capital	\$82,867	\$82,416	\$75,562	\$451	0.5%	\$7,305	9.7%
Cash Flow Operating Margin	\$8,294	\$8,616	\$11,489	(\$322)	-3.7%	(\$3,195)	-27.8%
Capital- Depreciation and Amortization	5,604	5,624	5,681	(20)	-0.4%	(78)	-1.4%
Total Operating Expense	\$88,471	\$88,040	\$81,243	\$431	0.5%	\$7,228	8.9%

Operating Income (Loss)	\$2,690	\$2,992	\$5,808	(\$301)	-10.1%	(\$3,117)	-53.7%
Operating Margin %	3.0%	3.3%	6.7%		-0.3%		-3.7%
Gain (Loss) on Investments	(2,167)	1,831	685	(3,998)	-218.4%	(2,852)	-416.5%
Other Non-Operating	2	(437)	(604)	439	-100.4%	606	-100.3%
Net Income	\$525	\$4,385	\$5,888	(\$3,860)	-88.0%	(\$5,364)	-91.1%
Net Margin %	0.6%	4.7%	6.8%		-4.2%		-6.2%

UIHC Comparative Financial Results

Fiscal Year to Date August 2011



Dollars in Thousands

NET REVENUES:	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Patient Revenue	\$170,032	\$173,892	\$162,646	(\$3,860)	-2.2%	\$7,386	4.5%
Other Operating Revenue	8,185	8,006	7,372	179	2.2%	813	11.0%
Total Revenue	\$178,217	\$181,898	\$170,018	(\$3,681)	-2.0%	\$8,200	4.8%

EXPENSES:

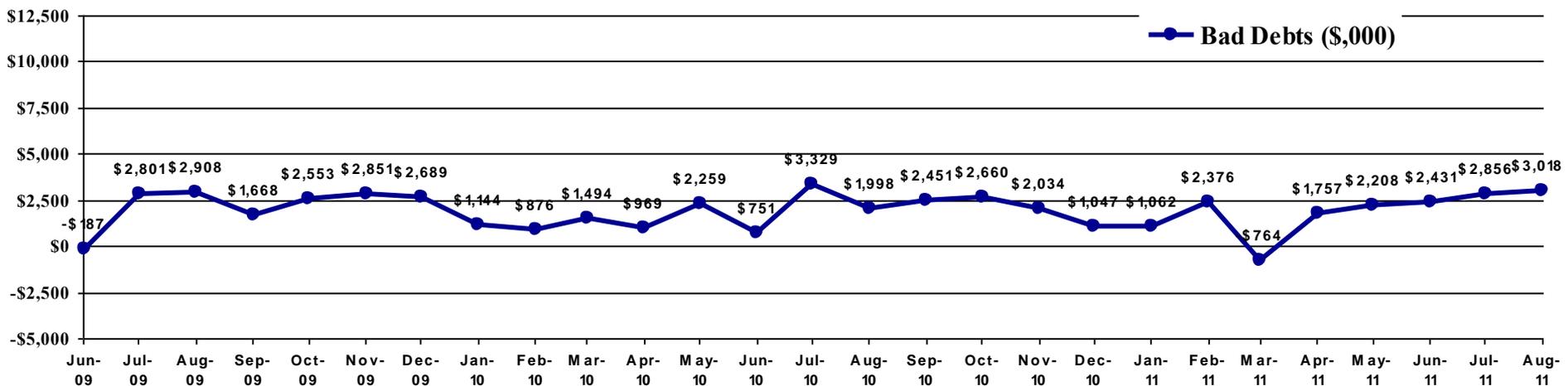
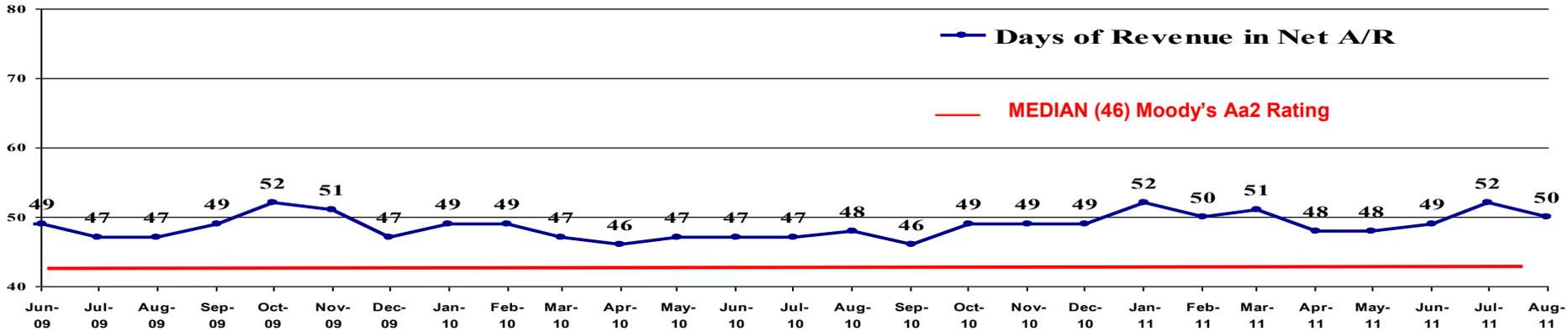
Salaries and Wages	\$90,073	\$93,589	\$79,886	(\$3,516)	-3.8%	\$10,187	12.8%
General Expenses	73,078	70,974	69,149	2,104	3.0%	3,929	5.7%
Operating Expense before Capital	\$163,151	\$164,564	\$149,035	(\$1,412)	-0.9%	\$14,116	9.5%
Cash Flow Operating Margin	\$15,066	\$17,334	\$20,983	(\$2,268)	-13.1%	(\$5,917)	-28.2%
Capital- Depreciation and Amortization	11,184	11,248	11,422	(64)	-0.6%	(237)	-2.1%
Total Operating Expense	\$174,336	\$175,812	\$160,457	(\$1,476)	-0.8%	\$13,879	8.6%

Operating Income	\$3,881	\$6,086	\$9,561	(\$2,205)	-36.2%	(\$5,679)	-59.4%
Operating Margin %	2.2%	3.3%	5.6%		-1.2%		-3.3%
Gain (Loss) on Investments	126	3,661	8,474	(3,535)	-96.6%	(8,348)	-98.5%
Other Non-Operating	(247)	(875)	(902)	628	-71.8%	655	-72.6%
Net Income	\$3,761	\$8,873	\$17,133	(\$5,112)	-57.6%	(\$13,372)	-78.0%
Net Margin %	2.1%	4.8%	9.6%		-2.7%		-7.5%

Comparative Accounts Receivable

at August 31, 2011

	June 30, 2010	June 30, 2011	August 31, 2011
Net Accounts Receivable	\$117,737,680	\$136,477,870	\$139,194,666
Net Days in AR	47	49	50





UI Hospitals and Clinics Salary and Benefit Costs – Benchmark Performance

Ken Kates, Chief Executive Officer
UI Hospitals & Clinics

UIHC FY12 Operating Budget (*)

Net Operating Revenue		
Net Patient Revenue		\$ 1,039,047
Other Operating Revenue		\$ 48,036
Total Net Operating Revenue		\$ 1,087,084
Operating Expenses		
Salary, Benefits, & Contract Labor		\$ 560,521
Supplies & Drugs		\$ 202,092
Services		\$ 91,601
Capital Expenses		\$ 30,152
Insurance		\$ 2,435
License, Fees, & Other Expenses		\$ 56,685
Administrative Services UI		\$ 32,625
Total Operating Expenses		\$ 976,111
Cash Flow Operating Margin		\$ 110,972
CFO Margin %		10.2%
Capital & Other Costs		
Total Depreciation & Amortization		\$ 67,488
Operating Income		\$ 43,484
Operating Margin %		4.0%
Non-operating Items		
Gain (Losses) Non-Operating		\$ 16,719
Net Income (Loss)		\$ 60,204
Net Income Margin %		5.5%



Salary and
Benefit Costs
Make Up 57% of
Total Operating
Costs

(*) (in 000's)



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[Calendar of upcoming events](#)

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- [Financial Performance Report](#)
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- [UHC Patient Safety Net®](#)
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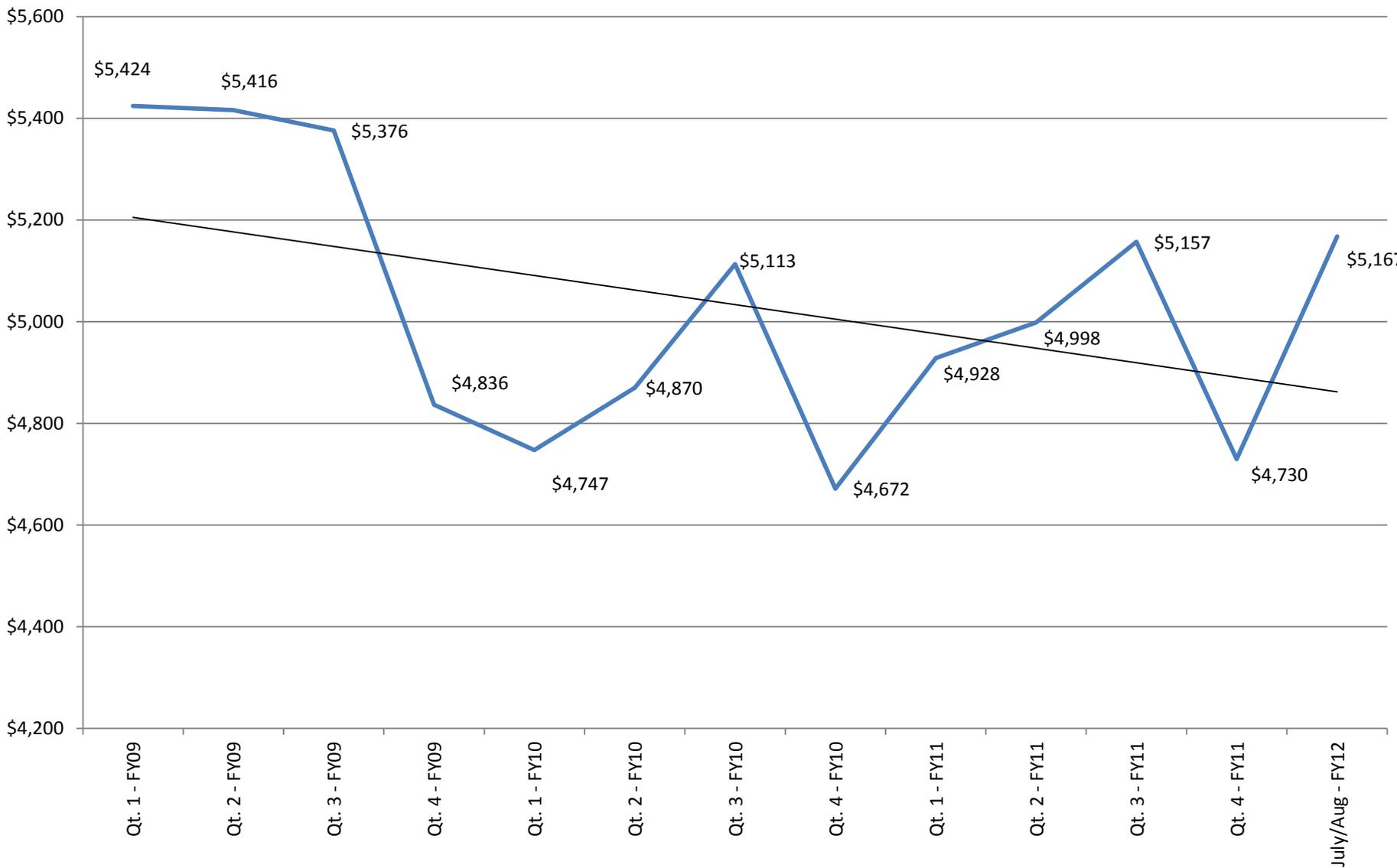
IMPROVE Performance

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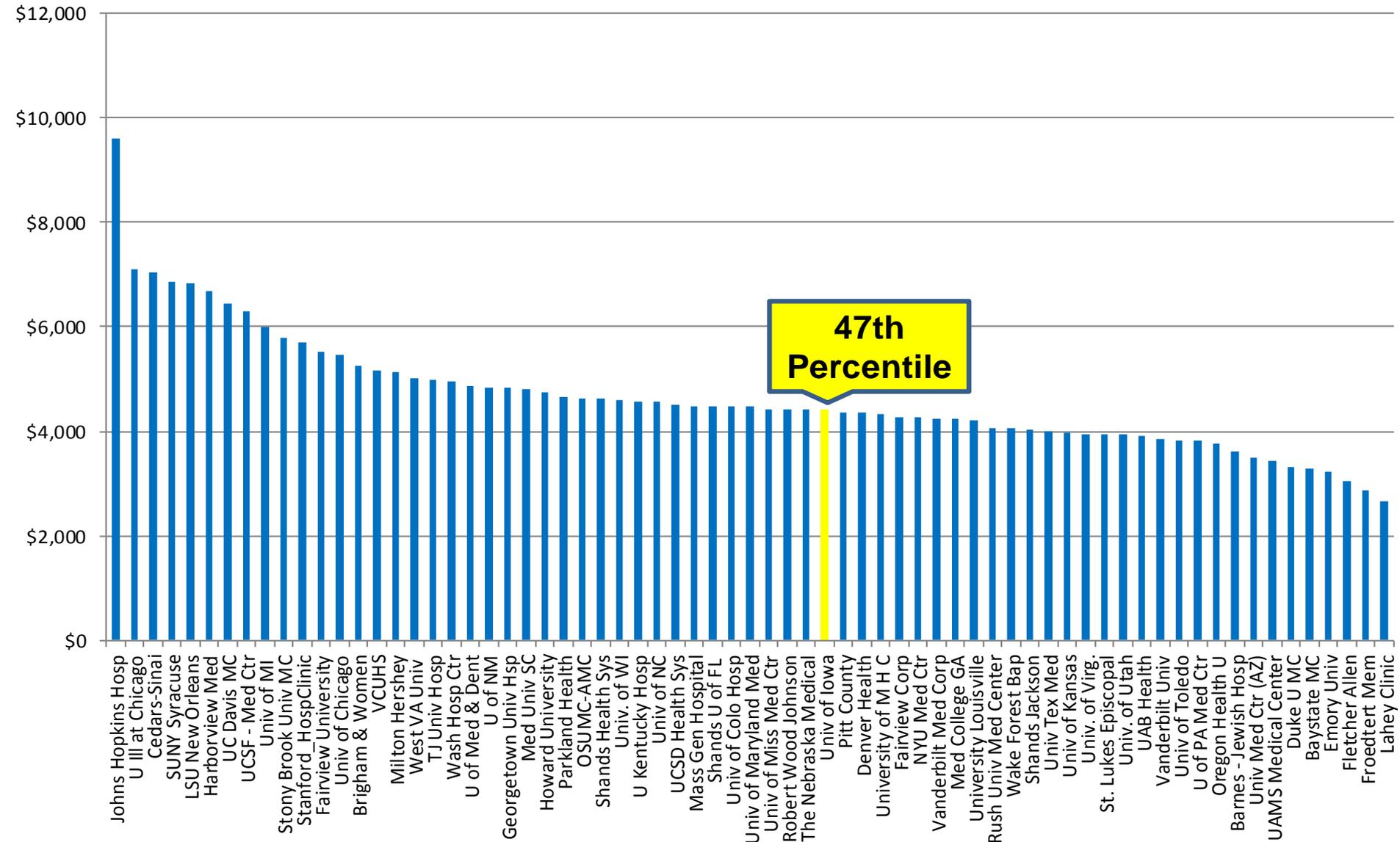
OPTIMIZE The Supply Chain

- [UHC Contracts](#)
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- [Capital Resource Program](#)
- [Emerging Technologies](#)
- [Non-Acute Purchasing Program](#)
- [Performance Excellence](#)
- [Collaborative Study \(2010\)](#)
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- [Supply Chain Data & Analytics](#)
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- [Value Analysis](#)

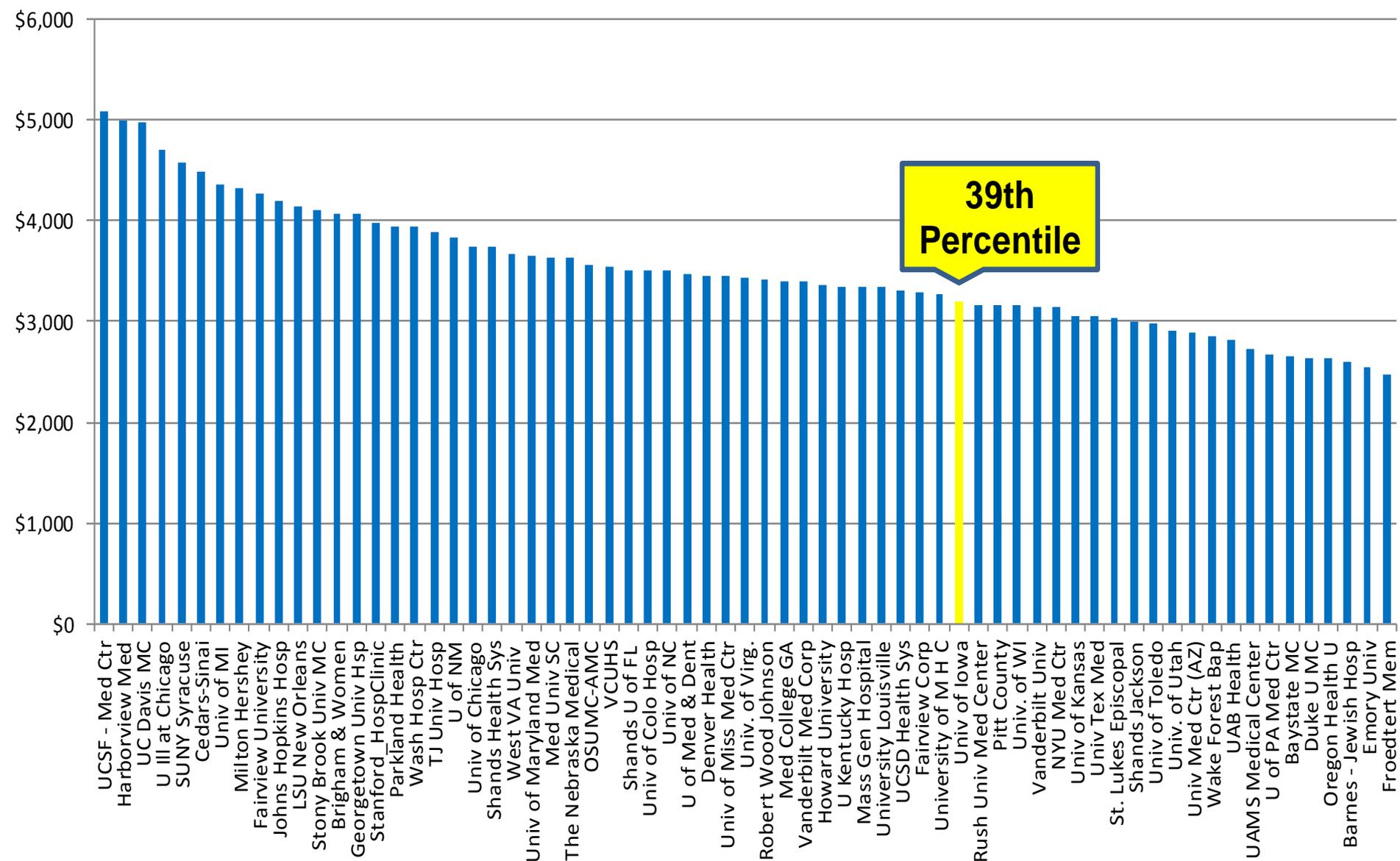
Total Salary and Benefit Expenses per Case Mix Index (CMI)- Weighted Adjusted Admission – FY09 to FY12 (July & August)



Total Labor Expenses - Area Wage Index (AWI)-Adjusted (Excluding Provider) per CMI-Weighted Discharge

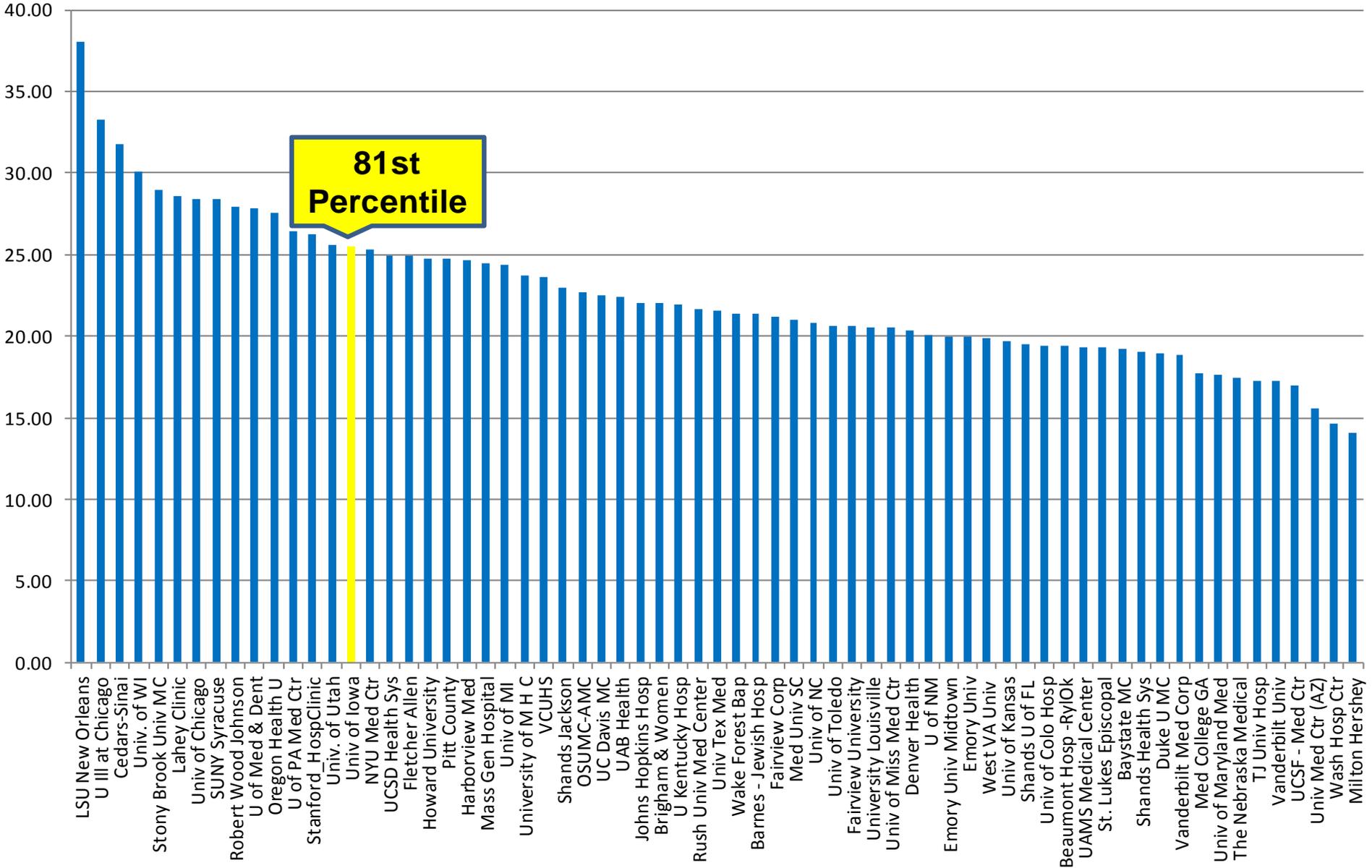


Total Staff Salary Expenses – AWI-Adjusted per CMI-Weighted Adjusted Discharge

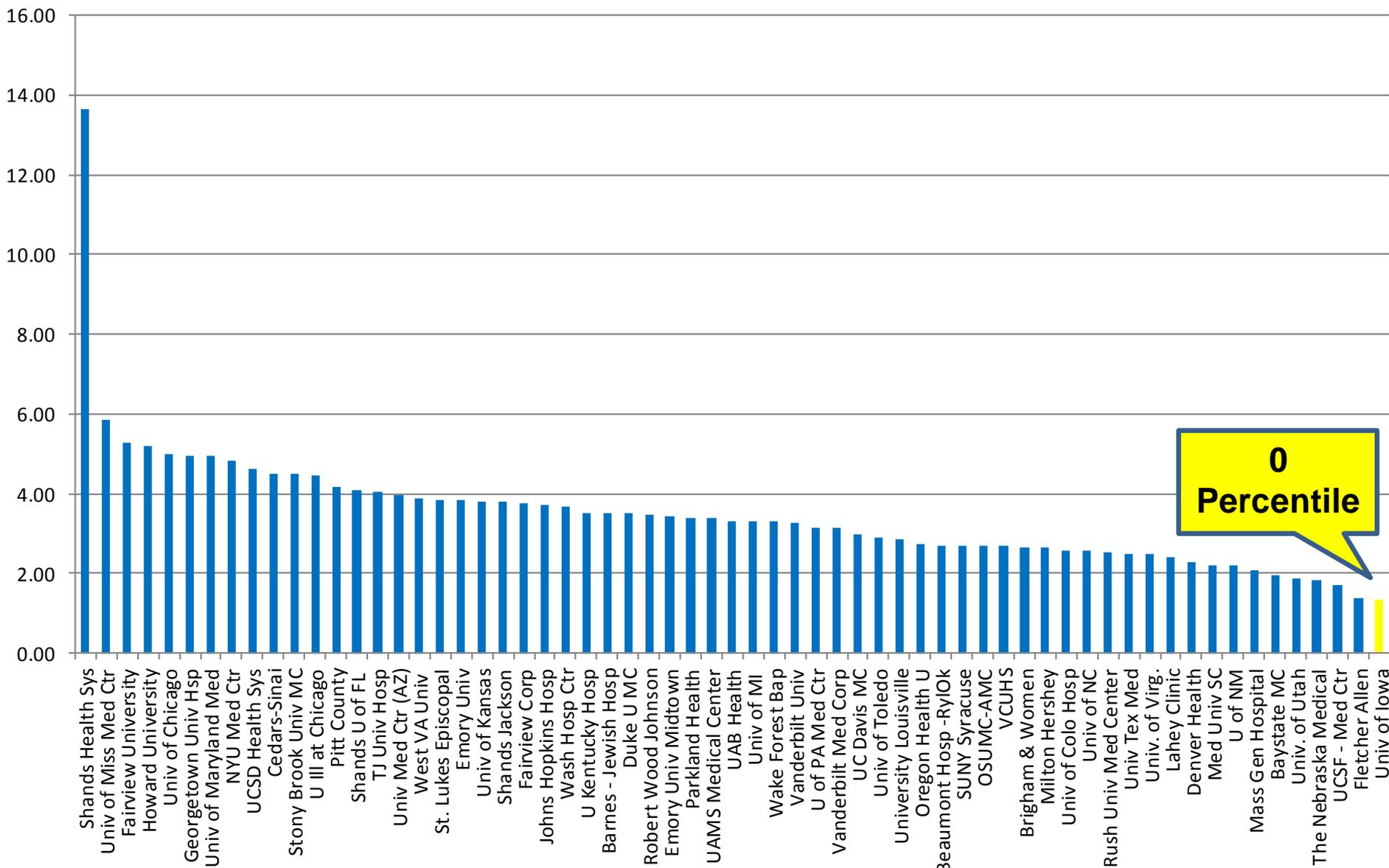


**39th
Percentile**

Benefits as % of Total Employee Labor Expense



Overtime Hours as % of Staff Worked Hours



0
Percentile



The Treatment of Children with Spinal Deformity

Stuart L. Weinstein, MD
Ignacio V. Ponseti Chair and Professor of Orthopaedic Surgery
Professor of Pediatrics

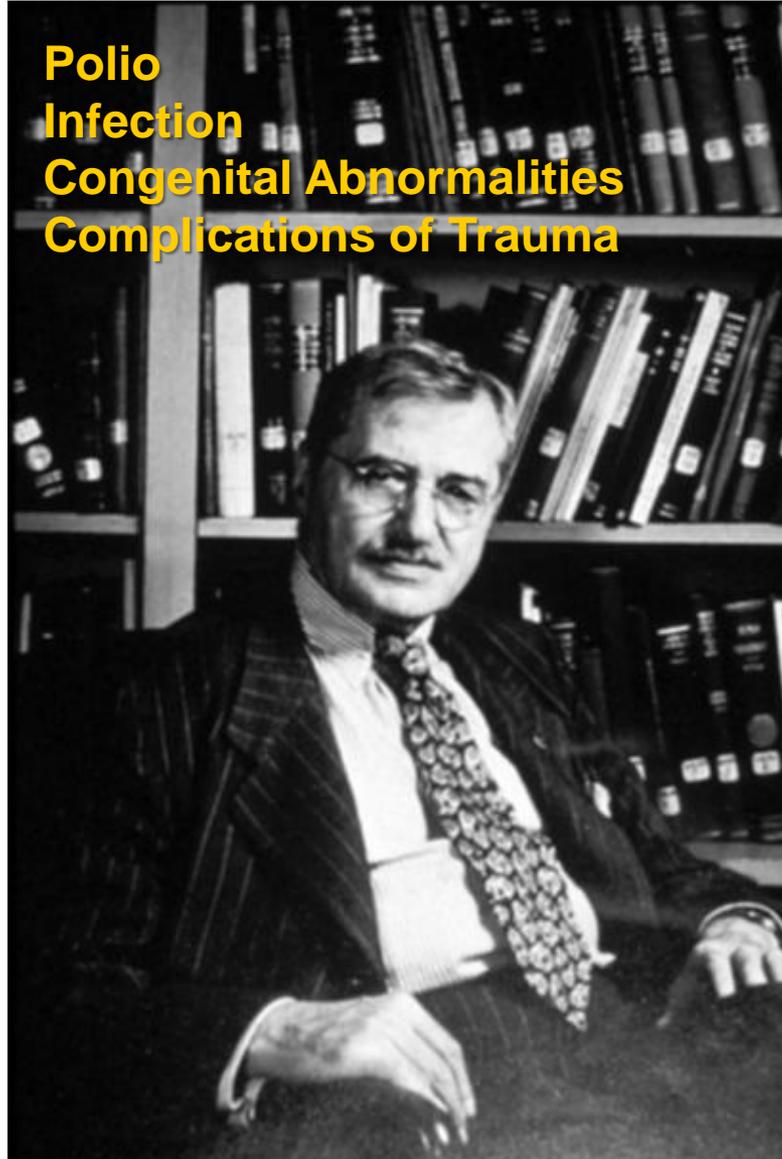


The Treatment of Children with Spinal Deformity

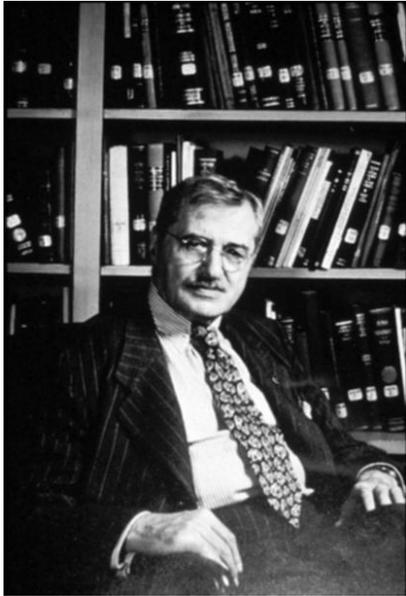
- A Service Unique to UIHC
- One of the Largest Spinal Deformity Services in the USA
- Clinical Service
- Research Program

Arthur Steindler, MD – 1913-1948

Polio
Infection
Congenital Abnormalities
Complications of Trauma

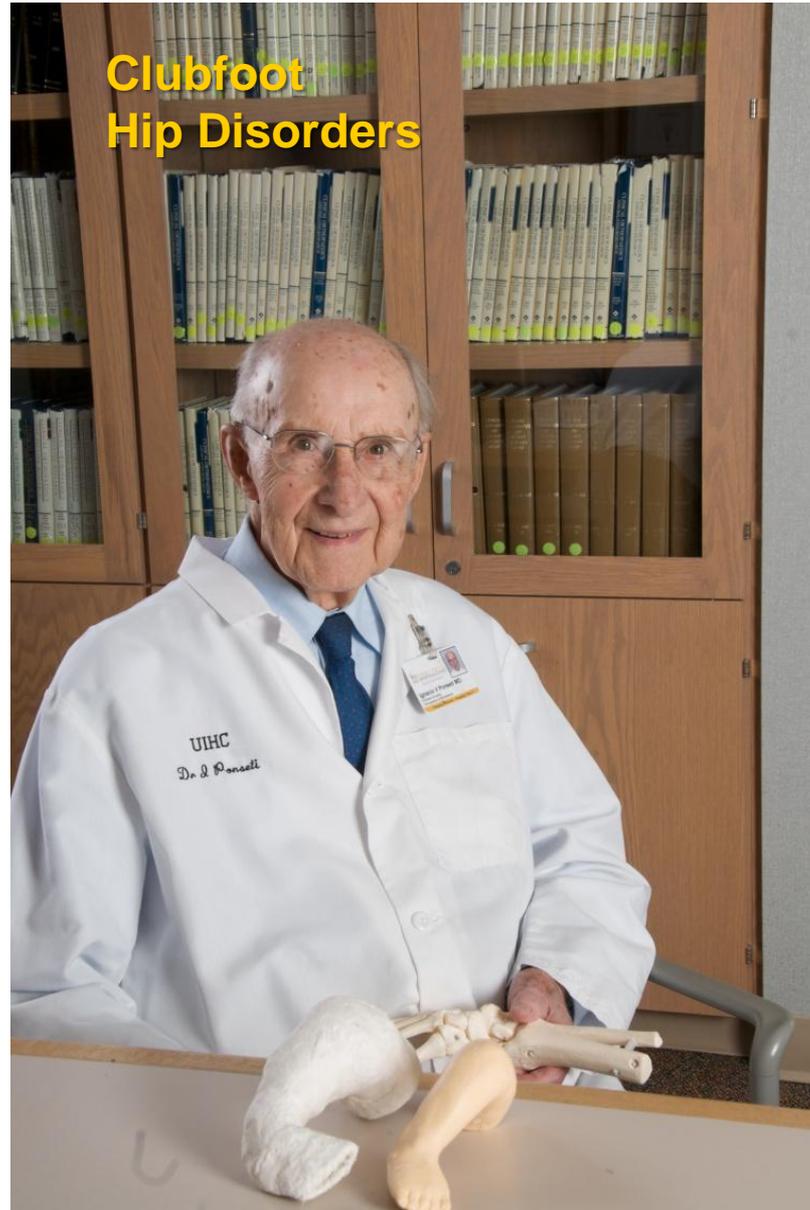


**Clubfoot
Hip Disorders**

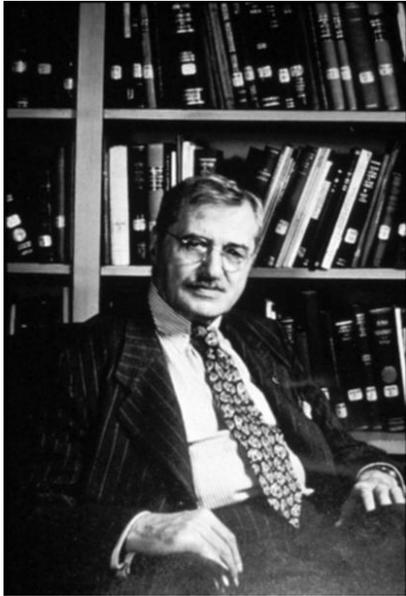


Arthur Steindler, MD

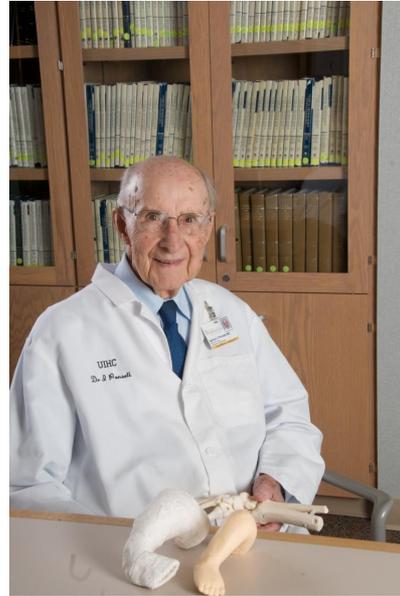
1913-1948



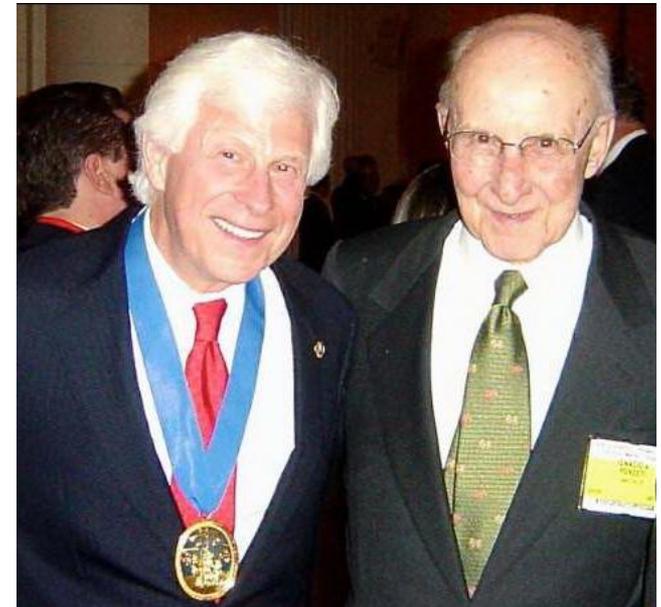
Stuart L. Weinstein, MD – 1976 - Present



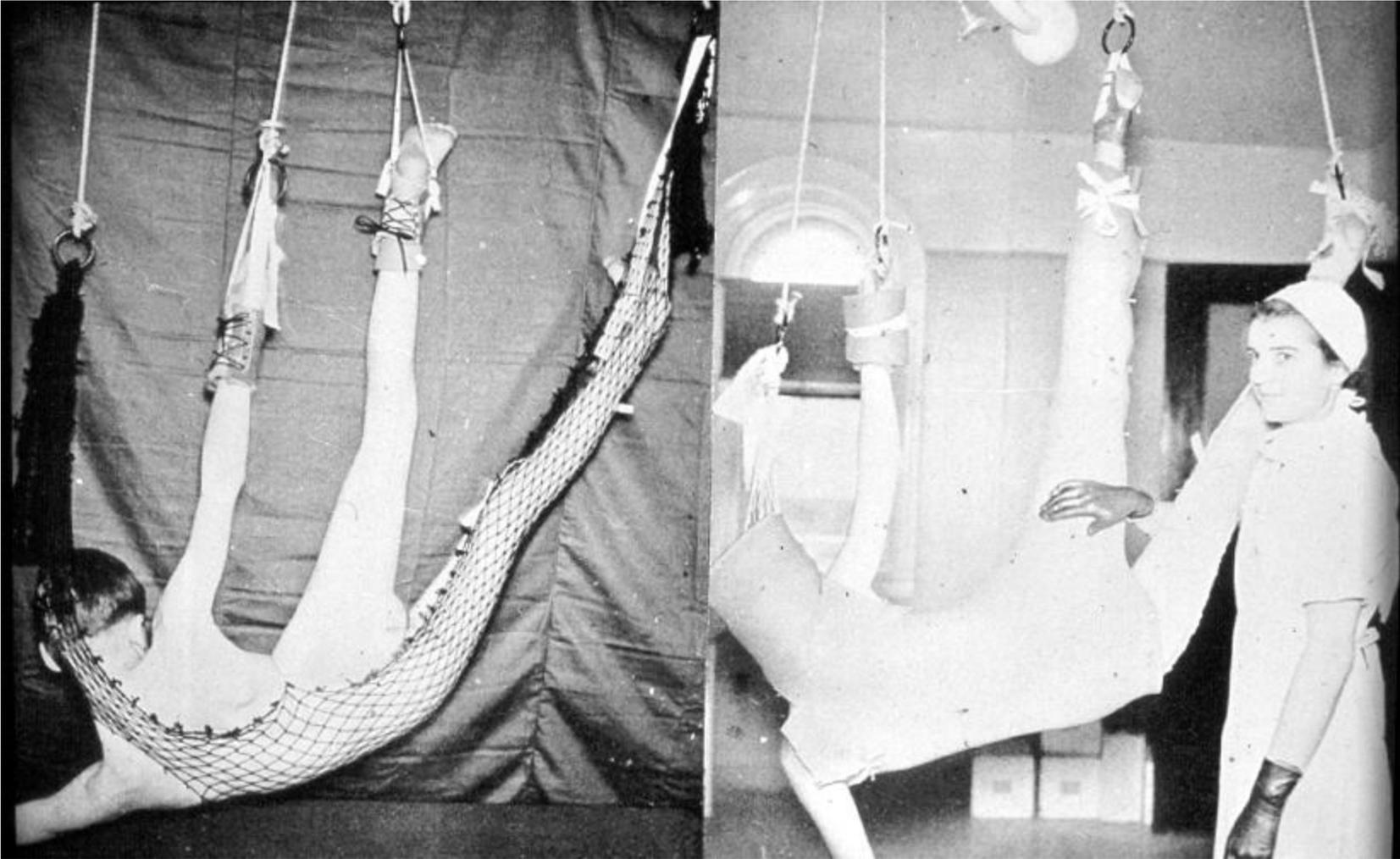
**Arthur Steindler, MD
1913-1948**



**Ignacio V. Ponseti, MD
1944-1984, 1986-2009**



Spinal Deformity Treatment



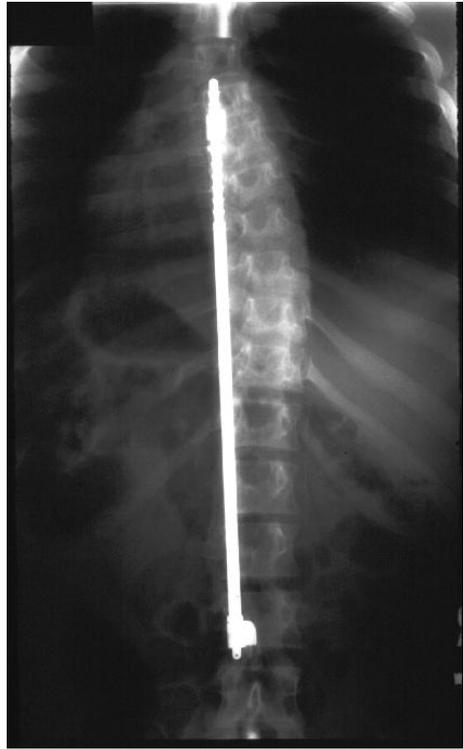
Treatment of Spinal Deformity – 1976



23 hours a day for 4-6 years



**Milwaukee Brace
1948**



**Harrington Rod
1960**



No surgical treatment at UIHC

- One of the largest programs in the country
 - Single Physician
- Comprehensive Care for All Spinal Deformities
- > 90% of all spinal surgeries in Children in Iowa

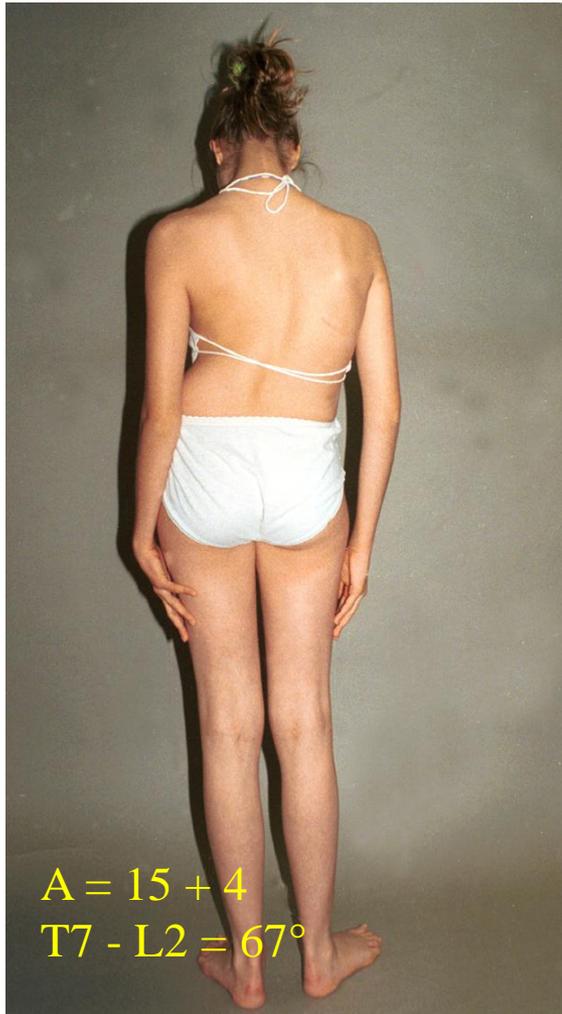
- >2000 Outpatient visits /year for spinal deformity
- >500 *new* patients /year with spinal deformity
- 2-4 surgical cases per week
- > 90% of all spinal deformity surgeries in Iowa
- 2000-3000 total surgical cases

- Isolated condition
- Associated with other conditions



Adolescent Idiopathic Scoliosis

2-3% children 10-16 years of age

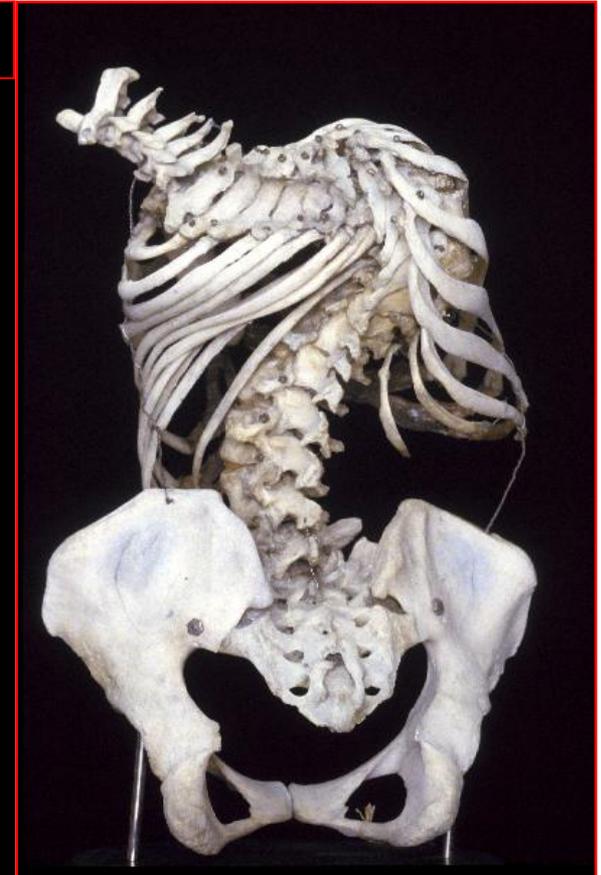
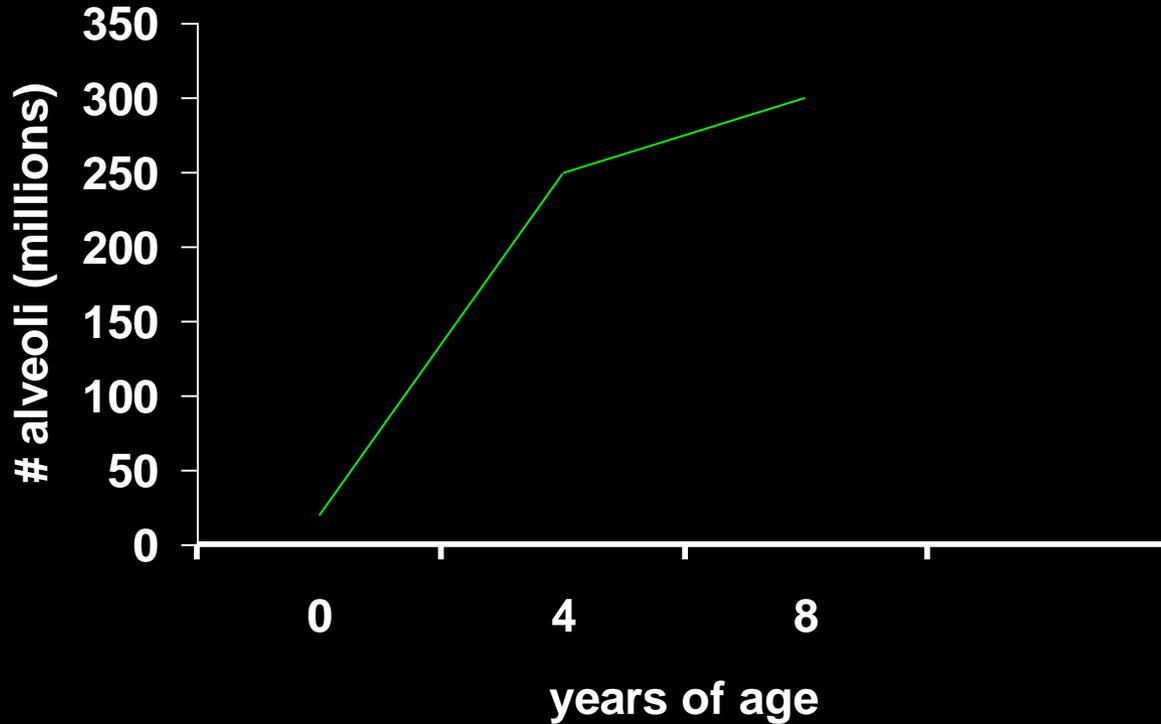


Infantile Idiopathic Scoliosis



Effect on Lung Development

Development of lung parenchyma

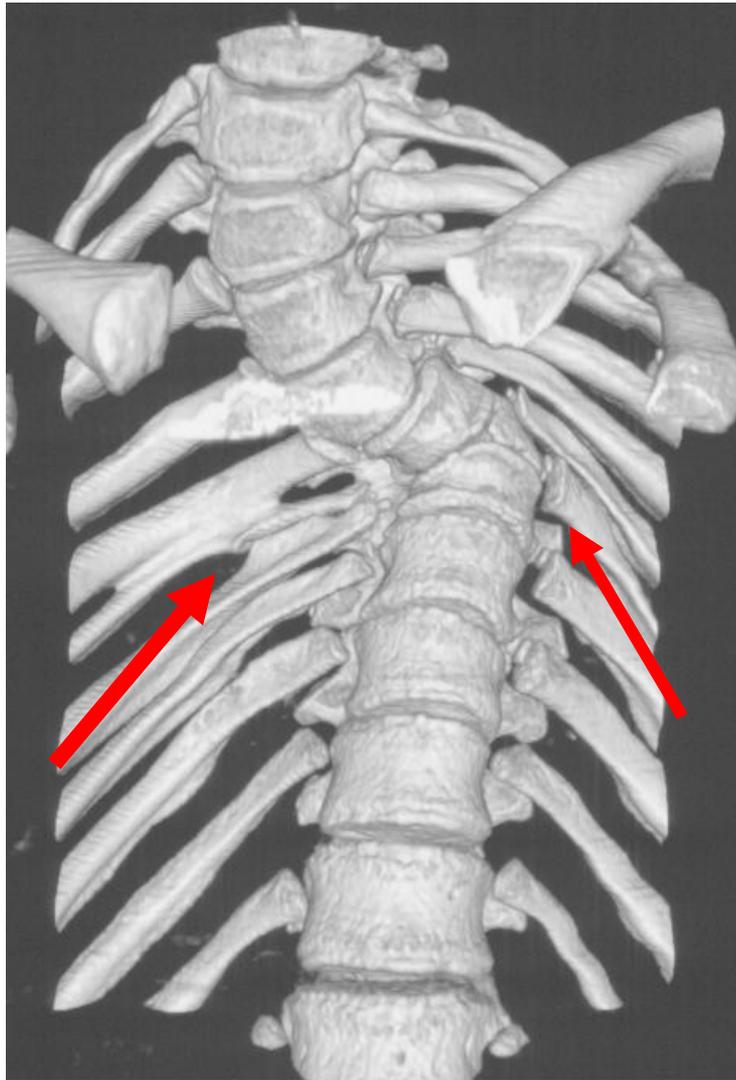


Dickson RA: Spine 24(24), 1999

Congenital Spine Deformity







Paralysis secondary to kyphosis

Disease

% Involvement

- | | |
|------------------------------------|-----|
| ● Cerebral Palsy | 25 |
| – 38% with curves >10 degrees | |
| – 2% curves >40 degrees | |
| ● Myelodysplasia | 60 |
| – 80% in T or upper L level | |
| – 23% in low L level | |
| – 9% in sacral level | |
| ● Spinal Muscular Atrophy | 67 |
| ● Friedreichs Ataxia | 80 |
| ● Duchenne muscular dystrophy | 90 |
| ● Traumatic paralysis (< 10 yrs.) | 100 |

Cerebral Palsy



12 year old male – Spinal Muscular Atrophy



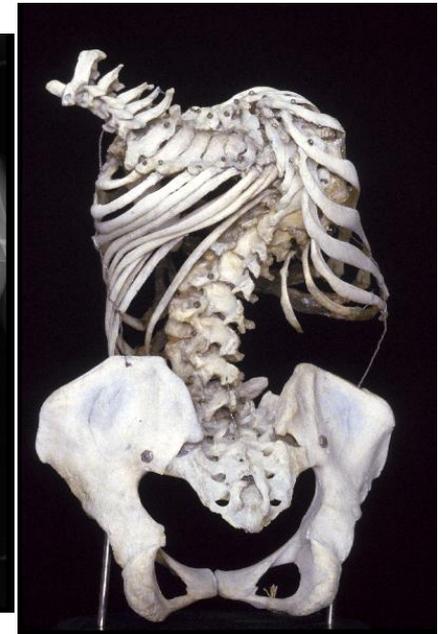
Scheuermann Kyphosis



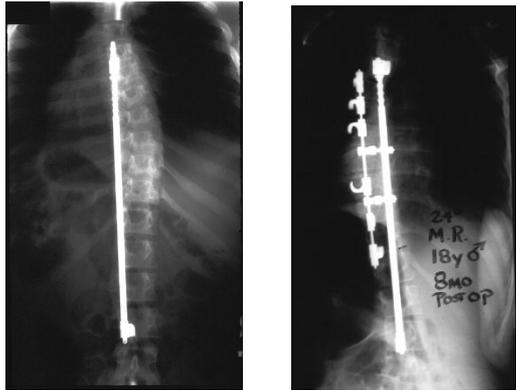
- Neurofibromatosis
- Marfan
- Prader Willie
- Vacteral
- Noonans
- Williams
- Smith McGinnis
- Many others

Effects of Deformity

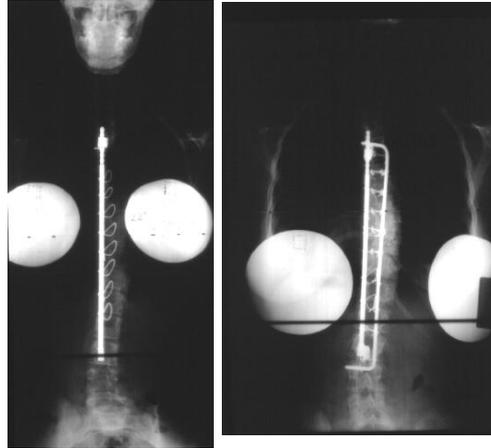
- Quality of Life
- Survival
- Pain
- Disability
- Deformity



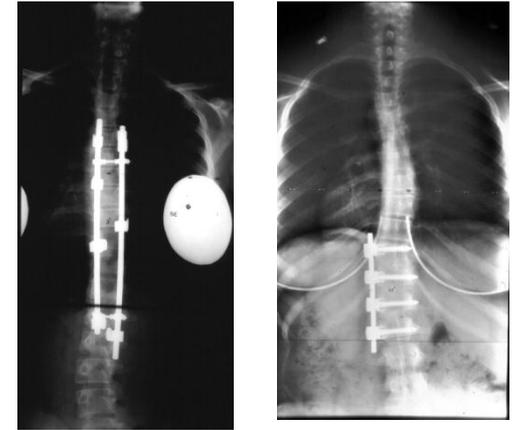
Personal Evolution



1970's



Early 1980's



1984



2000



2003

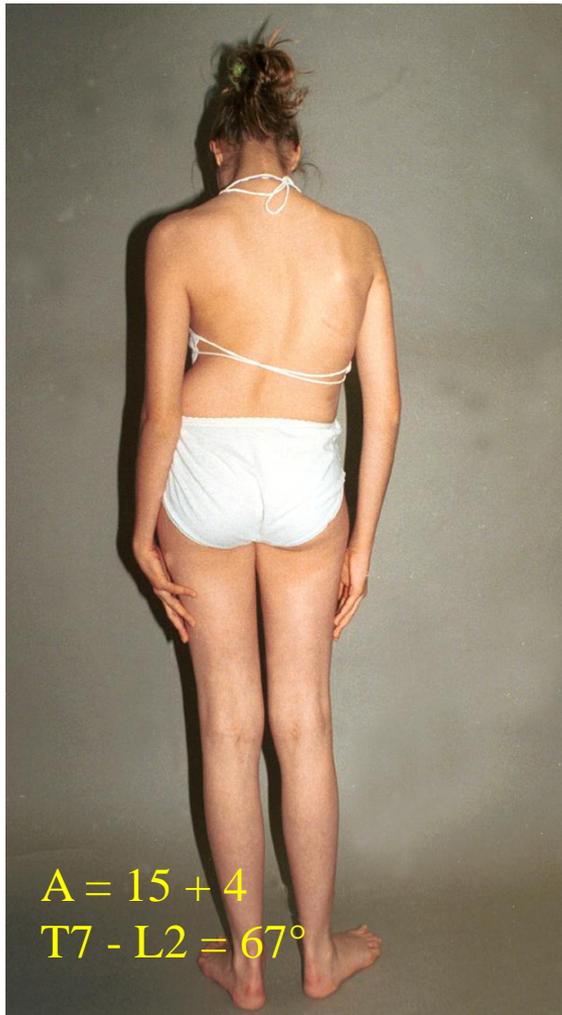


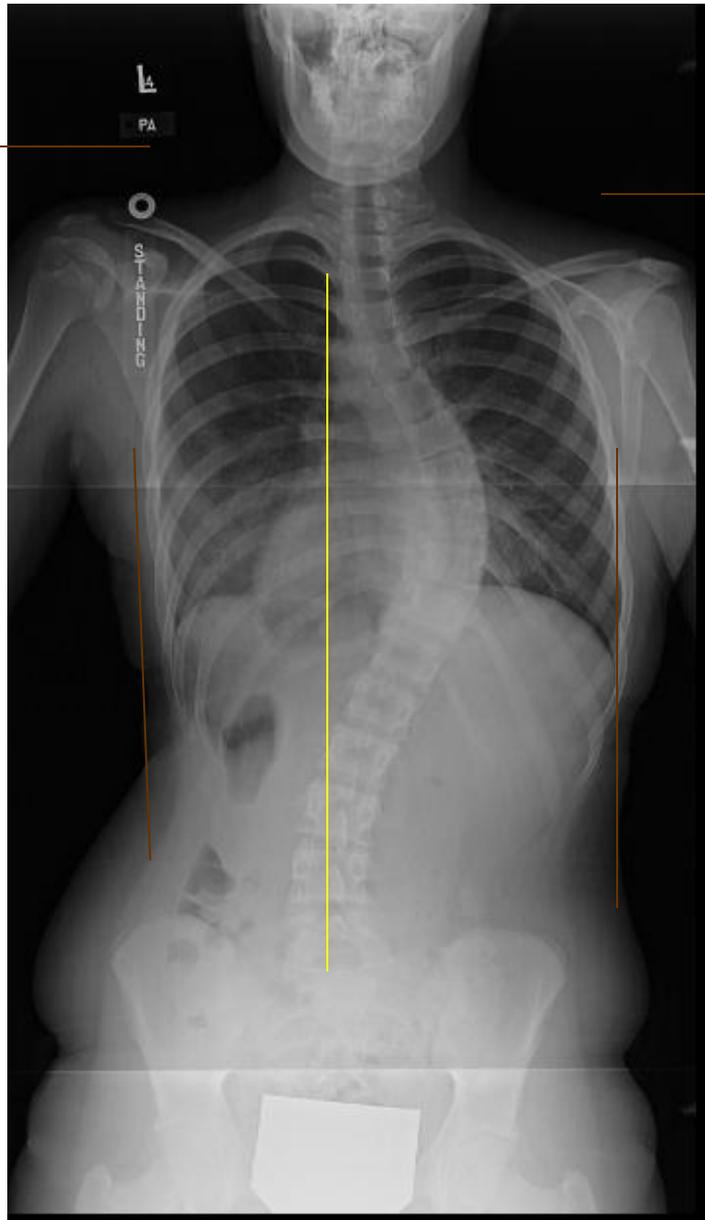
- 2 weeks traction
- Application of body cast
- Surgery through cast window
- 2 weeks in hospital recovery
- Body cast 6-9 months



Adolescent Idiopathic Scoliosis

2-3% children 10-16 years of age

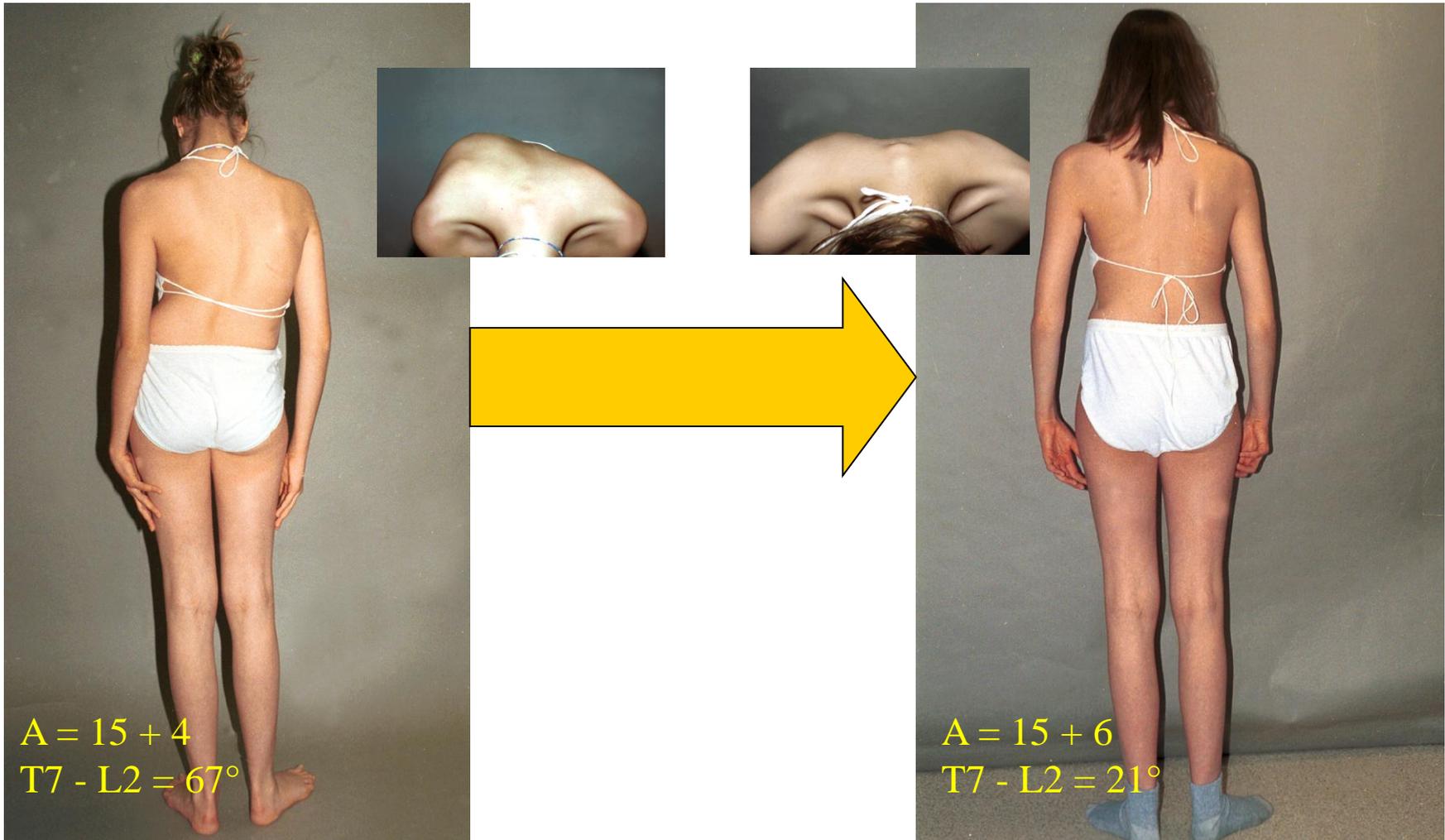




13+8 yr
R 1
M 18 mo
58 degrees
progressive



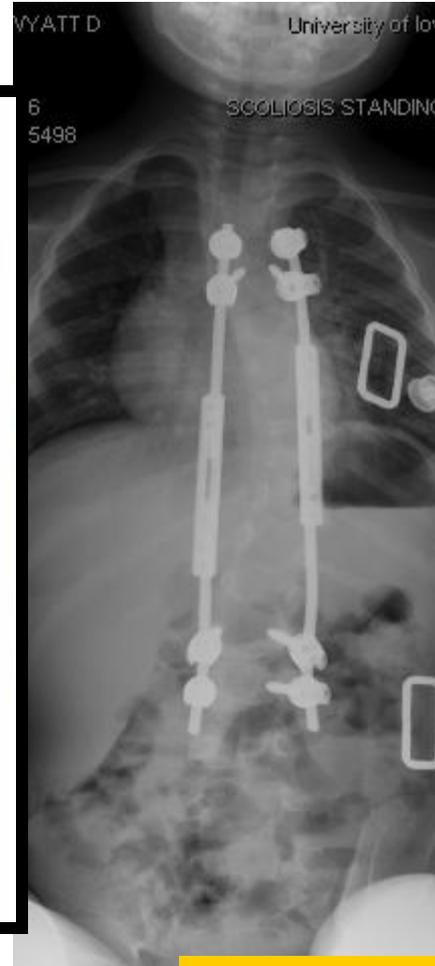
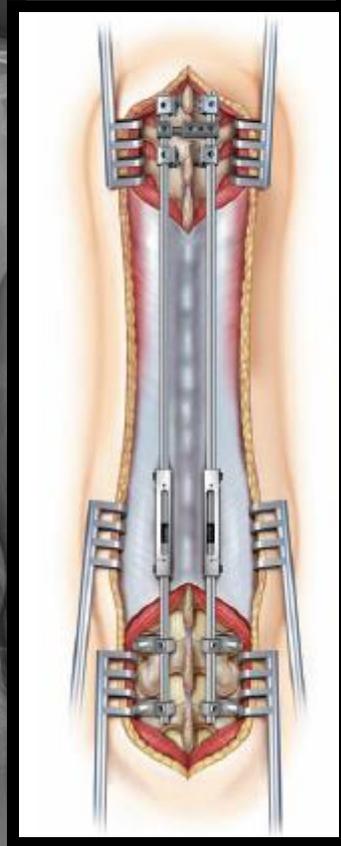
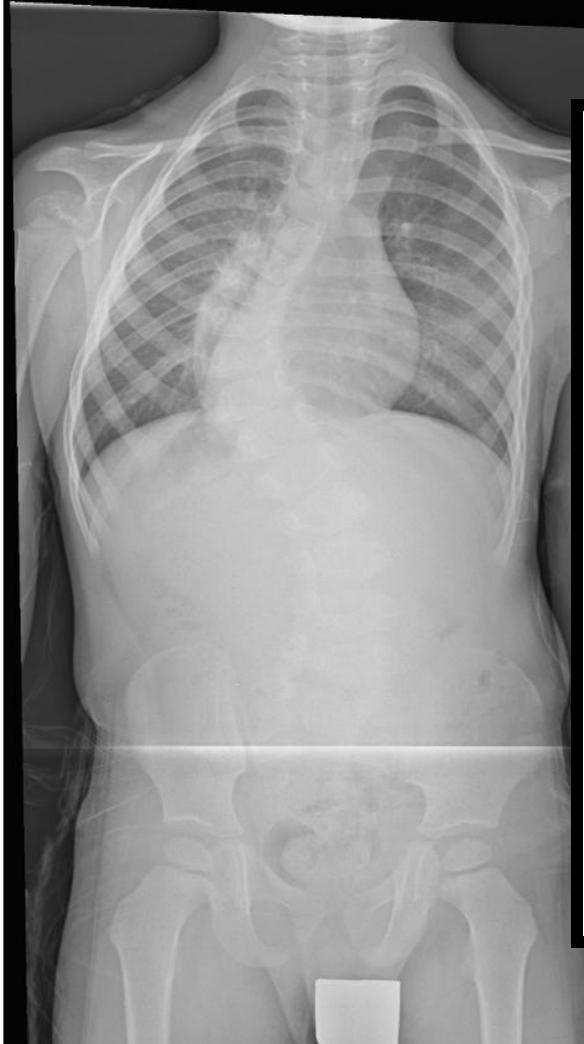
Surgical treatment:



- 5-7 Days in Hospital
- Back in School 2 weeks
- NO cast
- Full Sports 6 months



3 yr – 70 degrees



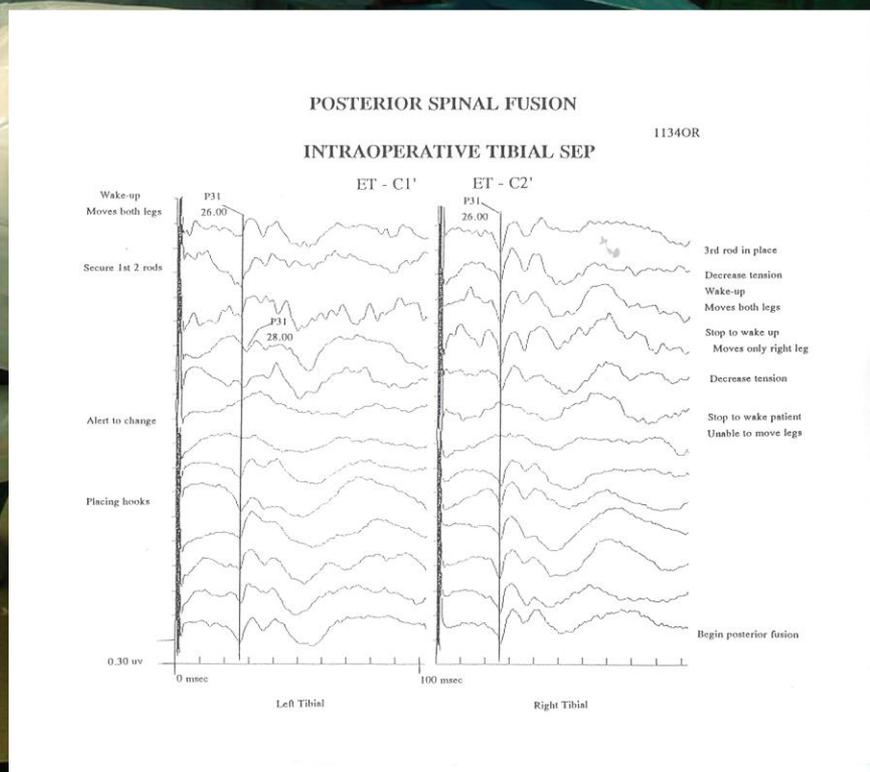
Growing Rods





Spinal Cord Monitoring Research

Making Surgery Safer





EOS

A breakthrough in orthopedic imaging

Biospace med: founded by Georges Charpak, 1992 Nobel Prize recipient for the revolutionary particle detector used in EOS



One of the first units in the US

- Significantly lower Dose (up to 10x)
- Simultaneous Biplane
- Weight bearing 3D image
 - New view
 - Enables computation of new and more accurate measurements



The Treatment of Children with Spinal Deformity

- A Service Unique to UIHC
- One of the Largest Spinal Deformity Services in the USA
- Clinical Service
- Research Program

The Evidence Base for Treating Pediatric Orthopaedic Conditions

Natural History and Long Term Outcomes of Pediatric Orthopaedic Conditions



First Step in Evidence Based Practice

Natural History of Pediatric Orthopaedic Conditions

Learn adult consequences



***Second Step* in Evidence Based Practice**

***Long term outcomes of
standard treatments***

Question:

***Has Natural History been
favorably altered?***



- Nachemson- Acta Scand Orth 1968
- Nilsonne and Lundgren Acta Scand Orth 1968

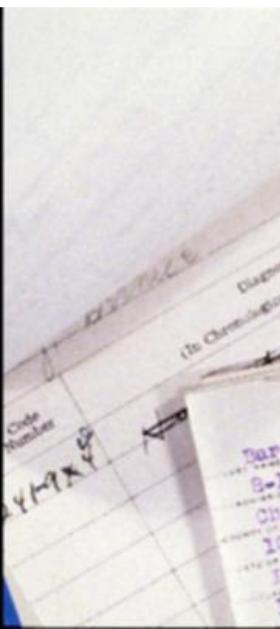
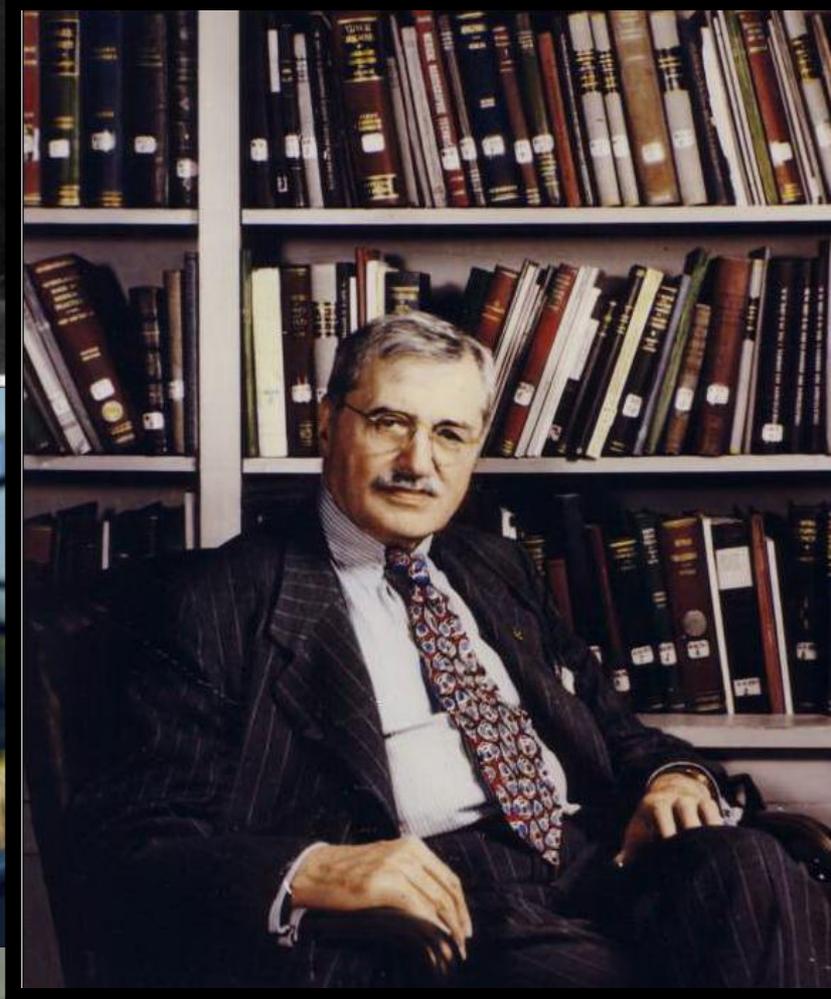
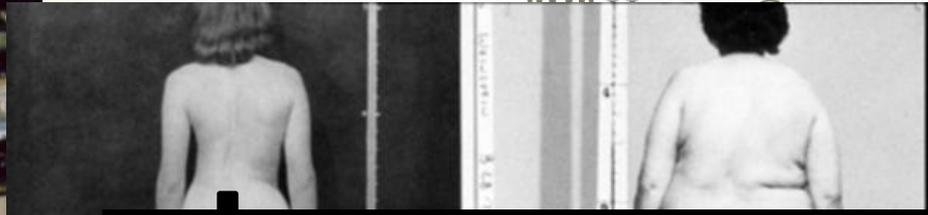
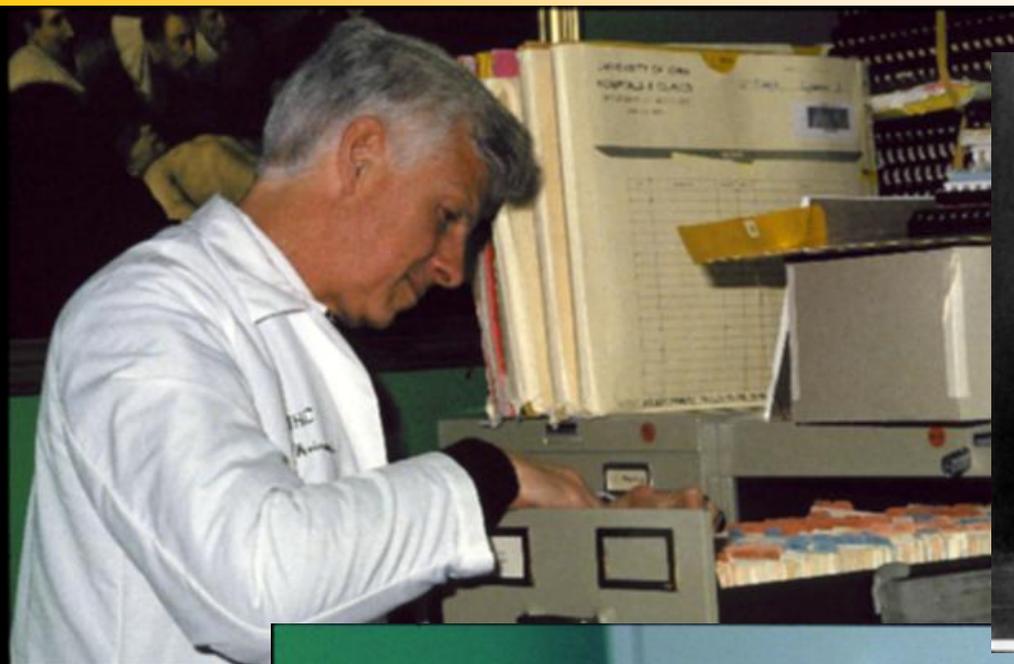
Grim prognosis

- Nachemson- Acta Scand Orth 1968
- Nilsonne and Lundgren Acta Scand Orth 1968
 - Grim prognosis
 - All of these studies have significant shortcomings
 - Multiple etiologies
 - Failure to evaluate specific curve patterns
 - **Misconceptions that all types of idiopathic scoliosis inevitably lead to disability from back pain and cardiopulmonary compromise**
 - *Has led to widespread misinformation amongst patients and health care policy makers –even after 50 years*

Good record
keeping system

Stable population





Date	8-13-37	Diagnosis	Chick	Code Number	10-14-36
Sex	Ind CK	Age	18	Location	New
Special Notes	Ortho	Procedure	P	Referral	Gong
Remarks	same	Referral	the Clatt Farm	Referral	



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Idiopathic Scoliosis

LONG-TERM FOLLOW-UP AND PROGNOSIS IN UNTREATED PATIENTS*

BY STUART L. WEINSTEIN, M.D.†, DONALD C. ZAVALA, M.D.†, AND IGNACIO V. PONSETI, M.D.†,
IOWA CITY, IOWA

*From the Departments of Orthopaedic Surgery and Internal Medicine,
University of Iowa Hospitals and Clinics, Iowa City*

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Curve Progression in Idiopathic Scoliosis

BY STUART L. WEINSTEIN, M.D.*, AND I. V. PONSETI, M.D.*, IOWA CITY, IOWA

From the Department of Orthopaedics, University of Iowa Hospitals, Iowa City

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Health and Function of Patients With Untreated Idiopathic Scoliosis

A 50-Year Natural History Study

Stuart L. Weinstein, MD; Lori A. Dolan, MA; Kevin F. Spratt, PhD; Kirk K. Peterson, MD;
Mark J. Spoonamore, MD; Ignacio V. Ponseti, MD

JAMA. 2003;289:559-567.



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Base line against which to measure the benefits of treatment

Patients With Untreated Idiopathic Scoliosis

A 50-Year Natural History Study

Stuart L. Weinstein, MD; Lori A. Dolan, MA; Kevin F. Spratt, PhD; Kirk K. Peterson, MD; Mark J. Spoonamore, MD; Ignacio V. Ponseti, MD

JAMA. 2003;289:559-567.

THE LANCET

"A common Alu3300id variant in LRP2 is associated with low bone mineral density, osteoporosis, and a 1.5-times increased risk of fracture."

Adolescent idiopathic scoliosis

Stuart L Weinstein, Lori A Dolan, Jack CY Cheng, Aina Danielsson, Jose A Morcuende

Adolescent idiopathic scoliosis (AIS) affects 1–3% of children in the at-risk population of those aged 10–16 years. The aetiopathogenesis of this disorder remains unknown, with misinformation about its natural history. Non-surgical treatments are aimed to reduce the number of operations by preventing curve progression. Although bracing and physiotherapy are common treatments in much of the world, their effectiveness has never been rigorously assessed. Technological advances have much improved the ability of surgeons to safely correct the deformity while maintaining sagittal and coronal balance. However, we do not have long-term results of these changing surgical treatments. Much has yet to be learned about the general health, quality of life, and self-image of both treated and untreated patients with AIS.

Introduction

Adolescent idiopathic scoliosis (AIS) is a structural, lateral, rotated curvature of the spine that arises in otherwise healthy children at or around puberty. The diagnosis is one of exclusion, and is made only when other causes of scoliosis, such as vertebral malformation, neuromuscular disorder, and syndromic disorders, have been ruled out. Patients are generally screened with

measurement of the degree of curvature in each affected individual and identification of any scoliosis in the family are of paramount importance for future genetic studies.

Several investigators have reported candidate-gene analyses of connective tissue genes. Results of these studies have excluded genes for fibrillin 1 (*FBN1*) and 2 (*FBN2*); collagen type I (*COL1A1*) and II (*COL1A2*); elastin (*ELN*); aggrecan (*ACAN*); and heparan sulfotransferases

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The Natural History and Long-Term Follow-up of Scheuermann Kyphosis*

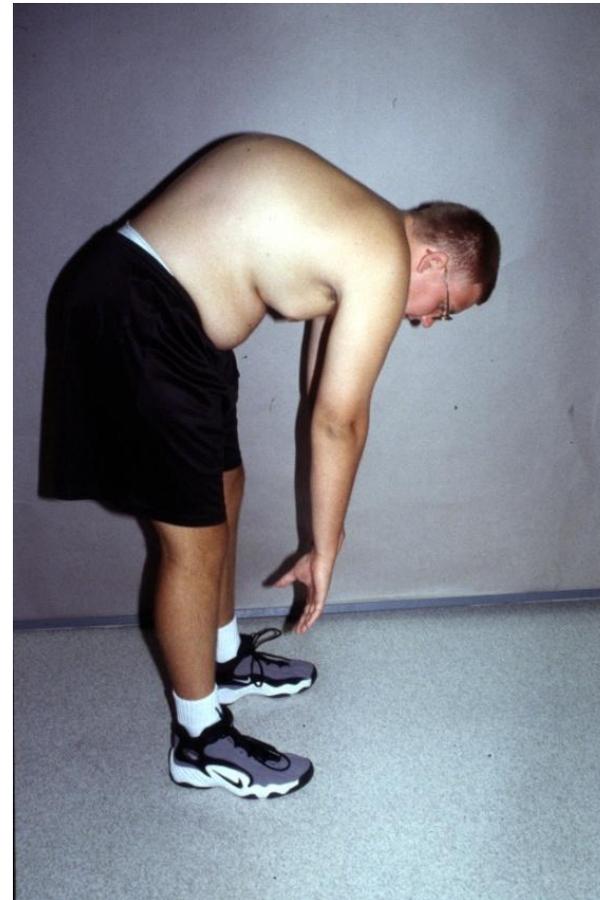
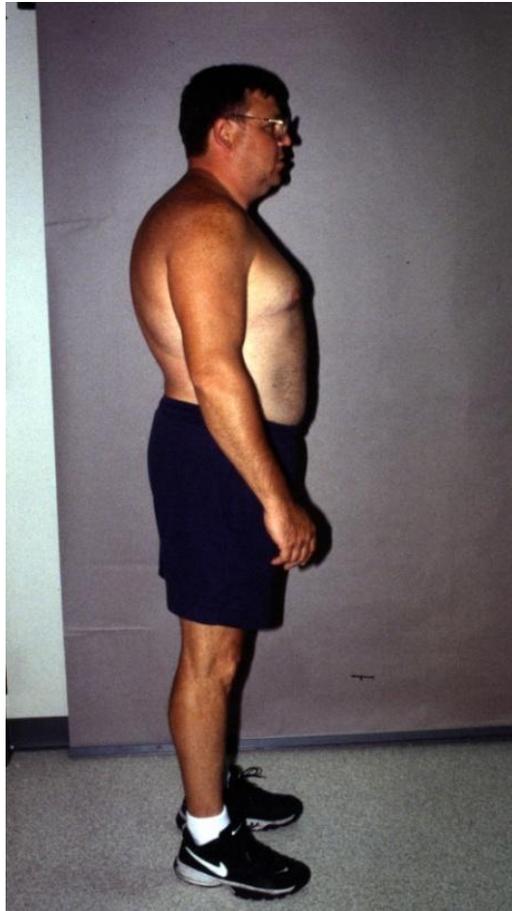
BY PETER M. MURRAY, M.D.†, STUART L. WEINSTEIN, M.D.‡, AND KEVIN F. SPRATT, PH.D.§, IOWA CITY, IOWA

Investigation performed at the Department of Orthopaedic Surgery, University of Iowa Hospitals and Clinics, Iowa City

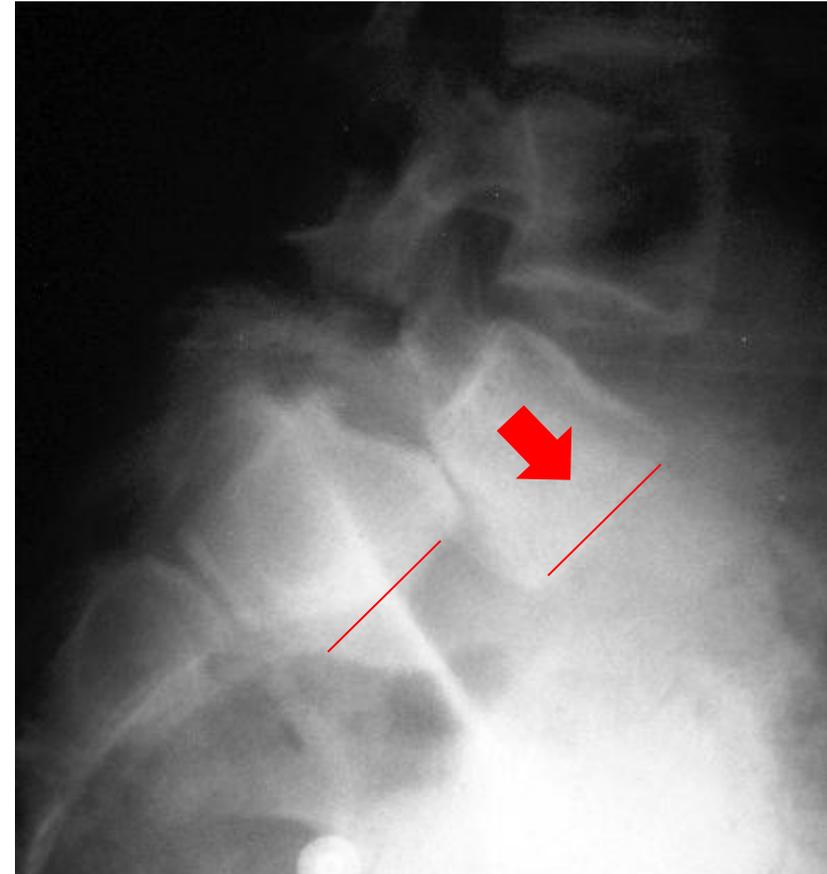


PM Murray, SL Weinstein and KF Spratt
J Bone Joint Surg Am. 1993;75:236-248.

Baseline (natural history) against which treatments can be compared



- 24 year natural history study of Grade III, IV spondylolisthesis compared to surgically treated group
 - Harris and Weinstein: JBJS: 69A



***Second Step* in Evidence Based Practice**

***Long term outcomes of
standard treatments***

Question:

***Has Natural History been
favorably altered?***



Do Braces Work?

- Long Term Follow Up of Milwaukee Bracing in Progressive Idiopathic Scoliosis
 - Noonan, Weinstein: JBJS: 78A



Curves resume natural history once bracing discontinued - *progress*

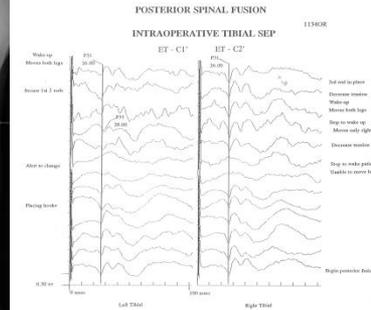
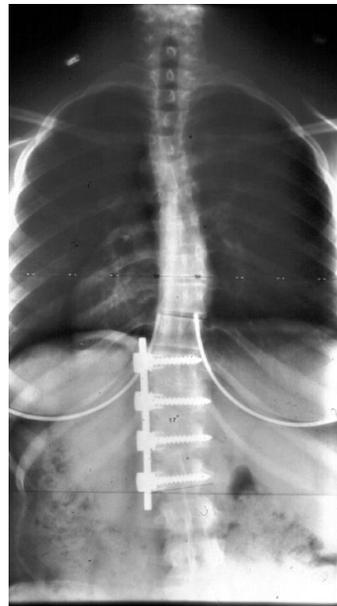
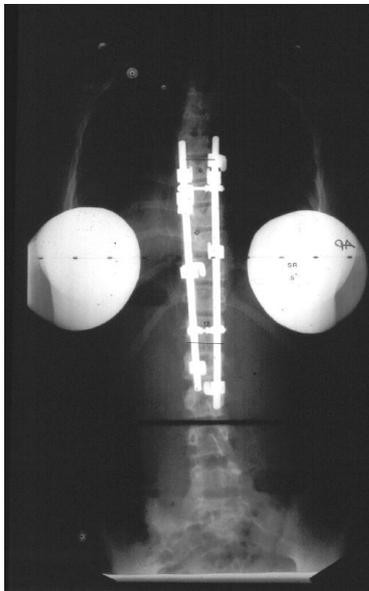
Psychological effects of bracing

- Long Term Follow Up of Milwaukee Bracing in Progressive Idiopathic Scoliosis
 - Noonan, Weinstein: JBJS: 78A



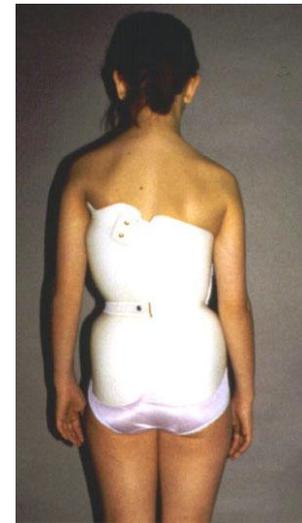
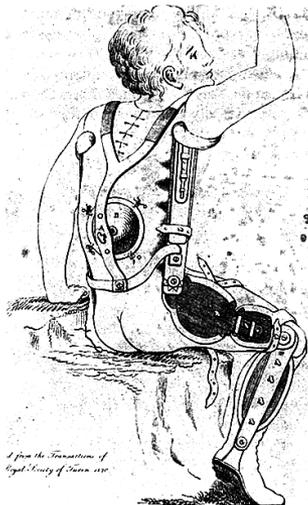
Psychosocial problems occur with brace treatment

- Many advances in surgical interventions
- Surgery safer and better at restoring coronal and sagittal contours



Spinal cord monitoring

- Few if any advances made
- Hippocrates 400 BC
 - System of intermittently applied distraction and lateral pressure to reduce deformity
- Milwaukee Brace; TLSO apply same principles



- **THE STANDARD OF CARE**
- Bracing has never been subjected to a rigorous evaluation of either its efficacy or effectiveness

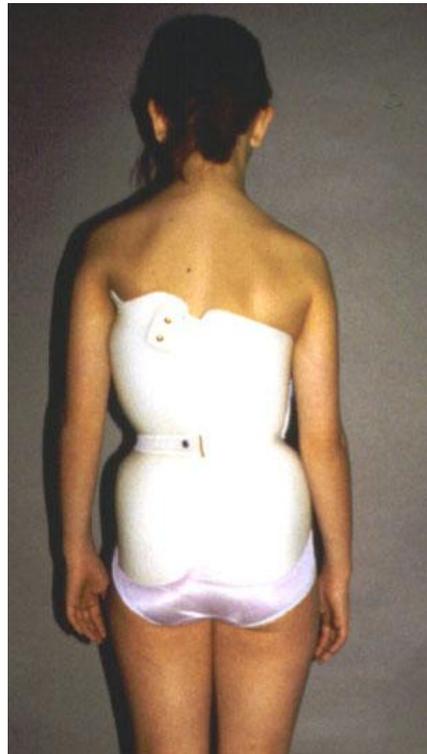
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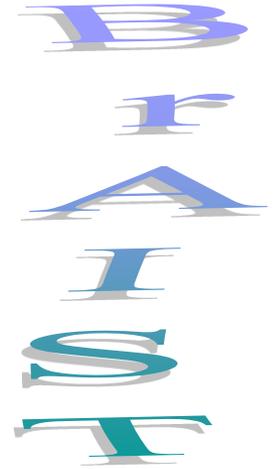


Adolescent Idiopathic Scoliosis

- *Expectation:* prevent progression until patient reaches skeletal maturity at which time risk of progression greatly diminishes

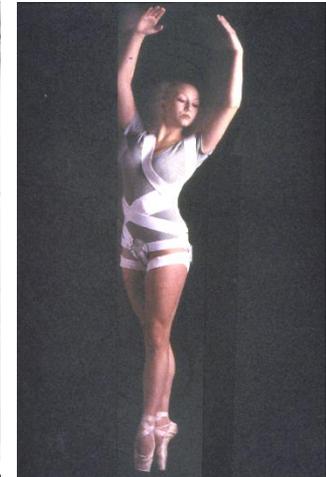
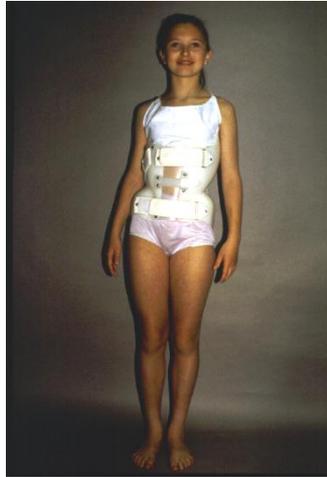
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- Many studies : Inadequate evidence concerning the effect of bracing on curve progression, rate of surgery, burden of suffering associated with AIS.

Do Braces Work in AIS?



NIAMS

National Institute of
Arthritis and
Musculoskeletal and
Skin Diseases



Melanie Donnelly
First Iowa Doris Duke Fellow

Planning Grant
1R21 AR49687 -01
Sept '02

Supported by a
grant from the

**National
Institutes
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U.S. Department of Health and Human Services

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Bracing in Adolescent Idiopathic Scoliosis Trial

UNIVERSITY OF IOWA

STUART L. WEINSTEIN, MD

PRINCIPAL INVESTIGATOR

NIH/NIAMS 1R01AR052113

www.clinicaltrials.gov

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\$4,907,288



\$1,100,000

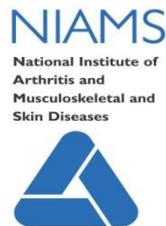


\$800,000

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This is a Phase III, *multi-center, prospective, randomized*, partially blinded clinical trial, designed to determine whether the use of **TLSOs** lowers the risk of curve progression (to ≤ 50 degrees) in subjects with AIS relative to **Observation** (watchful waiting) alone.

BrAIST



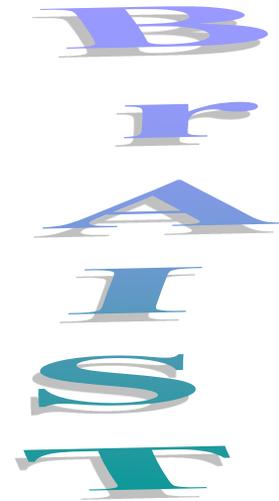
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A Work in Progress

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The Treatment of Children with Spinal Deformity

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Clinical Service

Research Program



The Treatment of Children with Spinal Deformity

Stuart L. Weinstein, MD
Ignacio V. Ponseti Chair and Professor of Orthopaedic Surgery
Professor of Pediatrics



Extension of Carver College of Medicine Basic Sciences Incentive Compensation Plan

Paul Rothman, MD
Dean, Carver College of Medicine