University of Iowa Health Care

Presentation to

The Board of Regents, State of Iowa

September 16, 2010

Agenda

- Opening Remarks (Robillard)
- Health Care Reform: Implications for UI Health Care (Robillard et al.)
- UI Health Care Strategic Plan (Robillard)
- Operational and Financial Performance Update (Kates and Fisher)

Health Care Reform: Implications for UI Health Care

Jean Robillard, MD
Vice President for Medical Affairs

Overview

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I. Introduction & historical perspective

II. The Patient Protection and Affordable Care Act of 2010 [P.L. 111-148] and the Health Care and Education Reconciliation Act of 2010 [P.L. 111-152]
   - A. Goals and benefits
   - B. The case for reform: chronic disease management

III. Implications of the new law for:
   - A. Health care delivery
   - B. Health insurance coverage
   - C. Higher education
   - D. Health care workforce
   - E. Biomedical research

IV. Select implications for UI Health Care

V. Timeline for implementation

Brief History of U.S. Health Care Reform Efforts

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- **1912** - President Theodore Roosevelt endorses social insurance including health insurance.
- **1943** - Wagner-Murray-Dingell bill is introduced proposing universal comprehensive health insurance. *Congress takes no action.*
- **1965** - Medicaid and Medicare programs are created and signed into law by President Johnson.
- **1993 – 2003**
  - President Clinton convenes White House Task Force on Health Reform; Health Security Act of 1993 gains little support.
  - Health Insurance Portability and Accountability Act of 1996 (HIPAA) signed into law by President Clinton.
  - Balanced Budget Act of 1997 creates SCHIP (State Children's Health Insurance Program) and Medicare Advantage (Medicare + Choice, Medicare Part C)
  - Medicare Prescription Drug, Improvement and Modernization Act of 2003 creates Medicare prescription drugs benefit (Medicare Part D) and health savings accounts.
- **2010** – President Obama signs the Patient Protection and Affordable Care Act of 2010 (March 23) and the Health Care and Education Reconciliation Act of 2010 (March 30).

Primary Goals of Health Care Reform

- Expand access to affordable health insurance to those without coverage,
- Improve the affordability and stability of insurance to those who already have it, and
- Control rising health care costs while reducing/ not adding to the federal budget deficit.

Key Benefits of New Health Care Law

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1. Uninsured individuals will have increased ability to get and afford the coverage and care they need.
2. Young adults will be eligible to stay on parents' health insurance plan or receive subsidies to purchase coverage.
3. Beginning in 2014, workers will no longer lose coverage when changing jobs.
4. Small business owners will be better able to offer health coverage by receiving a tax credit.
5. More families will face fewer difficulties paying out-of-pocket expenses.

Key Benefits of New Health Care Law (cont'd)

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6. Beginning in 2014, insurers will be prohibited from charging higher premiums because of gender, health status, or family history.
7. Access to preventive care and cancer screening for early detection will be increased.
8. Coverage no longer denied because of health problems and preexisting conditions.
9. Individuals with functional limitations will have increased ability to continue living at home.
10. Medicare beneficiaries will receive free preventive care, including annual wellness visit, without any cost-sharing, and the prescription drug "doughnut hole" will decrease over time.

The Case for Reform: Chronic Disease in Iowa

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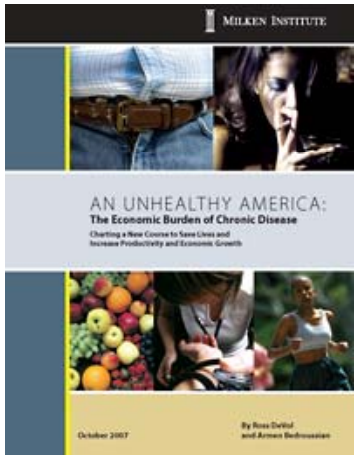
- Chronic diseases are the leading cause of death and disability in Iowa.
  - More than one million Iowans—almost two in five (38%) people living in the state—suffer from at least one chronic disease.
- The significant economic cost of chronic disease to state and local governments, communities, employers and individuals in Iowa is $7.6 billion.
  - This *estimated* cost reflects not only direct expenditures, such as payments for health care services, but also indirect costs, such as lost workdays and lower productivity.

Sources: "The Prevalence and Cost of Select Chronic Diseases," The Lewin Group, 2007.

The Case for Reform (cont'd)

- Even modest improvements in preventing and treating disease would, by 2023, avoid 40 million cases of chronic disease in the U.S. and reduce the economic impact of chronic disease by 27 percent, or $1.1 trillion annually.
  - For Iowa that would translate to avoiding 351,000 cases of chronic disease and a 28 percent reduction in costs.



Source: "An Unhealthy America," Milken Institute, 2007.

Implications for Health Care Delivery

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- Health improvements through increased emphasis on prevention and wellness.
- Health improvements through new incentives for safety, quality and care coordination.
- Better access to community health centers (FQHCs).
- Electronic medical records ensure more complete and accessible records when needed.
- Improvement of the discharge process and reduction of preventable readmissions.

Accountable Care Organizations

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Definition:

- ACOs are teams of providers that work together to coordinate care across health care settings to improve quality for a patient and reduce costs.
- Participating ACOs are required to meet performance and patient outcome standards and may share in the savings.
- ACOs change the model for taking care of patients by integrating care, improving quality, and reducing costs.

Accountable Care Organizations (cont'd)

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Necessary elements of an ACO:

- Must be able to manage the full continuum of care settings and services for its assigned patients.
- Must be financially integrated with both commercial and public payers, and all payers need to participate, so that at least 60 percent to 70 percent of patients in a provider's practice can be eligible.
- Must have a health information technology platform that connects providers in the ACO and allows for proactive patient management, along with a strong financial database and reporting platform.
- Commitment of the local hospital CEO and physician leadership team is vital to driving changes.
- Must have the process improvement capabilities required to change both clinical and administrative processes so that it can achieve its financial and quality goals.

Implications for Health Insurance Coverage

- Requirement for most U.S. citizens and legal immigrants to have health insurance.
- Changes to existing public programs
  - Medicaid
  - Children's Health Insurance Program (Hawk-I in Iowa)
  - Medicare
- Creation of Health Insurance Exchanges
- The Consumer Operated and Oriented (CO-OP) Program
- Private health insurance programs

Creation of Health Insurance Exchanges

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Purpose

- Facilitate individuals between 133-400% of FPL to buy insurance using premium and cost-sharing credits.
- To assist small employers and small businesses to obtain coverage for employees through the exchange via what is called the Small Business Health Options Program (SHOP).

How Will the Exchange Work?

Four benefit categories of plans plus a separate catastrophic plan will be offered through the Exchange

- **Bronze plan (or Essential Health Benefits package)**
  - represents minimum creditable coverage and provides the essential health benefits
  - covers 60% of the benefit costs of the plan, with an out-of-pocket limit equal to the Health Savings Account (HSA) current law limit.
- **Silver plan** - covers 70% of the benefit costs of the plan
- **Gold plan** - covers 80% of the benefit costs of the plan
- **Platinum plan** - covers 90% of the benefit costs of the plan
- **Catastrophic plan** available to those up to age 30 or to those who are exempt from the mandate to purchase coverage and provides catastrophic coverage only. This plan is only available in the individual market.

Implications for Higher Education

- Medicaid expenditures are expected to grow rapidly over the coming decades.
- Each new $1.00 in State Medicaid spending takes out about $0.70-$0.80 from higher education *(Brooking Institution Policy Brief, 2003).*

Implications for Health Care Workforce

- The new law contains numerous provisions reauthorizing health professions education and training programs authorized under Title VII of the Public Health Service Act.
- Through these programs, the Health Resources and Services Administration provides grants to medical and other health professions schools to improve the diversity, distribution, and supply of the health professions workforce with an emphasis on primary care and interdisciplinary education and training.
- The programs fall under five categories:
  - Student loans
  - Primary care
  - Health professions training for diversity
  - Interdisciplinary, community-based linkages
  - Health professions and public health workforce

Implications for Biomedical Research

The new law includes several provisions that affect medical research broadly and the National Institutes of Health (NIH) specifically.

- Creation of a Patient-Centered Outcomes Research Institute (PCORI) as a nonprofit corporation that is not “an agency or establishment of the U.S. Government.”
- Cure Acceleration Network (CAN)
  - To accelerate the development of high need cures, including development of medical products and behavioral therapies.
  - Managed by the NIH
  - $500 M authorized for FY-2010
- Access to Clinical Trials
  - Insurance companies cannot deny coverage nor discriminate against individuals participating in clinical trials

Implications for Biomedical Research (cont'd)

- Centers of Excellence for Depression
  - At least 20 centers
  - Focus on mental health services and subspecialty expertise for depressive disorders.
- Pain Research
- Post Partum Depression Research
- Congenital Heart Disease Research
- Breast Cancer Research in Young Women
- Emergency Medicine Research
- Minority Health
- Women Health
- Prevention and Wellness

Select Implications for UI Health Care

- Fewer of our patients will be uninsured
- IowaCare likely to be phased out in 2014
- Number of Medicaid patients could increase
- Prospects for greater continuity of care for our patients with significant needs will improve
- Multiple transparency and community reporting requirements

Select Implications for UI Health Care (cont'd)

- Medicare Hospital reimbursement subject to market basket reduction (ultimately representing a $157 billion decrease nationwide)
  - Impact on UI Health Care: $4.5 million (thru FY12)
- Potential reduction in Medicare Disproportionate Share Hospitals (DSH) payments
- UI Hospitals and Clinics (UIHC) and UI Physicians (UIP) should benefit from funding to address geographic disparities
- UIHC and UIP will face value-based purchasing and bundled payments
- Hospital negotiations with insurers will be tougher

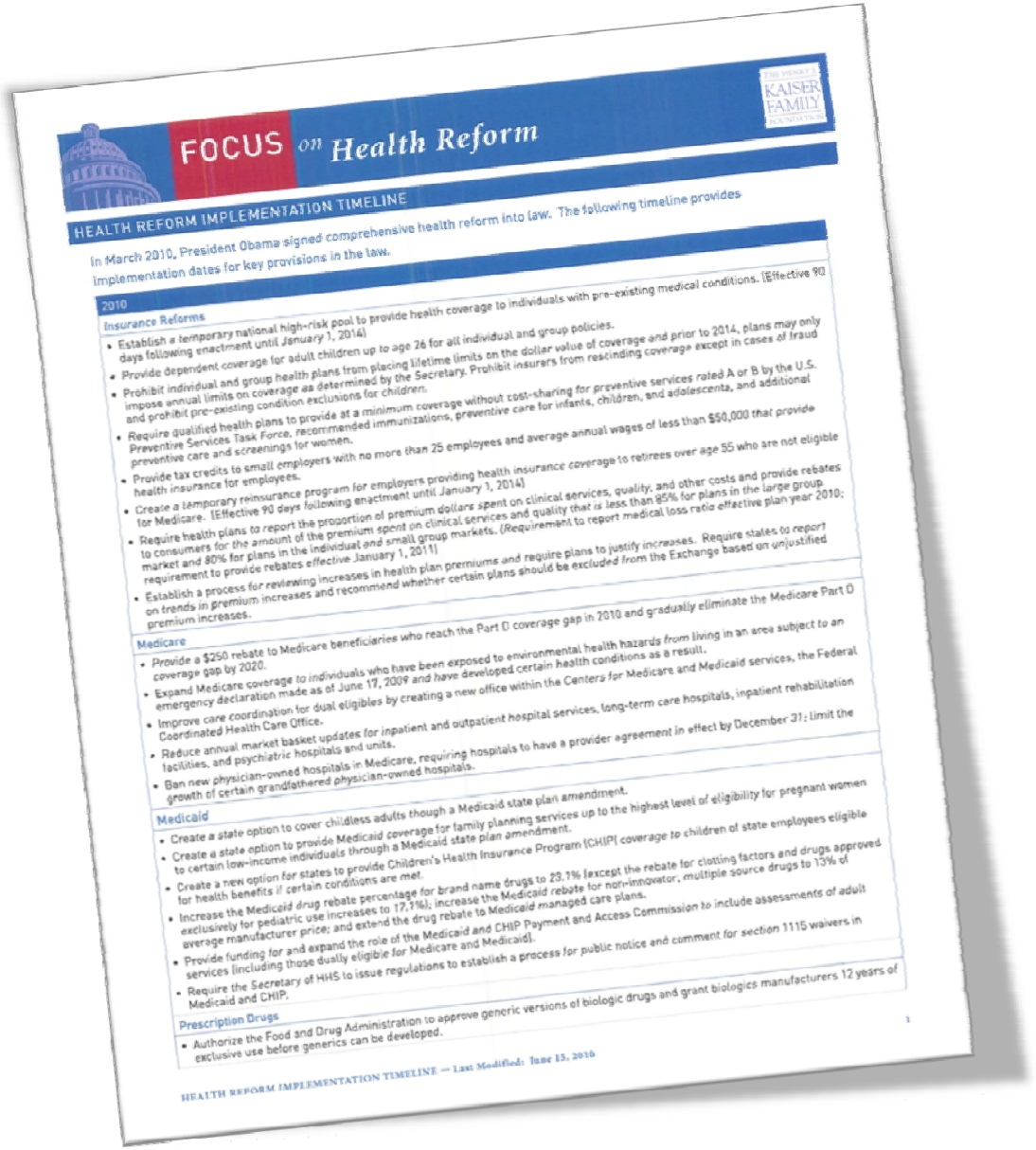
Select Implications for UI Health Care (cont'd)

- Penalties for excess readmissions within 30 days
- Penalties for high levels of hospital-acquired infection
- Need to prepare for increased workforce needs
- Large portion of costs of Graduate Medical Education (GME) will continue to be absorbed by UIHC and UIP
- MedPAC is looking at reducing IME payments to hospitals

How the Changes in Medicaid will be Funded

- Reduce aggregate Medicaid Disproportionate Share Payments (DSH) by $14.1 Billion starting in 2014.
  - DSH payments are to be reduced in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured.
- Prohibit federal payments to states for Medicaid services related to hospital-acquired conditions.
- Create new demonstration projects in Medicaid
  - To pay bundle payments for hospitals and physicians for episode of care
  - To allow pediatric medical providers to organize as Accountable Care Organizations to share in cost-savings
  - To make global capitated payments to safety net hospital systems

Timeline for Implementation



FOCUS on Health Reform

KAISER FAMILY FOUNDATION

HEALTH REFORM IMPLEMENTATION TIMELINE

In March 2010, President Obama signed comprehensive health reform into law. The following timeline provides implementation dates for key provisions in the law.

2010

Insurance Reforms

- Establish a temporary national high-risk pool to provide health coverage to individuals with pre-existing medical conditions. (Effective 90 days following enactment until January 1, 2014)
- Provide dependent coverage for adult children up to age 26 for all individual and group policies.
- Prohibit individual and group health plans from placing lifetime limits on the dollar value of coverage and prior to 2014, plans may only impose annual limits on coverage as determined by the Secretary. Prohibit insurers from rescinding coverage except in cases of fraud and prohibit pre-existing condition exclusions for children.
- Require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force, recommended immunizations, preventive care for infants, children, and adolescents, and additional preventive care and screenings for women.
- Provide tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that provide health insurance for employees.
- Create a temporary reinsurance program for employers providing health insurance coverage to retirees over age 55 who are not eligible for Medicare. (Effective 90 days following enactment until January 1, 2014)
- Require health plans to report the proportion of premium dollars spent on clinical services, quality, and other costs and provide rebates to consumers for the amount of the premium spent on clinical services and quality that is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. (Requirement to report medical loss ratio effective plan year 2010; requirement to provide rebates effective January 1, 2011)
- Establish a process for reviewing increases in health plan premiums and require plans to justify increases. Require states to report on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.

Medicare

- Provide a $250 rebate to Medicare beneficiaries who reach the Part D coverage gap in 2010 and gradually eliminate the Medicare Part D coverage gap by 2020.
- Expand Medicare coverage to individuals who have been exposed to environmental health hazards from living in an area subject to an emergency declaration made as of June 17, 2009 and have developed certain health conditions as a result.
- Improve care coordination for dual eligibles by creating a new office within the Centers for Medicare and Medicaid services, the Federal Coordinated Health Care Office.
- Reduce annual market basket updates for inpatient and outpatient hospital services, long-term care hospitals, inpatient rehabilitation facilities, and psychiatric hospitals and units.
- Ban new physician-owned hospitals in Medicare, requiring hospitals to have a provider agreement in effect by December 31; limit the growth of certain grandfathered physician-owned hospitals.

Medicaid

- Create a state option to cover childless adults though a Medicaid state plan amendment.
- Create a state option to provide Medicaid coverage for family planning services up to the highest level of eligibility for pregnant women to certain low-income individuals through a Medicaid state plan amendment.
- Create a new option for states to provide Children's Health Insurance Program (CHIP) coverage to children of state employees eligible for health benefits if certain conditions are met.
- Increase the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increase the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price; and extend the drug rebate to Medicaid managed care plans.
- Provide funding for and expand the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid).
- Require the Secretary of HHS to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

Prescription Drugs

- Authorize the Food and Drug Administration to approve generic versions of biologic drugs and grant biologics manufacturers 12 years of exclusive use before generics can be developed.

HEALTH REFORM IMPLEMENTATION TIMELINE — Last Modified: June 15, 2010

Preparing for Change

- Thousands of pages of rules and regulations are yet to be drafted to implement the new reforms.
- It is too soon to know the particular impact of various provisions of the health care overhaul—either on Iowa or on UI Health Care.
  - Many changes are months and even years away.
- We will continue to monitor developments closely, model different scenarios, explore participation in pilot programs and otherwise do our best to ensure that UI Health Care is as agile as possible in preparing to respond to the changes that lie ahead.

Discussion

UI Health Care Strategic Plan

Jean Robillard, MD
Vice President for Medical Affairs

One-Pager Strategic Plan

UI Health Care Strategic Plan - FY 2010-2012 (reviewed and updated July 2010)

Mission
Changing Medicine. Changing Lives.

Vision
World Class People. World Class Medicine. For Iowa and the World.

Values
I CARE. *Innovation, Collaboration, Accountability, Respect, Excellence.*

Clinical Quality & Service Goal

Provide world class healthcare and service to optimize health for everyone.

Accountable Leaders
Ken Kates & Craig Syrop

Strategies
- ☒ Lead efforts to improve health, access, quality and reduce fragmentation in the health care delivery system in collaboration with other health sciences colleges and community partners.
- ☒ Ensure that clinical services are provided with a seamless, integrated and patient-centered focus.
- ☒ Maximize current operational efficiency and expand clinical capacity to address immediate and long-term needs.
- ☒ Implement business plans for programmatic priorities:
  - Cancer
  - Children's Services
  - Heart and Vascular
  - Neurosciences
  - Transplant
  - Women's Health
  - Other emerging areas of clinical focus, including aging and age-related diseases.
- ☒ Develop processes to effectively implement evidence-based quality and safety initiatives.
- ☒ Lead efforts to ensure that all UI Health Care clinicians receive appropriate professional training on culturally competent care.

Tactics
- ☒ Develop effective, collaborative relationships with local communities using outreach, telemedicine and other tactics.
- ☒ Develop and implement UI Service and Operational Excellence.
- ☒ Fully implement the Quality and Safety work plans in process.
- ☒ Integrate residents and fellows into UI Service and Operational Excellence and Quality and Safety initiatives.
- ☒ Decrease length of stay.
- ☒ Continue the work of the OR Efficiency task force.
- ☒ Continue to develop and refine the Transfer Center.
- ☒ Improve efficiency and access in Ambulatory Care Clinics.
- ☒ Fully integrate Medical Directors into the clinical operations.
- ☒ Develop and implement performance-based, medical home model of primary care for targeted populations.
- ☒ Explore becoming an Accountable Care Organization.

Resources and Processes
- ☒ Continue to develop the full capabilities of **Epic** to facilitate quality/safety and enhance professional and consumer relationships, including UI CareLink and MyChart.
- ☒ Training and Development
- ☒ Marketing and Communications
- ☒ Policy and Practice changes

Metrics
- ☒ Patient and Referring Physician Satisfaction
- ☒ Inpatient and Outpatient throughput
  - Length of stay, next third available outpatient appointments
  - Main OR late starts; number of OR cases per room
- ☒ Evidence-based quality metrics
- ☒ JCAHO/CMS Core measures
- ☒ Ventilator Associated Pneumonia & Central Line Blood Stream Infection rates
- ☒ Medication errors that cause harm
- ☒ Satisfaction of Critical Access Hospital and Outreach partners
- ☒ Performance measures for patient-centered care for targeted populations

Research Goal

Advance world class discovery through excellence and innovation in biomedical and health services research.

Accountable Leaders
Paul Rothman
Michael Apicella, Pat Winokur, Gary Rosenthal

Strategies
- ☒ Identify areas of excellence in basic research in which to prioritize future growth and development.
- ☒ Integrate genomics with clinical care.
- ☒ Expand existing research that disseminates and implements evidence-based practices into routine clinical practice settings.
- ☒ Improve and grow scientific infrastructure.
- ☒ Expand existing "bench to bedside to community" research (CTSA).
- ☒ Promote development of new clinical and translational research programs that are strategically aligned with clinical programmatic priorities.
- ☒ Nurture the development of high quality, high reward interdisciplinary scientific programs.
- ☒ Recruit, develop, and retain a diverse cadre of world class investigators and support their academic development.
- ☒ Collaborate with other UI Colleges and CTSA Consortium.

Tactics
- ☒ Plan/build the Pappajohn Biomedical Institute.
- ☒ Renovate lab space in Medical Laboratories.
- ☒ Utilize existing open space at Oakdale for incubation.
- ☒ Focus DEO recruits and resources on Strategic Priorities: Cancer, Heart, Neuroscience and Health Service Outcomes.
- ☒ Develop and implement FUTURE Program.
- ☒ Improve Bioinformatics and IT infrastructure.
- ☒ Implement integrated DNA, blood and tissue procurement system.
- ☒ Initiate Neurosciences Institute.
- ☒ Facilitate collaboration between basic scientists and clinicians for submission of PPG/ translational grants.
- ☒ Improve infrastructure for human subjects research.

Resources and Processes
- ☒ Develop the full capabilities of **Epic** to facilitate innovation in research.
- ☒ Provide training and support for faculty and staff to incorporate translational research into clinical practice.

Metrics
- ☒ Number and dollar amount of extramurally funded projects
- ☒ Number and dollar amount of clinical trials
- ☒ Number and dollar amount of program project and other collaborative grants
- ☒ Recruitment and retention of a diverse faculty as measured by annual demographic data on the composition of UI Health Care faculty
- ☒ Increase in "optimal" rankings for the diversity recruitment and retention plan on NIH grant reviews
- ☒ Number of patents, royalties, licensing agreements
- ☒ Research revenue per net square foot
- ☒ Percent of faculty salaries offset by grant support

Education Goal

Develop world class health professionals and scientists through excellent, innovative and humanistic educational curricula for learners at every stage.

Accountable Leaders
Paul Rothman
Peter Densen, Mark Wilson, Christopher Cooper, LouAnn Montgomery

Strategies
- ☒ Recruit, develop and retain diverse world class faculty and students.
- ☒ Continue the evolution of an innovative curriculum through competency and evidence-based learning across a continuum of undergraduate, graduate and continuing medical education.
- ☒ Limit medical student debt.
- ☒ Recognize and reward excellence in teaching.
- ☒ Cultivate critical thinking, an environment of curiosity and life-long learning, a spirit of inquiry, a passion for excellence.
- ☒ Implement cultural competency and related diversity educational initiatives into the curriculum for all trainees.
- ☒ Develop world class international medical educational programs in targeted areas.
- ☒ Utilize interdisciplinary education in collaboration with other health sciences colleges to train health professionals and instill a team approach to patient care.
- ☒ Continue to play a key role in training allied health professionals for Iowa.
- ☒ Facilitate learning through the innovative application of information technologies.

Tactics
- ☒ Increase scholarships.
- ☒ Improve integration of UGME, OSCEP, GME and CME.
- ☒ Develop and deliver an excellent educational experience to residents and fellows.
- ☒ Implement annual review/meetings with departments.
- ☒ Respond to LCME and ACGME accreditation recommendations for residency and fellowship programs.
- ☒ Consider strategic affiliations with international medical education programs.
- ☒ Develop and implement FUTURE Program.
- ☒ Continue development of the Branch Campus.
- ☒ Evaluate the potential to increase medical school class size and allied health programs.
- ☒ Maintain diversity in each entering class, with particular focus on those groups under-represented in medicine.

Resources and Processes
- ☒ Develop the full capabilities of **Epic** to facilitate education.
- ☒ Provide training and support for "learners" to understand and implement patient-centered care and service.

Metrics
- ☒ # of hours/faculty devoted to education efforts as logged in participation database
- ☒ Applications, admissions, and yield including increased GPA and MCAT scores and diversity of applicants and admitted students
- ☒ USMLE scores
- ☒ Match results; all available CCOM slots filled
- ☒ Student evaluations of curriculum and instruction to include residents and fellows
- ☒ % increase in annual student debt compared to national benchmarks and prior year
- ☒ Placements of graduates, short term and long term
- ☒ National rankings of graduate programs and professional schools
- ☒ Success in student diversity retention initiatives
- ☒ Increase in positive data from OSAC-commissioned minority focus groups

People Goal

Foster a culture of excellence that values, engages and enables our workforce.

Accountable Leaders
Jana Wessels
Ann Williamson

Strategies
- ☒ Seek, hire and retain outstanding people including individuals from groups traditionally under-represented in academic medicine.
- ☒ Ensure that all UI Health Care employees receive appropriate training regarding UI Health Care diversity goals and values.
- ☒ Engage staff and encourage strong personal responsibility, accountability and empowerment directed toward achieving organizational goals.
- ☒ Define performance expectations for all.
- ☒ Develop and promote programs that recognize and reward excellence.
- ☒ Foster an environment of continual learning, innovation and collaboration.

Tactics
- ☒ Develop plan and budget for Staff Climate/Satisfaction Survey.
- ☒ Develop and implement a unified rewards & recognition program.
- ☒ Develop and implement plan for state of the art recruiting and on-boarding processes.
- ☒ Continue bridging funding program for research faculty retention.

Resources and Processes
- ☒ Training and Development
- ☒ Communications
- ☒ Policy and Practice changes

Metrics
- ☒ Faculty and staff engagement, satisfaction and loyalty
- ☒ Success in retention initiatives measured by demographic data on the composition of our new/total faculty, staff, administrators by department, with measures of turnover by gender, age race/ethnicity, educational achievement and other factors

Diversity Goal

Create an environment of inclusion where individual differences are respected and all feel welcome.

Accountable Leaders
Benita Wolff
All Other Accountable Leaders

Strategies
- ☒ Provide a range of diversity education, cultural enrichment and acclimation programs for members of the UI Health Care community.
- ☒ Develop and implement innovative, effective recruiting and pipeline initiatives geared towards under-represented groups.
- ☒ Nurture a culture of respect and equal opportunity.
- ☒ Each Accountable Leader will advance diversity in each strategy.

Tactics
- ☒ Phase I of this approach is the implementation of the strategies articulated in the Diversity Plan for CCOM 2009-2012.
- ☒ Phase II Years 2011-2012: Develop plan for UIHC and UIP focusing on opportunities identified in the baseline assessment.
- ☒ Explore the development of a shared services office to lead enterprise-wide diversity efforts.

Resources and Processes
- ☒ Support for Diversity programs, services and activities

Metrics
- ☒ Recruitment and retention of a diverse workforce/student population as measured by annual demographic data on the composition of UI Health Care students, residents, faculty, staff and post doctoral scholars
- ☒ Success in retention initiatives measured by demographic data on the composition of our new/total faculty, staff, administrators by department, along with measures of turnover by gender and race/ethnicity
- ☒ Climate and diversity as measured by UI Health Care climate survey compared to other AMCs
- ☒ Providers' ability to deliver culturally competent and sensitive patient care as measured by patient satisfaction surveys

Growth and Finance Goal

Optimize a performance-driven business model that assures financial success.

Accountable Leaders
Ken Fisher, Ken Kates, Paul Rothman
Kevin Collins

Strategies
- ☒ Ensure a sound financial position of clinical programs.
- ☒ Grow in scope, depth and volume in clinical programmatic priority areas.
- ☒ Assure a sound financial position of non-clinical programs.
- ☒ Devote appropriate resources, facilities and equipment to assure the success of clinical, education and research strategies.
- ☒ Develop a culture of philanthropy.

Tactics
- ☒ Implement Cost Moderation plan.
- ☒ Implement tactical business plans for clinical programmatic priority areas.
- ☒ Plan/build off-site ambulatory care facilities.
- ☒ Plan/build UI Children's Hospital.
- ☒ Plan/build/renovate main campus facilities resulting in all private rooms.
- ☒ Develop and implement CARTS model.
- ☒ Reorganize administrative structures in CCOM.
- ☒ Focus finances on strategic priorities.
- ☒ Develop unified clinical incentive plan.
- ☒ Expand the philanthropic base.

Resources and Processes
- ☒ Data-driven business planning
- ☒ Robust financial and performance-reporting systems

Metrics
- ☒ Volume for inpatient and outpatient services (total admissions, outpatient clinic visits, ETC visits and surgical cases)
- ☒ Volume for clinical programmatic priority areas
- ☒ Performance against flexed operating budget
- ☒ UIHC and UIP operating margin %
- ☒ Facility projects on budget, on schedule
- ☒ CARTS model productivity factor
- ☒ Annual fundraising productivity
- ☒ Philanthropic goal of $500M by the end of fiscal year 2013
- ☒ Comprehensive community benefit reporting
- ☒ Bond rating

Strategic Plan Report Card – FY10

UI Health Care Strategic Plan Scorecard					
As of August, 2010	FY09 Actual/Baseline	FY10 Target	FY10 Actual	vs. FY09	vs. Target
Overall					
Honor Roll for Best Hospitals by US News and World Report	Ranked in 9 specialties	Honor Roll	Ranked in 10 specialties	●	●
Children's Hospitals by US News and World Report	Ranked in Ped Neph only	Top 25	Ranked in 3 specialties	●	●
Public Medical Schools by US News and World Report	10th	Top 10	10th	●	●
Overall Medical School Ranking in Research by US News and World Report	31st	Improve	27th	●	●
NIH Funding among Public Medical Schools	12th	Top 10	Not yet available	○	○
Moody's Bond Rating	Aa2 rated	Maintain Aa2	Aa2	●	●
Clinical Quality and Service					
Patient Satisfaction a) Adult b) Pediatric	a) 37th %ile b) 12th %ile (Qtr 4)	90th percentile	a) 42nd %ile b) 63rd %ile (current Qtr)	●	●
Surgery Care Improvement Project (SCIP) Antibiotic Timing, Selection & Discontinuation (appropriate antibiotic administration)	87.9%	98%	97%	●	●
Operating Room - first case on time starts (main OR)	86%	95%	90% (current Qtr)	●	●
Transfer Center - Avg. time from intitial call to patient placement confirmation	113 minutes	120 minutes	91 minutes (current Qtr)	●	●
Research					
Number and dollar amount of extramurally funded projects	$212.5M	5% increase	$228.1 M	●	●
Research revenue per net square foot	$431/NSF	Increase	$488/NSF	●	●
Percent of extramurally funded faculty research effort	Data not available	35%	Not yet available	○	○
Education					
Increase applications for medical school	2,763	Increase applicants	3,410	●	●
Mean MCAT scores - Verbal Reasoning, Physical Sciences, Biological Sciences, Writing Sample	10.2, 10.5, 10.9, P	Improve	10.3, 10.7, 11.0, P	●	●
Increase GPA	3.76	Improve	3.77	●	●
Limit % increase in annual student debt compared to national benchmarks and prior year	UI Class of 2008 average $135K; National average $154K	Maintain below national average	UI Class of 2009 average $136K; National average $156K	●	●
People					
Develop plan and budget for Staff Climate/Satisfaction Survey	NA	Develop plan in FY11 and Budget in FY12	In process	○	○
Develop and implement plan for state of the art recruiting and onboarding processes	NA	Develop plan in FY11 Implement in FY12	In process	○	○
Design and implement a unified program for reward and recognition	NA	Develop plan in FY11 Implement in FY12	In process	○	○
Diversity					
Recruitment and retention of a diverse workforce/student population as measured by annual demographic data on the composition of UI Health Care students, residents, faculty, staff and post doctoral scholars	Data was collected for FY2009	Demographic data will be available by September 1, 2010 for faculty and students	In process	○	○
Explore the development of a shared services office to lead enterprise-wide diversity efforts	NA	Formalize office by end of FY11	In process	○	○
Growth and Finance					
Acute Admissions (excl.Normal Newborn and OP Obs)	29,542	30,393	28,873	●	●
UIHC Operating Margin %	-0.7%	1.0%	2.9%	●	●
UIP Operating Margin %	1.9%	4.2%	6.5%	●	●
Outpatient Clinic visits (incl. ETC & Hosp Dentistry)	742,312	757,481	753,823	●	●
Surgical Cases (Main OR and ASC)	23,136	23,126	24,272	●	●
Philanthropic goal of $500M by the end of FY 2013	$86M	$86M	$77.97M	●	●
KEY	● At or better than target	● Worse than target	○ Not available		

Strategic Plan Report Card – FY11

UNIVERSITY of IOWA HEALTH CARE

UI Health Care Strategic Plan Scorecard					
As of August, 2010	FY10 Target	FY10 Actual	FY11 Target	vs. FY10	vs. Target
Overall					
Honor Roll for Best Hospitals by US News and World Report	Honor Roll	Ranked in 10 specialties	Honor Roll		
Children's Hospitals by US News and World Report	Top 25	Ranked in 3 specialties	Top 25		
Public Medical Schools by US News and World Report	Top 10	10th	Top 10		
Overall Medical School Ranking in Research by US News and World Report	Improve	27th	Improve		
NIH Funding among Public Medical Schools	Top 10	Not yet available	Top 10		
Moody's Bond Rating	Maintain Aa2	Aa2	Maintain Aa2		
Clinical Quality and Service					
Patient Satisfaction a) Adult b) Pediatric	90th percentile	a) 42nd %ile b) 63rd %ile (current Qtr)	90th percentile		
Surgery Care Improvement Project (SCIP) Antibiotic Timing, Selection & Discontinuation (appropriate antibiotic administration)	98%	97%	98%		
Operating Room - first case on time starts (main OR)	95%	90% (current Qtr)	95%		
Transfer Center - Avg. time from intitial call to patient placement confirmation	120 minutes	91 minutes (current Qtr)	120 minutes		
Research					
Number and dollar amount of extramurally funded projects	5% increase	$228.1 M	5% increase		
Research revenue per net square foot	Increase	$488/NSF	Increase		
Percent of extramurally funded faculty research effort	35%	Not yet available	35%		
Education					
Increase applications for medical school	Increase applicants	3,410	Increase applicants		
Mean MCAT scores - Verbal Reasoning, Physical Sciences, Biological Sciences, Writing Sample	Improve	10.3, 10.7, 11.0, P	Improve		
Increase GPA	Improve	3.77	Improve		
Limit % increase in annual student debt compared to national benchmarks and prior year	Maintain below national average	UI Class of 2009 average $136K; National average $156K	Maintain below national average		
People					
Develop plan and budget for Staff Climate/Satisfaction Survey	Develop plan in FY11 and Budget in FY12	In process	Develop plan in FY11 and Budget in FY12		
Develop and implement plan for state of the art recruiting and onboarding processes	Develop plan in FY11 Implement in FY12	In process	Develop plan in FY11 Implement in FY12		
Design and implement a unified program for reward and recognition	Develop plan in FY11 Implement in FY12	In process	Develop plan in FY11 Implement in FY12		
Diversity					
Recruitment and retention of a diverse workforce/student population as measured by annual demographic data on the composition of UI Health Care students, residents, faculty, staff and post doctoral scholars	Demographic data will be available by September 1, 2010 for faculty and students	In process	Develop plan in FY11		
Explore the development of a shared services office to lead enterprise-wide diversity efforts	Formalize office by end of FY11	In process	Formalize office by end of FY11		
Growth and Finance					
Acute Admissions (excl.Normal Newborn and OP Obs)	30,393	28,873	29,248		
UIHC Operating Margin %	1.0%	2.9%	3.0%		
UIP Operating Margin %	4.2%	6.5%	6.1%		
Outpatient Clinic visits (incl. ETC & Hosp Dentistry)	757,481	753,823	787,435		
Surgical Cases (Main OR and ASC)	23,126	24,272	24,468		
Philanthropic goal of $500M by the end of FY 2013	$86M	$77.97M	$86M		

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

July 2010

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Discharges	2,622	2,354	2,497	268	11.4%	125	5.0%
Patient Days	16,221	14,847	14,699	1,374	9.3%	1,522	10.4%
Length of Stay	6.27	6.25	5.79	0.02	0.3%	0.48	8.3%
Average Daily Census	523.26	478.92	474.16	44.34	9.3%	49.10	10.4%
Surgeries – Inpatient	934	942	928	(8)	-0.9%	6	0.7%
Surgeries – Outpatient	1,267	1,182	1,179	85	7.2%	88	7.5%
Emergency Treatment Center Visits	4,722	4,274	4,347	448	10.5%	375	8.6%
Outpatient Clinic Visits	64,918	63,322	64,178	1,596	2.5%	740	1.2%

Case Mix	1.7587	1.7802	1.7571	(0.0215)	-1.2%	0.0016	0.1%
Medicare Case Mix	1.9022	2.0271	1.8223	(0.1249)	-6.2%	0.0799	4.4%

Greater than 2.5% Favorable | Neutral | Greater than 2.5% Unfavorable

Discharges by Type

July 2010

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Adult Medical	928	840	850	88	10.5%	78	9.2%
Adult Surgical	1,137	1,050	1,117	87	8.3%	20	1.8%
Adult Psych	150	146	144	4	2.7%	6	4.2%
Subtotal – Adult	*2,215*	*2,036*	*2,111*	*179*	*8.8%*	*104*	*4.9%*
Pediatric Medical	277	206	270	71	34.5%	7	2.6%
Pediatric Surgical	18	12	12	6	50.0%	6	50.0%
Pediatric Critical Care	75	77	69	(2)	-2.6%	6	8.7%
Pediatric Psych	37	23	35	14	60.9%	2	5.7%
Subtotal – Pediatrics w/o newborn	*407*	*318*	*386*	*89*	*28.0%*	*21*	*5.4%*
Newborn	142	110	107	32	29.1%	35	32.7%
TOTAL w/o Newborn	**2,622**	**2,354**	**2,497**	**268**	**11.4%**	**125**	**5.0%**

Greater than 2.5% Favorable | Neutral | Greater than 2.5% Unfavorable

Discharge Days by Type

July 2010

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Adult Medical	5,200	4,476	4,369	724	16.2%	831	19.0%
Adult Surgical	5,645	5,409	5,545	236	4.4%	100	1.8%
Adult Psych	1,739	1,536	1,745	203	13.2%	(6)	-0.3%
Subtotal – Adult	*12,584*	*11,421*	*11,659*	*1,163*	*10.2%*	*925*	*7.9%*
Pediatric Medical	1,810	1,238	1,026	572	46.2%	784	76.4%
Pediatric Surgical	71	122	46	(51)	-41.8%	25	54.4%
Pediatric Critical Care	1,693	1,658	1,570	35	2.1%	123	7.8%
Pediatric Psych	275	281	150	(6)	-2.1%	125	83.3%
Subtotal – Pediatrics w/o newborn	*3,849*	*3,299*	*2,792*	*550*	*16.7%*	*1,057*	*37.9%*
Newborn	321	247	257	74	30.0%	64	24.9%
TOTAL w/o Newborn	**16,433**	**14,720**	**14,451**	**1,713**	**11.6%**	**1,982**	**13.7%**

Greater than 2.5% Favorable | **Neutral** | **Greater than 2.5% Unfavorable**

Average Length of Stay by Type

July 2010

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Adult Medical	5.60	5.34	5.14	0.26	4.9%	0.46	9.0%
Adult Surgical	4.96	5.17	4.96	(0.21)	-4.1%	0.00	0.0%
Adult Psych	11.59	10.56	12.12	1.03	9.8%	(0.53)	-4.4%
Subtotal – Adult	5.68	5.63	5.52	0.05	0.9%	0.16	2.9%
Pediatric Medical	6.53	6.07	3.80	0.46	7.6%	2.73	71.8%
Pediatric Surgical	3.94	10.24	3.83	(6.30)	-61.5%	0.11	2.9%
Pediatric Critical Care	22.57	21.73	22.75	0.84	3.9%	(0.18)	-0.8%
Pediatric Psych	7.43	12.47	4.29	(5.04)	-40.4%	3.14	73.2%
Subtotal – Pediatrics w/o newborn	9.46	10.48	7.23	(1.02)	-9.7%	2.23	30.8%
Newborn	2.26	2.25	2.40	0.01	0.4%	(0.14)	-5.8%
TOTAL w/o Newborn	**6.27**	**6.28**	**5.79**	**(0.01)**	**-0.2%**	**0.48**	**8.3%**

Greater than 2.5% Favorable | Neutral | Greater than 2.5% Unfavorable

Outpatient Surgeries – by Clinical Department

July 2010

UNIVERSITY of IOWA HEALTH CARE

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Cardiothoracic	5	6	8	(1)	-16.7%	(3)	-37.5%
Dentistry	47	49	58	(2)	-4.1	(11)	-19.0%
Dermatology	7	5	7	2	40.0%	-	0.0%
General Surgery	220	182	174	38	20.9%	46	26.4%
Gynecology	73	64	58	9	14.1%	15	25.9%
Internal Medicine	-	1	1	(1)	-100.0%	(1)	-100.0%
Neurosurgery	55	39	40	16	41.0%	15	37.5%
Ophthalmology	283	260	272	23	8.9%	11	4.0%
Orthopedics	269	285	286	(16)	-5.6%	(17)	-5.9%
Otolaryngology	199	179	169	20	11.2%	30	17.8%
Pediatrics	-	-	2	-	0.0%	(2)	-100.0%
Radiology – Interventional	3	4	5	(1)	-25.0%	(2)	-40.0%
Urology *w/ Procedure Ste.*	106	108	99	(2)	-1.9%	7	7.1%
Total	**1,267**	**1,182**	**1,179**	**85**	**7.2%**	**88**	**7.5%**

Greater than 2.5% Favorable | **Neutral** | **Greater than 2.5% Unfavorable**

Inpatient Surgeries – by Clinical Department

July 2010

UNIVERSITY of IOWA HEALTH CARE

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Cardiothoracic	98	103	108	(5)	-4.9% 🔴	(10)	-9.3% 🔴
Dentistry	12	11	9	1	9.1% 🟢	3	33.3% 🟢
General Surgery	245	239	230	6	2.5% 🟢	15	6.5% 🟢
Gynecology	69	69	83	-	0.0% ⚪	(14)	-16.9% 🔴
Neurosurgery	137	141	137	(4)	-2.8% 🔴	-	0.0% ⚪
Ophthalmology	19	11	6	8	72.7% 🟢	13	216.7% 🟢
Orthopedics	243	232	205	11	4.7% 🟢	38	18.5% 🟢
Otolaryngology	59	59	66	-	0.0% ⚪	(7)	-10.6% 🔴
Pediatrics	-	-	-	-	0.0% ⚪	-	0.0% ⚪
Radiology – Interventional	7	19	23	(12)	-63.2% 🔴	(16)	-69.6% 🔴
Urology *w/ Procedure Ste.*	45	59	61	(14)	-23.7% 🔴	(16)	-26.2% 🔴
Total	**934**	**942**	**928**	**(8)**	**-0.9%** ⚪	**6**	**0.7%** ⚪

🟢 **Greater than 2.5% Favorable** ⚪ **Neutral** 🔴 **Greater than 2.5% Unfavorable**

Emergency Treatment Center

July 2010

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
ETC Visits	4,722	4,274	4,347	448	10.5%	375	8.6%
ETC Admits	1,277	1,111	1,086	166	14.9%	191	17.6%
Conversion Factor	27.0%	26.0%	25.0%		4.0%		8.2%
ETC Admits / Total Admits	49.1%	47.4%	42.8%		3.6%		14.7 %

Greater than 2.5% Favorable | Neutral | Greater than 2.5% Unfavorable

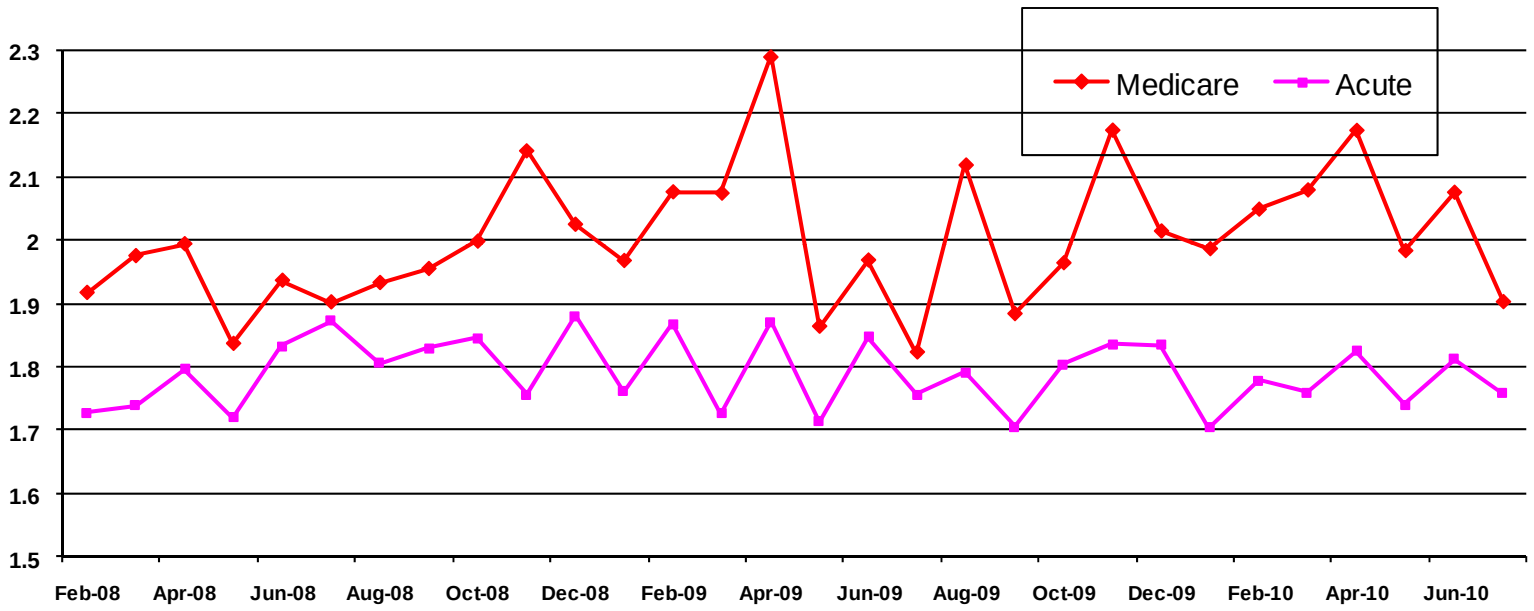
Clinic Visits by Clinical Department

July 2010

Operating Review (YTD)	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Anesthesia	1,334	1,327	1,433	7	0.5%	(99)	-6.9%
CDD	1,216	725	630	491	67.7%	586	93.0%
Clinical Research	978	923	886	55	6.0%	92	10.4%
Dermatology	2,026	2,227	2,080	(201)	-9.0%	(54)	-2.6%
ETC	4,722	4,274	4,347	448	10.5%	375	8.6%
Employee Health Clinic	1,321	1,207	1,062	114	9.4%	259	24.4%
Family Care Center	6,949	7,492	7,746	(543)	-7.3%	(797)	-10.3%
General Surgery	2,175	1,668	2,481	507	30.4%	(306)	-12.3%
Heart and Vascular	2,974	2,985	-	(11)	-0.4%	2,974	100.0%
Hospital Dentistry	1,095	1,024	1,091	71	6.9%	4	0.4%
Internal Medicine	8,439	7,988	9,884	451	5.7%	(1,445)	-14.6%
Neurology	1,278	1,477	1,492	(199)	-13.5%	(214)	-14.3%
Neurosurgery	749	750	895	(1)	-0.1%	(146)	-16.3%
Obstetrics/Gynecology	6,443	6,172	6,442	271	4.4%	1	0.0%
Ophthalmology	5,872	6,206	6,163	(334)	-5.4%	(291)	-4.7%
Orthopedics	4,770	4,646	4,663	124	2.7%	107	2.3%
Otolaryngology	2,294	2,290	2,386	4	0.2%	(92)	-3.9%
Pediatrics	3,852	3,299	3,632	553	16.8%	220	6.1%
Primary Care Clinic North	1,540	1,780	1,573	(240)	-13.5%	(33)	-2.1%
Psychiatry	3,469	3,449	3,622	20	0.6%	(153)	-4.2%
Thoracic – Cardio Surgery	16	-	260	16	100.0%	(244)	-93.9%
Urology	1,267	1,363	1,353	(96)	-7.0%	(86)	-6.4%
Other	139	50	57	89	178.0%	82	143.9%
Total	**64,918**	**63,322**	**64,178**	**1,596**	**2.5%**	**740**	**1.2%**

Greater than 2.5% Favorable Neutral Greater than 2.5% Unfavorable

Case Mix Index



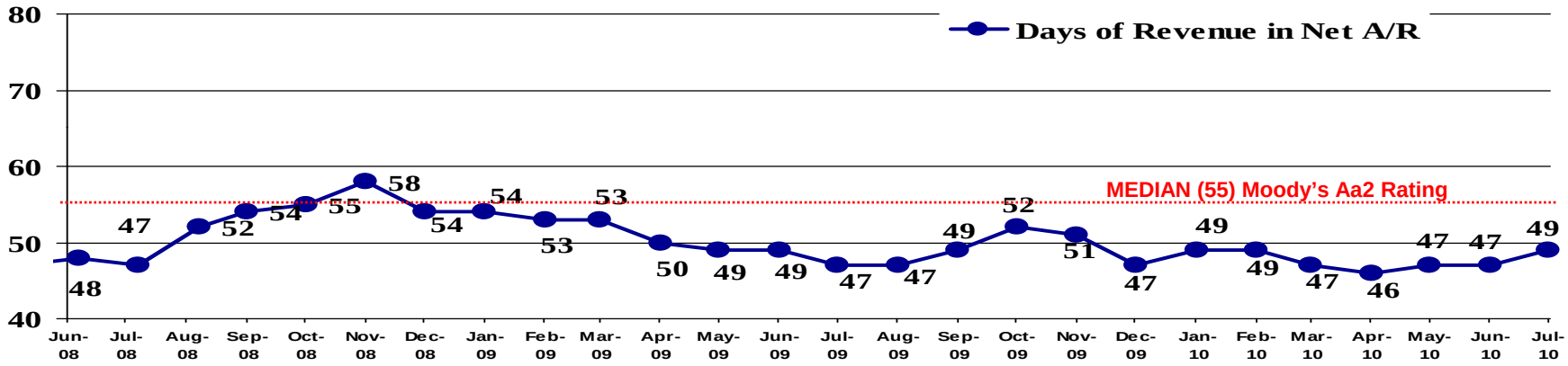
UIHC Comparative Financial Results

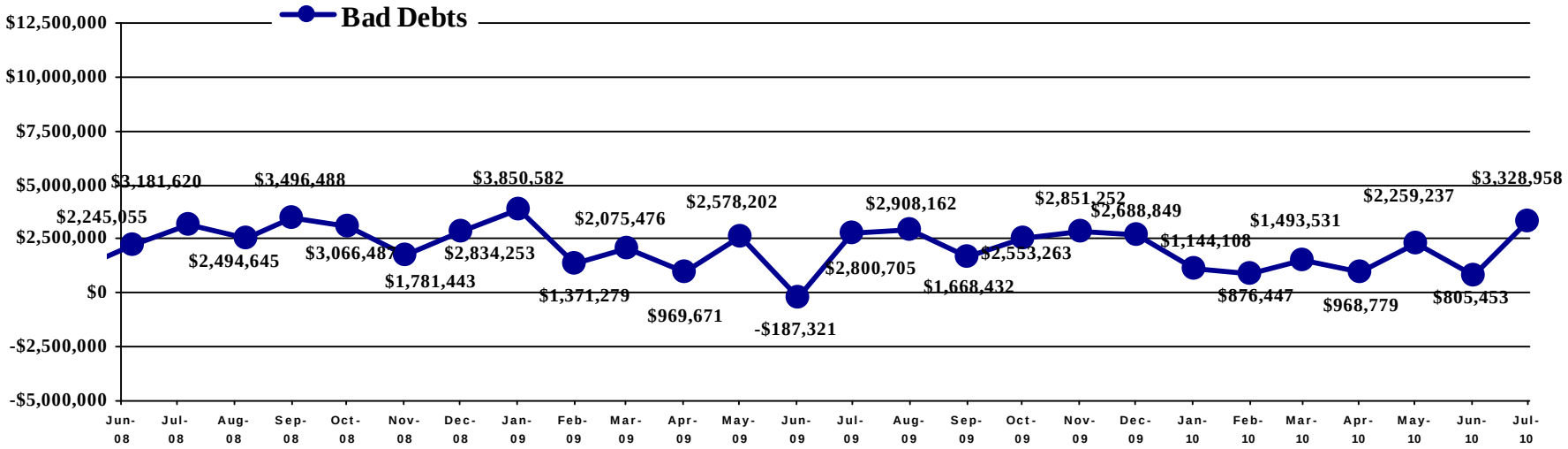
July 2010

NET REVENUES:	Actual	Budget	Prior Year	Variance to Budget	% Variance to Budget	Variance to Prior Year	% Variance to Prior Year
Patient Revenue	$79,279	$77,145	$71,995	$2,134	2.8%	$7,284	10.1%
Appropriations	-	-	-	-	0.0%	-	0.0%
Other Operating Revenue	3,878	4,043	4,317	(165)	-4.1%	(439)	-10.2%
Total Revenue	**$83,157**	**$81,188**	**$76,312**	**$1,969**	**2.4%**	**$6,845**	**9.0%**
EXPENSES:							
Salaries and Wages	$39,596	$41,154	$39,785	($1,558)	-3.8%	($189)	-0.5%
General Expenses	33,838	33,913	30,066	(75)	-0.2%	3,772	12.6%
Operating Expense before Capital	$73,434	$75,067	$69,851	($1,633)	-2.2%	$3,583	5.1%
Cash Flow Operating Margin	**$9,723**	**$6,121**	**$6,461**	**$3,602**	**58.9%**	**$3,262**	**50.5%**
Capital- Depreciation and Amortization	5,739	6,090	6,194	(351)	-5.8%	(455)	-7.4%
Total Operating Expense	$79,173	$81,157	$76,045	($1,984)	-2.4%	$3,128	4.1%
Operating Income	**$3,984**	**$31**	**$267**	**$3,953**	**12,752%**	**$3,717**	**1,392%**
Operating Margin %	**4.8%**	**0.0%**	**0.4%**		**4.8%**		**4.4%**
Gain (Loss) on Investments	7,789	1,308	6,909	6,481	495.5%	880	12.7%
Other Non-Operating	(488)	(517)	(327)	29	5.6%	(161)	-49.2%
Net Income	**$11,285**	**$822**	**$6,849**	**$10,463**	**1,273%**	**$4,436**	**64.8%**
Net Margin %	**12.5%**	**1.0%**	**8.3%**		**11.5%**		**4.2%**

Comparative Accounts Receivable at July 31, 2010

	June 30, 2009	June 30, 2010 (preliminary)	July 31, 2010
Net Accounts Receivable	$121,515,935	$119,437,031	$125,728,499
Net Days in AR	49	47	49



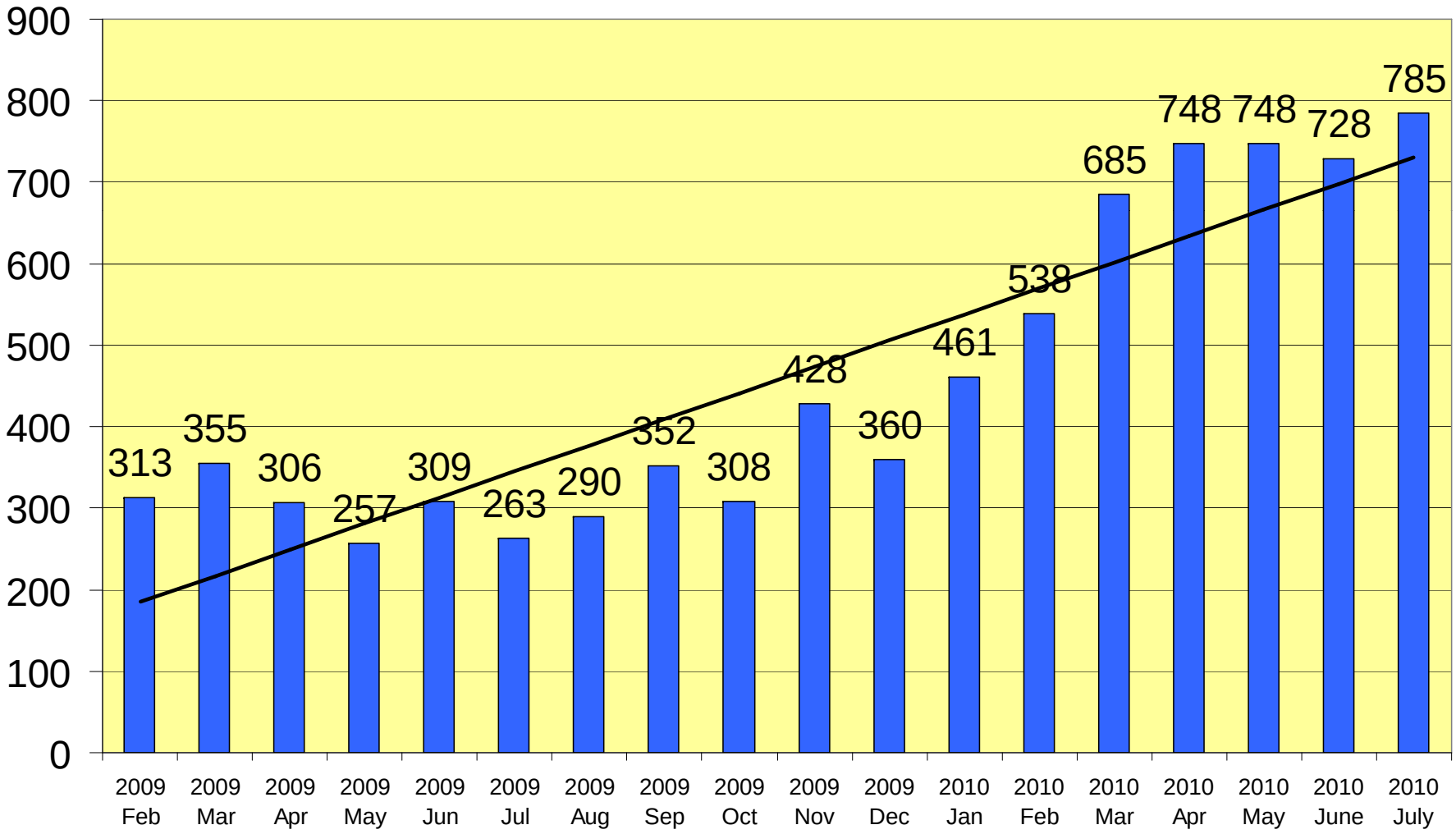


UIHC Transfer Center

- Established in February 2009
  - Initially targeted inpatient to inpatient transfers only
  - ER to ER calls added incrementally starting January 2010
- Coordinates hospital to hospital transfers in accordance with state and federal regulations
- Provides one call convenience for referring physicians and hospitals, 24 hours a day, 7 days a week
- Serves as a hospital and physician resource
  - Obtains medical information from referring sources and provides the information to accepting UIHC physicians for interpretation of diagnoses and specialized patient needs

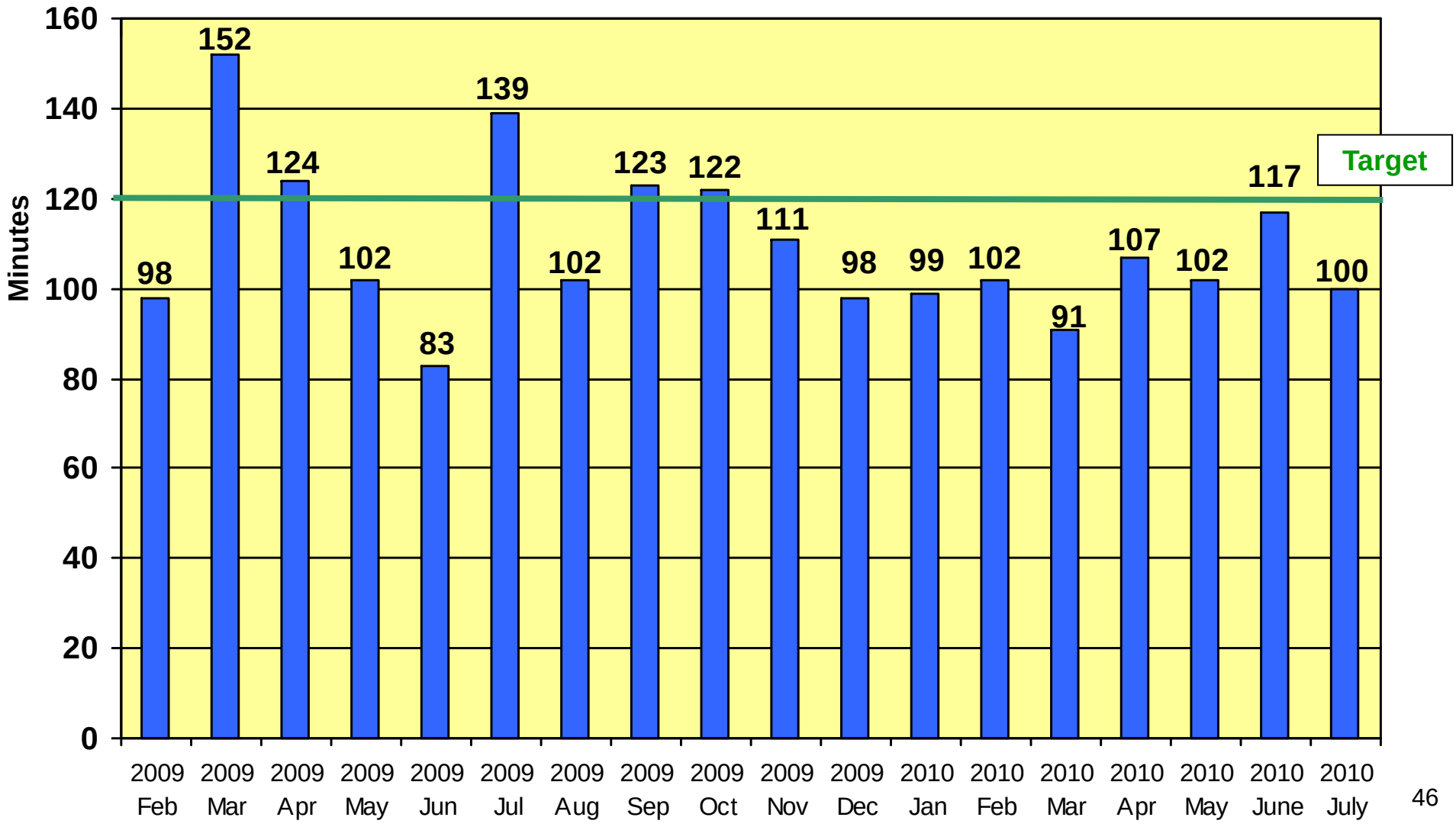
Transfer Requests

Over the past seventeen months, requests for transfers managed by the transfer center to UIHC from other hospitals has increased tremendously.



Average Time from Initial Call to Acceptance of Transfer to UIHC

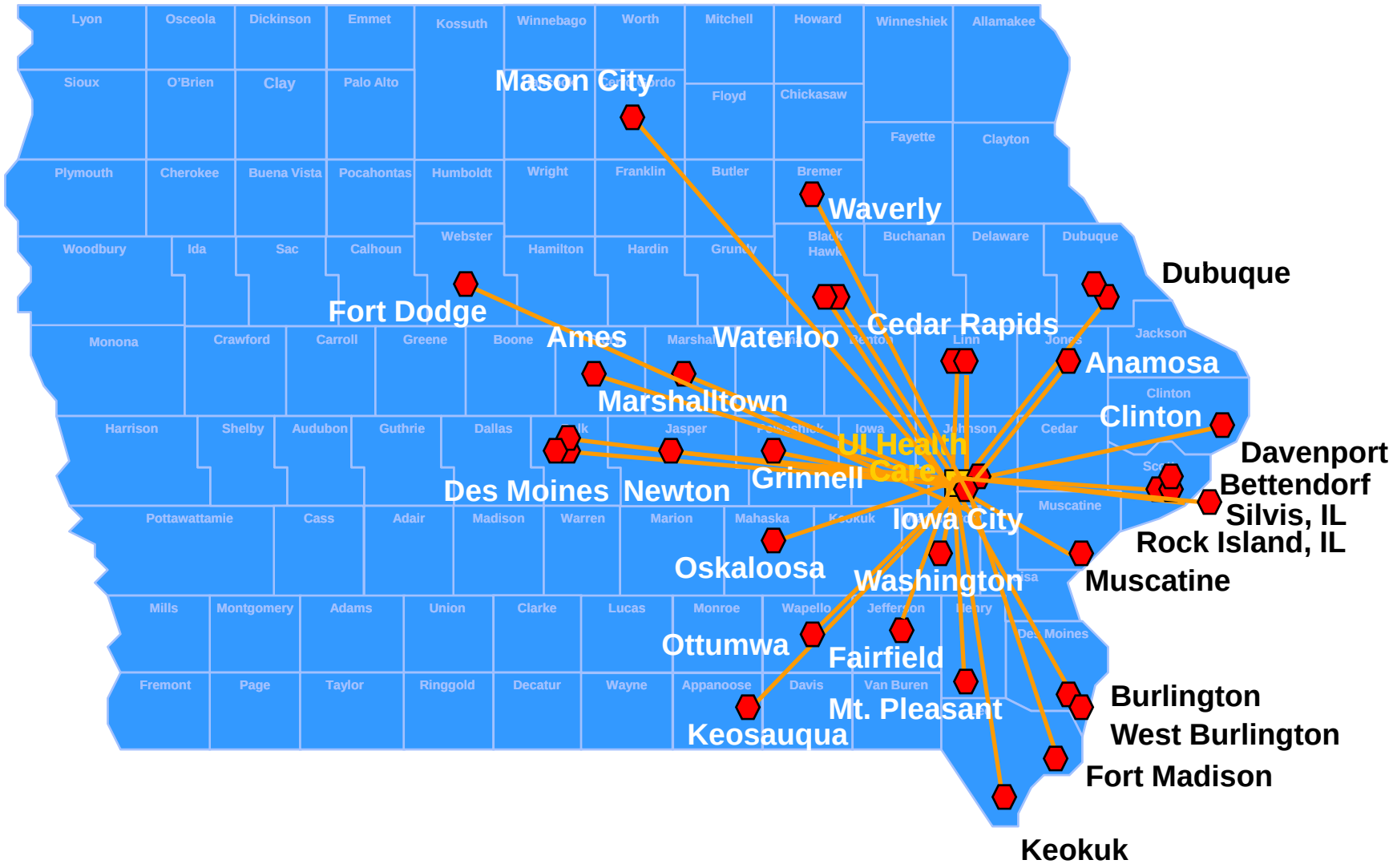
Improvements in service to referring physicians continues to be achieved with turnaround time targets being realized for the past nine months.



Facilities Sending Greatest Number of Transfers

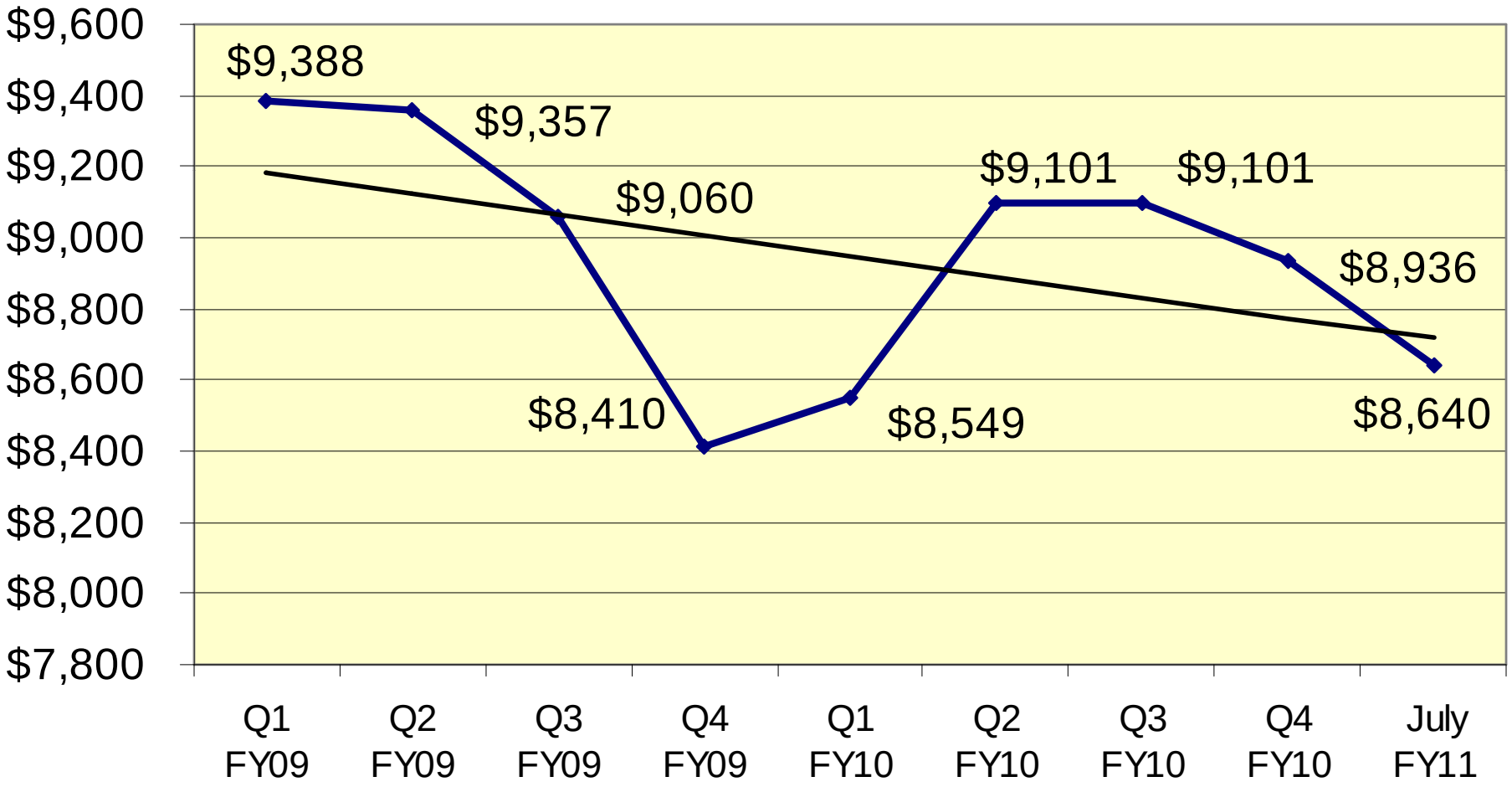
Davenport - Genesis Medical Center
Clinton - Mercy Medical Center-Clinton
Waterloo - Allen Health System
Waterloo - Covenant Medical Center
Cedar Rapids - St. Luke's Hospital
Ottumwa - Ottumwa Regional Health Center
Dubuque - Mercy Medical Center-Dubuque
West Burlington - Great River Medical Center
Marshalltown - Marshalltown Med./Surg. Center
Dubuque - The Finley Hospital
Fort Madison - Fort Madison Community Hospital
Iowa City - Mercy Iowa City
Cedar Rapids - Mercy Medical Center
Des Moines - Mercy Medical Center-Des Moines
Des Moines - Broadlawns Medical Center
Mount Pleasant - Henry County Health Center
Keosauqua - Van Buren County Hospital
Keokuk - Keokuk Area Hospital
Washington - Washington County Hospital & Clinics
Rock Island, Illinois- Trinity Hospital
Mason City - Mercy Medical Center-North Iowa
Muscatine - Unity HealthCare
Fort Dodge - Trinity Regional Medical Center
Newton - Skiff Medical Center
Ames - Mary Greeley Medical Center
Burlington - Great River Hospital
Des Moines - Iowa Methodist Medical Center
Grinnell - Grinnell Regional Medical Center
Bettendorf - Trinity at Terrace Park
Anamosa - Jones Regional Medical Center
Waverly - Waverly Health Center
Iowa City - Veteran Admin Medical Center
Fairfield - Jefferson County Health Center
Oskaloosa - Mahaska Health Partnership
Silvis, Illinois – Illini Hospital

Facilities Sending Greatest Number of Transfers



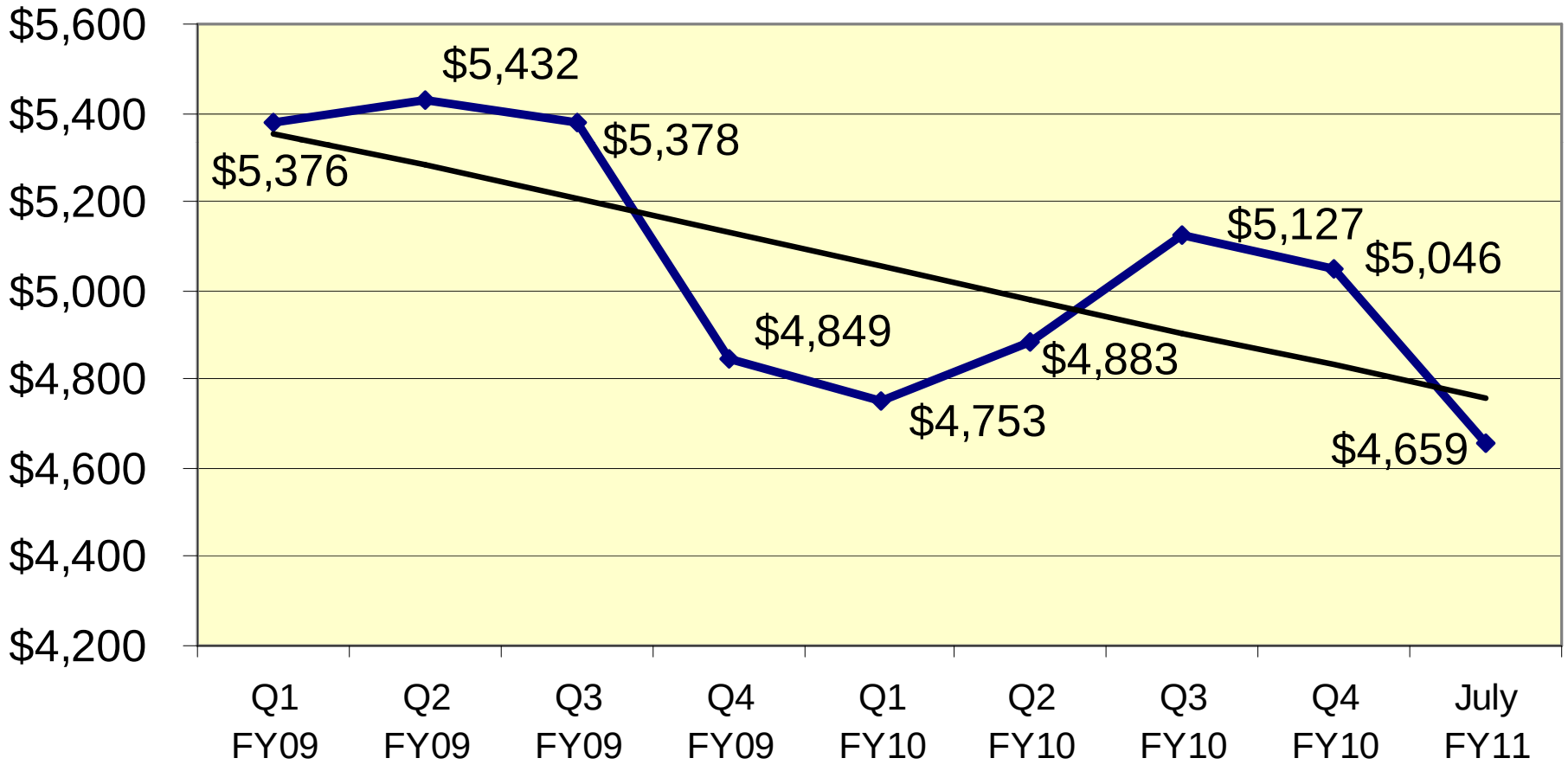
Total Operating Expenses per CMI-Weighted Adjusted Admission

Total operating expenses per unit of service over the past eight quarters and July of this fiscal year continues to trend nicely downward.



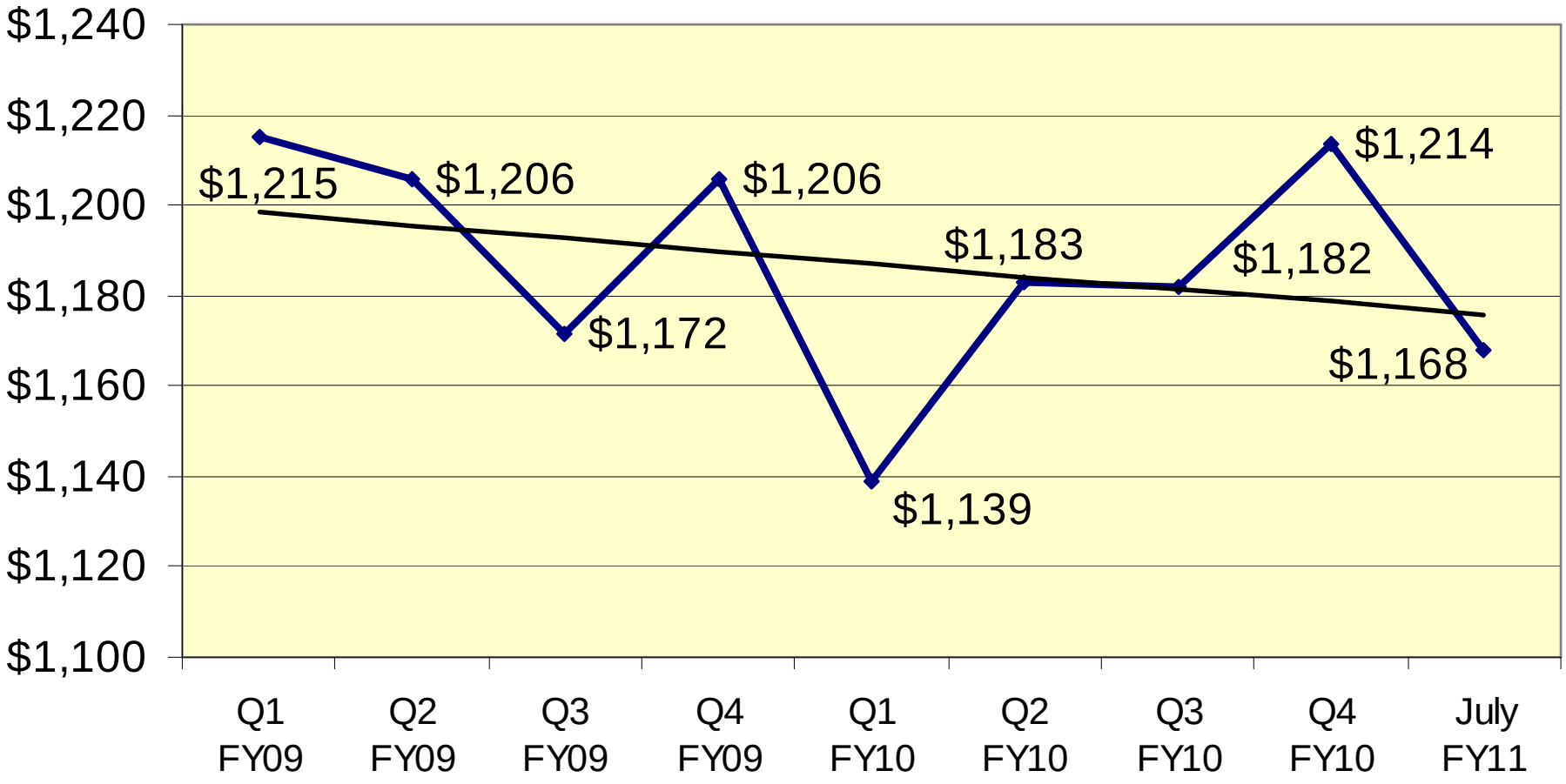
Salary and Benefit Expenses per CMI-Weighted Adjusted Admission

Labor expenses continue to decline. In July, salary and benefit expense per CMI-weighted adjusted admission, was 1.7% less than the prior July. In FY10, salary expenses per unit of service declined by 6.0% compared to FY09.



Supply Expenses per CMI-Weighted Adjusted Admission

Supply expenses per unit of service continue to improve with ongoing supply chain initiatives. In July, supply expense per CMI-weighted adjusted admission was 1.0% less than July of a year ago.



Supply Chain Savings FY09-To-Date

Extensive focus on managing the UIHC supply chain with strong partnerships between faculty/other clinical staff and the supply chain management team, has resulted in $6.8 million of annual savings in supplies and medical devices.

COMPLETED PROJECTS	
Project	**Implemented Savings**
Implants Spine	$1,190,531
Cardiac Rhythm Management	$1,064,810
Insulin Syringes, Lancets and Test Strips	$487,582
Thrombin	$229,382
Heart Valves	$220,460
DES Stents	$170,500
Gloves Exam	$168,645
Sterile Non Wovens	$158,379
Neurological Products	$157,354
Orthopaedic Implants	$557,409
CRM Devices	$250,000
Pharmacy	$937,469
Inventory	$60,800
Multiple Vendors	$431,868
Inventory Management	$150,000
Anspach Motors & Accessories	$14,316
UHC Partnership	$193,047
Orthopaedic Products	$28,000
Partnership	$325,157
TOTAL SAVINGS:	**$6,795,709**

Supply Chain In Progress

We continually look for additional opportunities related to supply chain management. There is a potential savings of approximately $7.1 million from supply chain projects currently in progress.

PROJECTS IN PROGRESS	
Project	**Potential Savings**
Neuro and Ortho Implants	$2,550,000
Endomechanical	$300,000
Inventory Management	$2,000,000
H-Card	$780,000
CARES	$200,000
Neuro Interventional Supplies	$250,000
Urology	$50,000
Service Contracts	
Custom Sterile Packs	$100,000
Labor & Delivery	$130,000
Pharmacy	$195,428
GI/Standardization/Contract Negotiation	$200,000
Spendlink	$348,394
TOTAL POTENTIAL SAVINGS:	**$7,103,822**

U.S. News & World Report Rankings

UNIVERSITY of IOWA HEALTH CARE

For the 21st Consecutive Year, UI Health Care Specialties Earned High Rankings In U.S. News & World Report

4th	Otolaryngology
6th	Ophthalmology & Visual Sciences
9th	Orthopaedic Surgery
19th	Urology
21st	Neurology/Neurosurgery
22nd	Cancer
22nd	Pulmonary
26th	Diabetes & Endocrinology
33rd	Gynecology
35th	Kidney Disorders