

The Regents of the University of California

COMMITTEE ON HEALTH SERVICES

March 17, 2015

The Committee on Health Services met on the above date at UCSF–Mission Bay Conference Center, San Francisco.

Members present: Regents De La Peña, Island, Lansing, Makarechian, Ruiz, Sherman, and Zettel; Ex officio member Napolitano; Advisory members Davis, Gorman, and Hare; Staff Advisors Acker and Coyne

In attendance: Regents Engelhorn, Kieffer, and Leong Clancy, Faculty Representative Gilly, Secretary and Chief of Staff Shaw, General Counsel Robinson, Chief Compliance and Audit Officer Vacca, Executive Vice President and Chief Operating Officer Nava, Executive Vice President Stobo, Chancellors Hawgood and Wilcox, and Recording Secretary Johns

The meeting convened at 1:20 p.m. with Committee Chair De La Peña presiding.

1. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of January 22, 2015 were approved.

2. OVERVIEW OF UC HEALTH'S CLINICAL ENTERPRISE

[Background material was provided to Regents in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Committee Chair De La Peña stated that this meeting would review UC Health's progress over the past several years. He reviewed the Committee's oversight responsibilities as described in the Regents Bylaws. The healthcare environment has changed substantially in recent years and in 2014 revenue from UC medical centers represented 36 percent of the University's total revenue. Following discussions with the Office of the President and the General Counsel, Committee Chair De La Peña was planning a future Committee meeting to review UC Health strategic plans and budget approvals. The current meeting would review UC Health transactions approved the prior two years, comparing results with projections. UC medical center chief executive officers (CEOs) would describe the transactions from a governance and structural standpoint, their original goals and current status, and evaluate whether the transactions have met original goals, their effect on the University, and what lessons have been learned. The CEOs would lead a discussion on measures that could be taken to help their entities move more nimbly in the rapidly changing, highly competitive healthcare environment. Finally, consideration would be given of the optimal ways for the Committee to receive future updates on UC Health

activities and what topics the Regents would like to be presented at regular Committee meetings.

Executive Vice President Stobo provided a review of UC Health over the past seven years, with an emphasis on the clinical enterprise and its financial status. He would also present UC Health's programmatic activities as a context for the CEOs' presentations.

Dr. Stobo reported that UC medical centers' operating revenues have increased from \$4.6 billion in fiscal year (FY) 2007 to \$8.6 billion in FY 2014, a 1.9-fold increase over that time period or a nine percent annual increase. More than 90 percent of this operating revenue is net patient revenue; a small amount is from interest earned. These results are a tribute to the skills of the medical center CEOs and their colleagues in managing these complex clinical entities. During the same period, UC medical center operating expenses have increased ten percent annually, from \$4.3 billion in FY 2007 to \$8.1 billion in FY 2014, also an increase of 1.9-fold. Dr. Stobo pointed out that in FYs 2012 and 2013 changes in Government Accounting Standards Board accounting rules required pension expenses to be included in expense calculations; this difference must be considered when comparing those years' expenses with prior years'. Operating expenses increased just four percent from FY 2013 to FY 2014. Dr. Stobo recalled his earlier projection that UC Health would need to reduce the rate of annual increase of operating expenses from its prior rate of six percent to four percent. This had been accomplished in the past year.

As of June 20, 2014, the operating margins at all UC medical centers were significant: 3.6 percent at UC Davis Medical Center; 8.7 percent at UC Irvine Medical Center; 6.2 percent at Ronald Reagan UCLA Medical Center; 11.4 percent at UC San Diego Medical Center; and 6.7 percent at UCSF Medical Center. UC medical centers' average operating margin of six percent is significantly above the national benchmark and attests to their excellent management. UC Health's standard that its medical centers have more than 60 days cash on hand was exceeded with UC medical centers' having days cash on hand ranging from 75 days to 172 days as of June 30, 2014, and very favorable debt service coverage ratios ranging from greater than two to more than four. In summary, these financial data show that UC medical centers are entering the period of healthcare reform with strong balance sheets and in good financial positions.

Dr. Stobo emphasized the critical importance of UC medical center operating margins in supplying the capital to replenish necessary medical center equipment and to support programmatic growth outside of the medical centers, mainly in UC's schools of medicine. Each year, UC medical centers contribute in the aggregate roughly \$500 million to such programmatic development, with \$250 million coming from the medical centers' operating margins. Year after year, roughly 50 percent of UC medical centers' operating margins supports programmatic development in UC's medical schools. The remaining \$250 million supports individuals associated with the schools of medicine who provide clinical services in the hospitals and elsewhere, and education of medical residents. This support from UC medical centers is critically important as support from State General Funds has diminished.

In FY 2007, UC medical centers provided 29 percent of the University's total revenue of \$15.9 billion. By FY 2014, UC medical centers' contribution had increased to 36 percent of the University's \$23.6 billion revenue. UC's overall revenue increased 1.5 fold from 2007 to 2014, a six percent year-over-year increase, while UC medical center revenue increased 1.9-fold, a nine percent year-over-year increase. Support from sources other than UC medical centers increased only 1.3-fold in that time period, a year-over-year increase of four percent. Dr. Stobo expressed his view that this trend would continue in the upcoming several years.

UC medical centers have been very successful, even though they receive no support from State General Funds. While the absolute amount of State General Fund support for UC schools of medicine has increased from \$208 million in FY 1990 to \$319 million in FY 2013, the proportion of State support of UC medical schools' overall budgets has diminished from 21 percent to seven percent in that time. During this time, the proportion of UC medical schools' budgets received from UC medical centers has increased to more than two times the amount received from State General Funds. UC medical schools currently receive from 14 to 17 percent of their budget from UC medical centers, and only seven percent from State General Funds.

Regent Makarechian asked why the debt service coverage ratio for UCLA and UC San Diego medical centers had decreased from June 30, 2013 to June 30, 2014, while their operating margins had increased. Dr. Stobo said he would provide that information to Regent Makarechian.

Dr. Stobo observed that the implementation of the Patient Protection and Affordable Care Act (PPACA) and the establishment in January 2014 of the California Health Benefit Exchange were supposed to increase the number of individuals enrolling in health insurance, either through the exchange or through Medi-Cal, and to decrease the proportion of Californians with no health insurance. The overall proportion of UC medical center patients with Medi-Cal coverage has increased over the past year by an average of six percent, including nine percent at UC Davis Medical Center, eight percent at UC Irvine Medical Center, 12 percent at UC San Diego Medical Center, seven percent at UCSF Medical Center, and a slight decline at the Ronald Reagan UCLA Medical Center. There has been a concomitant decrease in the proportion of patients who do not have health insurance. What was intended to happen under the PPACA has in fact happened. More Californians are enrolled in health insurance plans and the number of individuals who do not have health insurance has diminished. UC Health is in the process of understanding the overall effect of this change on its medical centers. While Medi-Cal reimbursement rates are low, they are higher than no reimbursement. However, a future reduction in federal payments to hospitals that care for low-income patients complicates the overall financial picture and could offset increases resulting from increased Medi-Cal enrollment. UC medical centers in the aggregate spent roughly \$450 million the prior year to provide care for individuals without health insurance who could not afford to pay for care.

Committee Chair De La Peña added that over the past 14 months, following California legislation, patients who have both Medicare and Medi-Cal have been moved into health maintenance organizations. This would have an effect on the rates UC would be paid for care of these patients. He suggested that future presentations show the percentage of Medicare and Medi-Cal patients in managed care.

Regent Lansing asked about the overall effect of the PPACA on reimbursements for patient care. Dr. Stobo responded that there was not enough information yet to determine the overall financial effect. If a patient has Medi-Cal coverage instead of no coverage, reimbursement would improve from nothing to 60 cents on the dollar. Part of the PPACA expanded the roles of Medi-Cal and Medicaid. UC medical centers receive roughly \$1.40 from commercial insurers for every \$1 of expense. Medicare reimburses 90 cents for every \$1 spent. If UC is to fulfill its public mission of providing care to underserved patients, then the reimbursement received from patients with commercial insurance is critically important in helping to subsidize the public mission. Having a strong payer mix with a significant portion of patients having commercial insurance is critical to sustain UC's public mission. In general, Dr. Stobo agreed that UC medical centers' finances should be helped by the PPACA, which UC supported and continues to support.

Dr. Stobo highlighted UC Health activities benefiting from a systemwide approach. Contracting with commercial insurers must include all UC medical centers or none. A systemwide Center for Health Quality and Innovation is designed to improve quality and outcomes in clinical services systemwide. Leveraging scale for value serves to reduce expenses in activities such as purchasing and revenue cycle. UC Care, the University's first self-insured health plan for its employees, was initiated about a year prior. Dr. Stobo's office is working with President Napolitano's office to determine if the University's self-insured plans should be expanded. Recent challenges such as the Ebola epidemic and the drug-resistant "superbug" have been addressed systemwide, with the chief medical officers and chief nursing officers meeting regularly to learn from one another. Systemwide efforts have also addressed the challenges associated with healthcare reform. Individual medical centers benefit from this systemwide approach much more than if they had to address these issues on their own.

UC Health has been engaged in activities associated with healthcare reform. Each UC medical center is working to expand its provider base by becoming part of a larger network, thus increasing its ability to provide care and its market share. Other activities include building primary care, focusing on population health, and developing lower-cost venues to provide care rather than delivering health care only in high-cost medical center facilities. UC Health is learning to transition from a fee-for-service model to a model in which it assumes financial risk, with reimbursement based on outcomes and quality of care. UC Health would also explore expanding its portfolio of self-insured health plans for UC's students, employees, and beyond.

Regent Makarechian asked how the self-insured health plans save money and who has the responsibility for implementing these programs. Dr. Stobo responded that the goal of the self-insured health plans is to have a year-over-year increase in employer and

employee premiums less than medical inflation, thus saving money. The plans are implemented by Dr. Stobo's office, using an established administrator that can process claims and perform other functions. Success of self-insured plans would require: addressing the health needs of a population, in this case the employees enrolled in the self-insured plan; taking financial risk, such as capping year-over-year employer premium increases, which is currently being considered; and building a robust network of primary care providers and expanding the provider base.

Regent Ruiz asked for a clarification of taking financial risk in this context. Dr. Stobo explained that under a fee-for-service model, when UC Health provides health care, it is guaranteed reimbursement simply by the fact that it provided that care. The more care it provides, the more UC Health would be paid, irrespective of the quality of the service or its outcome. Financial risk would be taken when UC Health is paid a set amount for providing health care to a population of patients. If the health care provided costs more than that set amount, UC Health would be at financial risk for the difference; if it costs less than the set amount, UC Health would keep the difference. Regent Ruiz asked if assuming such financial risk would offer the potential of greater profits. Dr. Stobo said UC Health would have both upside and downside potential.

Regent Sherman asked why there was such a range of operating margins among UC's medical centers and whether that range would be reduced as more systemwide activities are put in place. Dr. Stobo explained that the margins would never be identical and that the centers with the highest operating margins change from year to year because of unique expenses in certain years and variations in patient mix. For example, the proportion of patients with Medi-Cal is higher at UC Davis Medical Center than at Ronald Reagan UCLA Medical Center. Regent Sherman asked if it was possible to manage this variation. Dr. Stobo responded that it would be more difficult to manage the proportion of patients with commercial insurance than to manage expenses, which was UC Health's current focus. Committee Chair De La Peña added that there is downward pressure on reimbursements from commercial insurers also.

Regent Makarechian stated that the University's 2014 A-133 audit shows the UC medical centers having revenue of \$8 billion, rather than the \$8.6 billion cited by Dr. Stobo earlier. Dr. Stobo said he was unsure whether the revenue figures referred to net patient revenue or total operating revenue. He said he would review the data and get back to Regent Makarechian. Regent Makarechian asked Dr. Stobo about another line in the audit that referred to revenue of \$3.6 billion from "educational activities and auxiliary enterprises." Dr. Stobo explained that part of the clinical enterprise is revenue that comes into the practice plans for services provided by UC faculty. In every medical center other than UCSF, that revenue is separate from medical center revenue. At UCSF, this revenue is considered part of the medical center revenue.

Dr. Stobo observed that UC medical centers have been extremely well managed for the past several years and have been enormously successful from a programmatic and financial standpoint, which is critically important for the University's overall success. UC Health is well poised to be successful in the new era of healthcare reform.

3. **MEDICAL CENTER UPDATE ON TRANSACTIONS COMPLETED IN FISCAL YEAR 2013-14 AND FISCAL YEAR 2014-15**

[Background material was provided to Regents in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Committee Chair De La Peña introduced the discussion, which would provide information about the status of prior UC Health transactions. He recommended having a similar review each year. He introduced the UC medical center chief executive officers (CEOs): UC Davis Medical Center CEO Ann Madden Rice, UCSF Medical Center CEO Mark Laret, Ronald Reagan UCLA Medical Center CEO David Feinberg, UC Irvine Medical Center CEO Terry Belmont, and UC San Diego Medical Center CEO Paul Viviano. He thanked the CEOs for their able service to the University.

Ms. Rice observed that UC Davis Medical Center is the most geographically remote of UC's medical centers and serves a mixed rural and urban area. The Sacramento area does not have a safety net hospital, such as a county hospital, so UCD Medical Center provides more care to the underserved population than any other hospital in the region. UCD Medical Center has 13 percent of overall local market share, but provides more than 50 percent of the undercompensated care in the community. This demographic is reflected in UCD Medical Center's operating margins. UC Davis Medical Center has built on UC Davis' long tradition of working with partners across its region, resulting in a collaboration-based, rather than an acquisition-based, approach.

Ms. Rice highlighted four areas of current focus at UC Davis Medical Center: its cancer care network, telemedicine network, primary care network, and work with community hospitals. UCD Medical Center has four cancer care networks, which are part of its National Cancer Institute (NCI)-designated Comprehensive Cancer Center. Two of these centers are structured as joint ventures that were approved by the Regents several years prior; two centers are contractual affiliates. These centers have been functioning well, with one of the joint ventures operating since 1999. In 2013, an expansion, funded entirely from accumulated earnings, with one partner enabled the addition of 21,000 square feet of new construction, adding more examination rooms, more state-of-the-art equipment, and more treatment facilities for the community. UC Davis Medical Center's 2000 cancer care joint venture with Mercy Medical Center in Merced has continued to be successful. Another cancer center in San Joaquin Community Hospital was added in 2013 with no capital investment by UC Davis. The fourth cancer center in Truckee serves the Lake Tahoe area community. These cancer centers provide care for their communities, participate in UC Davis Medical Center's Virtual Tumor Board, and provide teaching opportunities. All four cancer care networks are very successful and may grow in the future. One center earned about \$17 million over its time of operation; these funds were reinvested in UCD Medical Center's local cancer center to help achieve the NCI designation three years prior. The quality of patient care has been improved in these communities.

Ms. Rice remarked that UCD Medical Center had learned the importance of selecting affiliation partners carefully so that the University of California brand does not suffer. It is advisable to be flexible in affiliations, since different partners have different types of boards: county hospitals may have political officials on their boards; other hospitals may have religious affiliations. Understanding the healthcare needs of local markets and whether those needs are being met is also important.

The UCD Health System Telehealth Program, supported originally with mostly grant funding, is one of the nation's largest and has provided 45,000 telehealth consultations from more than 100 sites throughout California. UCD Health has contractual arrangements with remote sites that either reimburse UCD Health on an hourly basis or pay a monthly rate for services available around the clock. In some cases, since California has been extremely progressive about telehealth, UCD Health has been able to bill a patient's insurance company directly. The goal of the Telehealth Program is to augment training and education of healthcare providers at remote sites. Over time, it has been UCD Health's experience that when local healthcare providers are coached through treatment of a new type of case the first few times by UCD faculty using telemedicine, more of the care can be delivered locally in subsequent cases, thus improving the standard of care in remote communities. This collaboration can help keep patients at home when medically appropriate and comfortable for their families. Telemedicine has improved care, has been financially viable, and has led to community hospitals looking to UCD to provide that type of expertise. UCD Health entered into a relationship with Adventist Health whereby two UCD physicians are the telehealth medical directors for the Adventist Health System. While UCD Health is not directly providing medical care, it is leveraging its intellectual investment in telemedicine to help a broader segment of Californians.

Through its experience with telemedicine, UC Davis Health has learned that some issues about reimbursement for telemedicine have yet to be clarified in California and nationally. UC Davis would like to be part of that discussion. Because UC Davis was an early adopter of telemedicine, its physicians have published in the area and are asked to comment on State and national policy around telemedicine. UC Davis Health has worked through having licenses in multiple states, necessary to practice telemedicine on a national basis. The collective intellect of UC in this area would be a tremendous national and international resource. Working with partner sites on improving the medical transfer of ill patients would be important.

UC Davis Medical Center's primary care network was initiated many years ago and its model continues to be refined and the network increased. UCD has not recently acquired practices, since there are very few remaining independent physician practices in the greater Sacramento region. UCD's primary care network has been expanded more by employing physicians than by buying their practices. UCD Medical Center earned the Patient Centered Medical Home Designation from the National Committee for Quality Assurance and has emphasized management of chronic diseases, gaining some early experience in population health. In 2012 UCD Health partnered with Rideout Health to open its first joint primary care network. This is not a joint venture. University physicians

provide care and Rideout Health provides offices and staff, using UC Davis Medical Center's electronic medical records, improving care to patients in that community and facilitating patient referrals to UC Davis Medical Center. In 2015, there would be four full-time physicians at that site. The primary care network's governance structure involves UC Davis either owning or more frequently leasing the facilities, and employing the staff (with the exception of the arrangement with Rideout Health) and physicians. Physicians are paid on a productivity model and also have an appointment with their home academic department within the UC Davis School of Medicine. Currently 120 physicians at 14 locations in ten cities make 500,000 visits per year. The primary care network has met the goal of obtaining specialty and sub-specialty referrals from the primary care physicians. Quality of care is closely monitored and has been excellent. The City of Davis location was recently expanded in anticipation of treating more UC employees who enroll in UC Care.

Ms. Rice stated that maintaining a proper balance between the primary care and specialty care networks is very important. If the primary care network is too big, it could generate more specialty referrals than could be accommodated. On the other hand, if the primary care network is too small, the medical center must rely on specialty referrals from primary care physicians outside its network. UC Davis Health has learned that it must continually recalibrate the size of its networks. When planning to open a primary care location in a new area, consideration must also be given to not disrupt referral relationships with physicians already practicing in that community.

UC Davis Medical Center works with community hospitals. A few years prior, UCD Medical Center pursued, and then walked away from, a potential merger or acquisition of a Stockton community hospital. This process helped clarify goals for acquisitions for all UC medical centers. In 2011, the Regents approved a UCD Medical Center joint venture to operate a 200-bed hospital in Stockton with the goal of improving the quality of care in that underserved area and to increase the referral base for tertiary and quaternary care at UC Davis. However, changes in the board and management of the Stockton hospital and other concerns led UC Davis to not complete the joint venture. Ms. Rice said UC Davis management learned from that experience that time can kill potential deals, in that more variables can be introduced the longer a transaction takes. Preparing standardized documents in advance of transactions could help streamline the process. Currently, UCD Health is pursuing professional services agreements with community hospitals. Rural hospitals in Northern California request assistance with physician coverage because they have a need for physicians who are able to see patients in their community. Providing such assistance would not involve acquisitions or financial risk for UC, but would make a real difference in the quality of care delivered in rural areas.

Committee Chair De La Peña commented that UC Davis' Telehealth Program is probably the best in the world. He noted the opportunity for it to produce revenue and to assist in other areas, such as providing cost-effective consultations for UC student health and counseling centers that have insufficient professional staff.

Mr. Laret discussed five UCSF transactions approved by the Regents since January 2013. At that time, UCSF gained approval to take an ownership share of an important regional independent practice association. However, negotiations were terminated by UCSF because of a difference in the association's perceived fair market value. He reinforced Ms. Rice's earlier comment that the Regents should have confidence that the UC medical centers are judicious in approaching such transactions, even ones that have been approved by the Regents.

Mr. Laret discussed UCSF's affiliation with Children's Hospital Oakland, effective January 1, 2014. Shortly after the affiliation was announced, Marc and Lynne Benioff, who had already given substantial sums to Benioff Children's Hospital at UCSF, gave a \$50 million gift to the newly named UCSF Benioff Children's Hospital in Oakland (BCHO). The two separately licensed hospitals, one public and one private, are referred to collectively as the Benioff Children's Hospitals. Mr. Laret reviewed the affiliation's original financial projections of \$540 million in revenue for the first year, Earnings before Interest, Depreciation, and Amortization (EBIDA) of \$46 million, net operating income of about \$13 million, and cash of \$282 million. The affiliation's actual finances were less than projected: \$488 million total revenue, still strong EBIDA of \$25 million, an operating loss of \$11 million, and cash of \$261 million. In January 2015, net income improved to over \$5 million. Mr. Laret explained the performance of the past year. The timing of State and federal approvals regarding Provider Fees cost UCSF \$12 million in 2014. There was a nonrecurring debt refunding loss of \$7.5 million; additional marketing and strategic planning to highlight the merger cost \$8 million. Implementation of Epic electronic medical records reduced outpatient volume further than projected. BCHO's cash position is strong, with 206 days cash on hand.

A good deal has been accomplished in the Benioff Children's Hospitals in the past year. Some core operating functions have been combined. The UC Office of the President provides legal, risk management, and compliance services to BCHO. UCSF and BCHO have co-located billing and collections. Approximately \$2.5 million in annual operating synergies have been achieved and significant integration of clinical services has been accomplished.

Mr. Laret discussed major challenges of the affiliation. Maintaining two corporations, one public and one private, added complexity to decision-making and financial alignment. Mr. Laret affirmed that this is the best model for the transaction, but noted that it is more complex than a simple acquisition. Merging two different cultures and decision-making processes has been challenging. Most importantly, BCHO relies on a private medical staff; UCSF has a faculty model. Some programs including urology, orthopedic surgery, and dermatology, have merged, but some programs at the two facilities are still competitive with each other. Improved alignment of physicians would take time to accomplish.

From its experience with the affiliation with CHO, UCSF management learned the need to over-communicate strategies and actions being taken to staff and physicians in both organizations. It would be important to clarify precisely responsibility for decision-

making and its processes. The integration requires dedicated staff resources at a high level inside the organization. The hospitals' competitors did not slow down while the integration was taking place. It would be helpful to have one team focus on the integration, and a completely separate team focus on strategy and market competition. He expressed confidence that the Benioff Children's Hospitals affiliation is accomplishing its goals.

Mr. Laret outlined another UCSF transaction, the three affiliations with John Muir Health, a leading East Bay community hospital system: first, an investment in a Bay Area Accountable Case Organization (ACO), putting together groups of hospitals and physicians in the Bay area who can take financial risks together; second, the formation of BayHealth, a 50-50 joint venture between John Muir Health and UCSF; and third, a physician network collaboration that was currently underway.

In summary, these transactions to increase scale and support network growth to compete in the PPACA environment remain extremely important to UCSF. More hospital and physician group transactions would be brought to the Regents. Mr. Laret emphasized that UCSF is judicious in evaluating such transactions.

Dr. Feinberg provided updates on five projects undertaken by the Ronald Reagan UCLA Medical Center in the past few years. The goal of the affiliation of its Jules Stein Eye Institute with Doheny Eye Institute, previously affiliated with the University of Southern California (USC), was to create the nation's best center for ophthalmologic patient care, research, and education. He expressed confidence that this goal would be achieved in the next couple of years. The affiliation has gone well and funding has already been received from the Doheny Eye Institute to help support UCLA faculty. There were 30 USC ophthalmology faculty members at USC; 90 percent of them left with the affiliation to join the UCLA faculty. The clinics are up and running well. Looking back, Dr. Feinberg observed that UCLA Health had underestimated the need for ambulatory surgery center space; that is being rectified.

Another UCLA Health transaction was acquisition of the Motion Picture Television Fund, a group of physicians and clinics, with 200 staff and 50 primary care physicians that serve the Screen Actors Guild, the Writers Guild of America, and the Directors Guild of America. This acquisition allowed Ronald Reagan UCLA Medical Center to increase its primary care geographic range, receive referrals of tertiary and quaternary care, and increase its relationship with the area's important entertainment industry. This acquisition has been completed and is ahead of budget on every measure, including patient volume, which has increased. The clinics remain exclusive to the motion picture industry until 2016, when they will accept other patients and be integrated further into UCLA's system.

The California Rehabilitation Institute, a new hospital in Century City, is a joint venture among Ronald Reagan UCLA Medical Center, Cedars-Sinai Medical Center, and Select Medical, the largest publicly traded rehabilitation company in the nation. A hospital that had been empty for a number of years was being retrofitted and would likely open at the end of 2015 or in the first quarter of 2016. The Chief Medical Officer is a UCLA faculty

member. Dr. Feinberg anticipated that this facility would provide the best rehabilitation services in the western United States and would help UCLA move inpatient volume to the new facility so UCLA can accommodate more appropriate cases at its Ronald Reagan Medical Center and Santa Monica facilities.

The Regents approved UCLA Health's purchase of a 25 percent equity position in Specialty Surgery Centers of Encino, a Symbion Surgery Partner. Providing surgery in ambulatory surgery centers is an important way to reduce the cost of providing care. Since UCLA Health acquired its 25 percent interest, surgeries at the facility have increased 62 percent, from 430 cases a year to 706, and this growth is anticipated to continue. Discussions were being held with the same organization about other possible equity opportunities in outpatient surgery centers. During this time, the number of surgeries at the Ronald Reagan UCLA Medical Center and UCLA's own outpatient centers continued to increase.

The Regents approved UCLA's participation in Anthem Blue Cross Vivity, a new LLC, a joint venture among Anthem Blue Cross and seven Southern California top-tier provider organizations, including UCLA Health. Vivity is offering a new product to the market, a Kaiser Permanente-like benefit, priced less than Kaiser. For a \$20 co-pay, enrollees will be able to go to any of the seven hospitals and their providers. Projected enrollment of approximately 15,000 in the first few months has already been accomplished. Most of the enrollment has come from particular providers who turned their whole staff over to this product and Dr. Feinberg reported that a rationalization of care was already evident, with care being directed to the most appropriate facility for a patient's condition. Patients are being seen at the appropriate facilities, lowering cost and decreasing travel burden on families. This project was going well, but it was too early to evaluate its finances.

Mr. Belmont updated the Regents on some of UC Irvine Medical Center's affiliations and other initiatives. UC Irvine Medical Center has strengthened its market position over the last several years and has added several new community access points. UC Irvine's Douglas Hospital opened in 2009 and its financial performance is strong. Quality and patient experience scores have continued to improve and UC Irvine Medical Center has grown in distinction in Orange County and beyond.

The intent of UC Irvine Medical Center's affiliation with Children's Hospital of Orange County (CHOC) was to enhance and combine their pediatric training, research, and care to create a world-class facility. Mr. Belmont described key proposed elements of the affiliation. Most inpatient and outpatient services were transferred to CHOC; UC Irvine Medical Center closed its pediatric unit. A joint venture in a neonatal intensive care unit (NICU) was being explored. Residency programs were combined into a single, UC Irvine-sponsored joint residency program. The University would have three of 13 directors on the CHOC board. The new position of Pediatrician in Chief would be created at CHOC. A funds flow model would be established to support the residency and academic programs.

Mr. Belmont reviewed the current status of the CHOC affiliation. The combination of the academic and research programs has been extremely successful, with an outstanding combined residency program. Research has grown. However, the intended funds flow program to enhance research and academics did not materialize. Mr. Belmont agreed with Mr. Laret's earlier comment that combining physicians from an academic medical center with private physicians is extremely challenging. Two years earlier, CHOC established a medical foundation, with their private physicians in that foundation; this changed the nature of the affiliation's clinical programs because UC Irvine physicians could not participate in that foundation. As a result, all clinical agreements had to be severed. Consideration is currently being given to a single employment model under which CHOC physicians would join UC Irvine faculty. Mr. Belmont expressed his view that this model would be adopted. The NICU joint venture would be explored further. Currently UC Irvine and CHOC have outstanding NICUs. Even better care for a larger population could be offered through a joint venture.

Mr. Belmont averred that the agreement for the CHOC affiliation was meant to be comprehensive, but many details were not clearly defined. It had taken five years to clarify details, particularly in the clinical enterprise, and having the details defined initially would have been preferable. He cautioned that it was important that the intent of both parties be clearly defined at the outset.

UC Irvine Medical Center's affiliation with another entity, MemorialCare, was intended to establish a UC Irvine-branded primary care network across the central, eastern, and northern portions of Orange County. The affiliation has two models, an employed medical group and a wrap-around independent physicians' association. UC Irvine would be able to access MemorialCare Medical Foundation healthcare contracts. There is a five-year non-compete agreement. UC Irvine was required to establish four medical group sites within the community. MemorialCare Medical Group, with its extensive experience managing primary care medical groups, would operate the sites, whose physicians are UC Irvine faculty leased to the sites. Two of these sites opened in November 2014 with 13 primary care physicians recruited, already doubling UC Irvine's number of primary care physicians, which had not been an emphasis. These physicians came from the community and joined UC Irvine faculty. The Tustin site also has radiology, laboratory, and urgent care services, and would have other faculty specialists soon. These community sites have generated referrals to UC Irvine physicians, have enriched the UC Irvine culture to include more emphasis on the patient experience, and would generate additional opportunities for non-primary care partnerships in ambulatory surgery and diagnostic centers. Next steps for the affiliation would be to improve electronic medical record interoperability, which has been challenging; MemorialCare uses Epic and UC Irvine uses Allscripts. UC Irvine is in the process of identifying and opening two more medical group sites in the community. UC Irvine Medical Center was at capacity, and was seeking to reduce the length of hospital stays and find more capacity in the community.

Mr. Belmont discussed UC Irvine Medical Center's expansion of its world-renowned Comprehensive Digestive Disease Center (CDDC), for which the Regents approved \$19.8 million to remodel and increase capacity. The CDDC had grown from 7,270 cases

in FY 2011 to 9,244 cases in FY 2015. The expansion would increase capacity to a projected 15,000 cases in FY 2020. Planning has been completed and the construction awarded.

Mr. Belmont noted that UC Irvine Medical Center's positioning strategies were to be a premier provider of tertiary and quaternary services, its traditional strength, and to manage the health of attributed populations cost-effectively with superior outcomes. Other upcoming UC Irvine Medical Center initiatives included evaluating equity positions in community hospitals in key expansion areas, establishing a low-cost network of ambulatory surgery centers, and recruiting community specialists who would join UC Irvine faculty. UC Irvine completed a clinical affiliation with Corona Regional Medical Center, a major opportunity that would allow expansion into an underserved area. UC Irvine also seeks ways to interact with the UC Riverside School of Medicine.

Mr. Viviano presented updates on UC San Diego Health System transactions. A Bone Marrow Transplant (BMT) joint venture with Sharp Healthcare since 1999 has become a stellar operation, both clinically and financially. The program has become one of the leading bone marrow transplant centers in Southern California. The Regents had recently approved an expansion of the joint venture to include liver transplants and UCSD Health System hopes to expand it further to include heart transplants. The goal is for UC San Diego Health System to become the host site of a number of clinical programs that are currently spread over two or three competing institutions. The programs would be structured so that the very expensive infrastructure could be isolated in one medical center, resulting in stronger outcomes.

UC San Diego Health System acquired the San Diego Cancer Center (SDCC), a small cancer center in Encinitas, in 2012. The acquisition got off to a very slow start. The UCSD Health System learned that it had alienated some local physicians in the way the SDCC was integrated into the UCSD network, which was perceived as heavy-handed. Mr. Viviano said it would have been preferable to have a designated integration team work more closely with the community to ensure continuation of referrals. The acquisition has recovered and the opportunity exists for expansion. First-year operating losses were improved to break-even performance in 2014; significant net income of nearly \$10 million was projected for 2015.

UC San Diego Health System acquired the Nevada Cancer Institute in 2012 with an \$18 million investment in the property and building. Its operations were shut down in early 2013 and the property, which had serious use constraints, would be sold for \$23 million. Lack of aggressive early due diligence, lack of interfacing with health plans, and lack of an early integration team to ensure success all contributed to the acquisition's lack of viability.

Mr. Viviano discussed UC San Diego Health System's current strategies. It plans to improve its footprint in San Diego County, expanding on its two current locations in Hillcrest and La Jolla. Its three competitors have county-wide distribution and delivery networks. UCSD Health System is examining seven different possible hospital

affiliations in San Diego, Riverside, and Imperial Counties. These would be clinical affiliations whereby UCSD faculty and management teams would assist with the development of new clinical services, use faculty to staff new and enhanced clinical services, or jointly operate new clinical services.

UCSD Health System has been working with the Office of the General Counsel and external counsel to develop a clinical integration network, a formal federal designation. Community physicians who want to remain independent could adopt UCSD's clinical protocols and pathways to implement electronic medical records in their practices and become part of UCSD's payer contracting strategy. Some initial success had been achieved, with 45 community physicians becoming part of the network. A second wave of 75 additional physicians would come into the network in June; 150 more would be added in September, including physicians in San Diego, Riverside, and Imperial Counties. About half the physicians in San Diego County want to remain independent. The clinical integration network would increase referrals for UCSD's tertiary and quaternary services.

UC San Diego Health System was in active discussions with potential affiliates to partner on care delivery in areas such as urgent care, home health, skilled nursing, hospice, dialysis, and acute rehabilitation. UCSD would seek to be a minority partner in population management affiliations that would be essential to success in the era of accountable care. One hospital was interested in becoming part of UCSD; should that opportunity continue to mature, it would be brought to the Regents.

Regent Engelhorn asked about the status of the transition from pay-per-procedure to pay-per-patient and whether that status varied among UC medical centers. Dr. Feinberg responded that UCLA's 152 outpatient clinics care for roughly 600,000 patients; half of those are primary care patients. More than half of those primary care patients were in some form of risk payment, meaning either fully capitated or with additional payment being available if the cost of care were kept down. Most of UCLA's primary care business is risk-based. Mr. Viviano added that UC San Diego Health had probably the smallest proportion of at-risk patients at UC, a very small population of about 50,000, or about ten percent of its overall patients. About 40 percent of UCSD Health System's revenue comes from Medicare, which is evolving toward an at-risk payment mechanism. Payment would depend upon quality indices such as patient satisfaction, quality scores, and readmission statistics. Medicare anticipates that by 2020 as much as 90 percent of Medicare reimbursement could be at risk. In the future, a very significant portion of patients currently cared for on a fee-for-service basis would transition to an at-risk model. Executive Vice President Stobo stated that systemwide 75 percent of revenue is fee-for-service; 25 percent is at risk. He anticipated that proportion would change very quickly over the next several years.

Regent Zettel asked about the challenges associated with billing for telemedicine services. Ms. Rice said that progress was being made. California has been an early adopter of paying for telemedicine. Better data are available to show that telemedicine saves money to payers. The bigger issue is that telemedicine improves access so that

patients are seen more quickly and knowledge is transferred to physicians in other communities, enabling those physicians to diagnose patients on site. UC medical centers need to prove the value of telemedicine to the payer community and to patients. Some systems provide more telemedicine directly to consumers, which UC medical centers could collectively consider. Dr. Stobo stated that in the current fee-for-service model, it was important whether the individual paying for the service would reimburse for telemedicine. Moving to a financial risk model in which a fixed amount of dollars would be paid for care, if telemedicine would increase access and decrease costs, it would save money. Regent Zettel suggested that using telemedicine could reduce some hospital readmissions; Dr. Stobo agreed, adding that telemedicine could also decrease emergency room visits.

Regent Zettel asked if there were government guidelines for securing reimbursement under the at-risk model. Mr. Viviano responded that Medicare guidelines are very explicit and a small portion of reimbursement is currently at risk. Penalties are clear and are withheld on a very specific basis. It is not clear what the guidelines would be in the future, when the at-risk model expands.

President Napolitano asked the medical center CEOs for their opinions of indicators of either success or failure for which the University should be alert over the coming year. Mr. Laret said it would be important to be able to evaluate the health of a population, including preventive measures such as immunizations, childhood education, and managing difficult conditions such as diabetes, heart disease, or mental health conditions. Health systems such as Kaiser Permanente have experience in population health management. Mr. Belmont observed that 30 percent of UC Irvine's volume is super-tertiary and quaternary super-sub-specialty services, with the remainder being services that can be provided elsewhere. It would be important that the UC medical centers not become isolated, but engage as parts of larger community networks. Dr. Feinberg commented that UC medical centers must operate based on a sense of patient-centeredness, providing patients and their families a high-quality experience with cultural sensitivity. Health care would be increasingly consumer-directed and customers would choose providers who take good care of them. The Committee should pay particular attention to patient satisfaction scores. Mr. Viviano added that controlling costs would be increasingly important; judgments would be made in terms of cost, not only clinical outcomes. The Committee should review various cost profiles.

Regent Lansing asked about UC Health research. Dr. Stobo agreed that the clinical enterprise and research are linked. The focus of the current presentation was to provide an update on UC Health transactions of the last few years. Regent Lansing suggested that a review of UC Health's research and clinical trials be included in a future update to the Committee.

Regent Makarechian asked about the cause of the range of operating margins at UC medical centers and why UC Davis Medical Center's operating margin was negative. Ms. Rice explained that in 2013 UC Davis Medical Center's operating margin was affected by catch-up pension plan contributions. In addition, there is no other safety net

hospital in Sacramento County, so UC Davis Medical Center cares for a large disproportionate share of patients who cannot pay. Also, beginning in 2008, Sacramento County, which has a constitutional commitment to take care of a certain population, left its contract and ceased paying UC Davis Medical Center, an amount equivalent to \$35 million per year. UC Davis Medical Center continued to provide care for those patients under the federal Emergency Medical Treatment and Labor Act. This situation is unique among UC medical centers and is the subject of a pending lawsuit. In response to a further question from Regent Makarechian, Ms. Rice reported that more than 50 percent of UC Davis Medical Center's patients are Medicare or Medicaid patients; its Medicaid population increased 19 percent in the past year. Less than five percent of its patients have no medical insurance. Under federal law, the majority of the uninsured population would now have access to the Medi-Cal reimbursement rate. Given its payer mix, Ms. Rice said it is uncertain yet whether UC Davis Medical Center's operating margin would benefit from healthcare reform. Mr. Laret added that at UCSF Medical Center for \$1 of patient care cost, Medi-Cal pays 60 cents; Medicare pays 90 cents; commercial insurance pays \$1.40. Therefore, operating margins are linked to the population for which a medical center cares. Regent Makarechian asked if the cost of providing care was the same at all UC medical centers. Dr. Stobo observed that labor costs vary among the UC medical centers. Mr. Laret pointed out that many hospitals care for very few Medi-Cal patients. There is an uneven distribution of Medi-Cal patients among hospitals. The University should be proud that UC medical centers do more than their share of treating such patients. Committee Chair De La Peña said that reimbursements for medications are negotiated. The Kaiser Permanente model is to care for more healthy populations with employer coverage rather than uninsured patients with difficult conditions. Dr. Stobo added that systemwide 60 percent of UC medical center volume is Medicare, Medi-Cal, and uninsured patients; the other 40 percent of patient volume accounts for 60 percent of revenue, allowing UC to fulfill its public mission.

Regent Kieffer summarized the goals expressed as increasing the number of patients served, affiliating with other healthcare providers to provide different kinds of care at the appropriate cost, achieving the right patient mix if possible, and reducing costs. Mr. Viviano agreed. Regent Kieffer asked what advisory boards are used by UC medical centers to provide expertise in these difficult endeavors. Dr. Stobo agreed that this is a fundamental question. UC medical centers have various types of local advisory boards, some more robust than others. On a systemwide basis, such expertise is provided on an ad hoc basis, according to the demands of various projects. There is no coherent, consistent systemwide advisory board of individuals with expertise in these areas. Regent Kieffer asked if it would be helpful for Dr. Stobo to choose an advisory board that would fill that function. Dr. Stobo agreed that would be beneficial.

Mr. Viviano explained that UC San Diego Medical Center has an advisory board comprised of leaders in medical insurance, physicians, community leaders, healthcare attorneys, and Regent Zettel. This board, while advisory and informal, meets four or five times annually to review UCSD Medical Center's strategic plans. This board is separate from UCSD Medical Center's fundraising foundation, which has a separate board.

Regent Kieffer asked if the advisory board would help evaluate potential acquisitions. Mr. Viviano answered in the affirmative.

Mr. Feinberg commented that UCLA Health has several fundraising boards that sometimes provide advice. He and Vice Chancellor and Dean of the David Geffen School of Medicine A. Eugene Washington established a board of overseers comprised of national experts to provide strategic advice to UCLA Health. This board, which meets a few times a year in person and a few times by telephone, has been extremely helpful.

Ms. Rice commented that UC Davis Medical Center has a national board of advisors that also advises its School of Medicine. The board does not meet on a regular basis, but is available when needed. UC Davis also has separate service line advisory boards, including ones for cancer and neurological diseases, to provide in-depth knowledge about scientific and medical issues.

Mr. Laret stated that UCSF Medical Center has an outstanding advisory board of about eight individuals chaired by Sanford Weill. The board meets four to six times a year and advises on every potential transaction. This board offers needed advice, but Mr. Laret expressed his opinion that it is insufficient because a fiduciary board is needed to evaluate risk of potential transactions.

Mr. Belmont added that most of UC Irvine Medical Center's advisory boards involve fundraising. He initiated a separate board including successful CEOs, physicians, health plan executives, and others. This board meets four to six times a year to evaluate strategies and has been extremely helpful. However, this board would be discontinued as a result of UCI structural management changes.

Committee Chair De La Peña observed that the medical centers need local boards that are familiar with the regional healthcare issues. Most UC medical centers have good local boards. As UC Health develops more systemwide strategies, expert advice on these strategies would have to be as robust as possible. The question of fiduciary responsibility is a legal issue. It would be difficult to bring in advisors who are not Regents or University employees to make substantial fiduciary decisions. He suggested that a systemwide advisory board, similar to the Investment Advisory Group, could be appropriate.

Regent Kieffer suggested that perhaps UC Health's experience in seeking affiliations to provide various kinds of patient care could be applied to the University's educational enterprise. Dr. Stobo responded that systemwide efforts in UC Health's clinical enterprise would be an important model for UC Health's research and educational enterprise. Efforts to collect data systemwide have been powerful in providing tools to allow more effective delivery of medicine. The increasing cost of educating health professionals and increasing debt incurred by health professional students indicate the need to find ways to teach health professionals more effectively.

Regent Ruiz expressed appreciation for the leadership of Dr. Stobo and the CEOs of UC medical centers in this time of great risk and opportunity in the healthcare field. UC Health has performed successfully because it has managed costs well and must continue to monitor the cost of proposed transactions. Continuing to manage UC medical centers to provide excellent patient care would also be important. Variations among UC medical centers show the importance of regional solutions. UC has been effective at managing its five medical centers with excellent local leadership combined with a strong systemwide approach. Regent Ruiz expressed concern about the continuing risk of medical lawsuits.

Mr. Laret said that the risk and complexity of the healthcare environment are increasing and UC must operate five medical centers in different markets throughout the state. At the same time, the University is increasingly dependent on the success of its medical centers, whose revenues make up for reduced State funding. He expressed his view that a different governance model for UC Health is needed. Other university systems have addressed this issue aggressively. For example, the University of Washington has a Board of Regents, but has set up a separate board for its health system. Every hospital that UCSF deals with has a board that meets every month and is actively engaged with issues such as finance, medical/legal risk, quality and safety, patient-centeredness, strategy, talent succession, and acquisition decisions. UC medical centers are at a disadvantage because of the current University governance system. The Committee on Health Services usually meets for about an hour every other month, to govern an \$8 billion a year high-risk enterprise. He expressed the view of the medical center CEOs that a governance model with a more specifically engaged board would better serve both the University and the medical centers to fully protect the interests of the University. Regent Ruiz agreed that examining other business models would be appropriate.

Staff Advisor Coyne asked if there were cost-effective options for using UC medical centers to provide services in areas such as Santa Cruz and Santa Barbara where services can be limited or very expensive. Dr. Stobo responded that this was being considered, particularly through expansion of options in its self-insurance healthcare plans for employees. Since the University is invested in assuming the financial risk of providing health care to its employees, it would be much more engaged in ensuring there are affordable, accessible healthcare services in areas such as Santa Cruz, Santa Barbara, and Merced. Ms. Coyne asked whether this would involve establishing some type of UC treatment facility in those areas. Dr. Stobo said this option had been discussed.

Regent-designate Davis asked about the collaboration that currently exists between UC medical centers and UC student health centers, and whether this relationship would change with increased use of telemedicine. Committee Chair De La Peña stated that this could be addressed in the later update about the student health centers.

Regent Lansing addressed Mr. Laret's prior comments about governance. She stated that the University must adapt its governance structure to changes in the healthcare environment to maintain the excellence of its medical centers. She recommended that the medical center CEOs and Dr. Stobo develop a new model for the governance structure of the medical centers to be considered by President Napolitano and the Regents. The

Regents would continue to have oversight. Regent Kieffer stated that he would like to be aware of the discussion of this issue, since it would be important to understand the structure of accountability.

Regent Island expressed support for Regent Lansing's comments. If the medical center CEOs were of the opinion that the current governance model did not provide necessary flexibility and was an impediment to their ability to be competitive in the new healthcare environment, their opinions should be taken seriously and considered by the Regents. The current competitive healthcare environment offered an opportunity to consider a new model that would provide the medical centers the flexibility to be competitive and adequate oversight for the Regents.

Committee Chair De La Peña asked the medical centers CEOs to describe an incident within the past five years in which the current governance structure had been an impediment to their transactions. Dr. Stobo said the CEOs want more oversight and accountability, rather than less. They would be happy to return to the Committee with a model that would allow them to be nimble in a competitive environment and would provide the oversight and accountability that everyone desires.

President Napolitano stated that this would be an opportune time to examine the issue of board governance in general for the institution, not just in the health services area, since the higher education environment is also changing. The Regents could be provided with suggestions on governance structure for their consideration.

4. **UC HEALTH CHALLENGES**

[Background material was provided to Regents in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

UCSF Medical Center Chief Executive Officer (CEO) Mark Laret presented areas in which the Regents could help the UC medical centers face current challenges. The first area is governance, which was discussed in the prior item. The CEOs seek more engagement from their advisory boards, which would provide the CEOs more protection.

The second challenge is probably the most acute the medical centers face daily. The medical centers' success as an \$8 billion self-supporting enterprise is based upon their ability to attract and retain top talent, in competition with other hospitals, by paying market-based compensation. The highly politicized, time-consuming, and ever-changing process that the UC medical centers must undergo to be able to offer executive-level compensation puts them at a large disadvantage. For example, unlike UC's competitors, UCSF cannot make an offer to a senior-level individual, even if the offer is within an established pay band, because the offer is contingent upon Regents' approval at some point in the future. UCSF has lost candidates to other institutions because of these requirements. UC medical centers must contend with their competitors' attempts to poach their best personnel. The University's current approach to compensation was not effective for the health enterprises, and in fact put it at substantial risk. Mr. Laret observed that

other state universities and UC's competitors have solved this problem by having their boards use independent consultants to determine appropriate compensation market comparisons. These boards then give hospital management the authority to recruit within those parameters; compensation issues outside the parameters would be brought to the board to be addressed in a timely fashion. The UC medical center CEOs' strong recommendation was that the Regents adopt a similar process. The Regents would review and approve market compensation data, then delegate authority to the President of the University or the chancellors to approve compensation within those parameters. This would greatly mitigate the medical centers' risk of losing top talent.

Mr. Laret said the CEOs would also suggest review of the threshold for items that require Regents' approval. Approval for acquisition of a physician practice or participation in a joint venture with liability limits could be delegated to the President up to certain parameters. The medical centers were not trying to avoid oversight. The Regents meet only every other month with full agendas and extensive lead time required for submitting items for the agendas. The current procedure was unwieldy when some transactions have to be completed nimbly.

Regent Lansing suggested that these requests be made part of the new governance model that would be presented to the Regents. Mr. Laret suggested that the Regents consider acting to improve the compensation process separately, before considering a new governance model.

Regent Ruiz asked about the future potential for UC Health. Mr. Laret said there was a risk that UC Health's potential would not be reached if the compensation process were not corrected.

Regent Makarechian asked if there had been any instances where the Committee on Compensation did not approve requested hires. He suggested establishing a pilot program for delegating medical center acquisitions to test a new procedure and review it after a year. Ronald Reagan UCLA Medical Center CEO David Feinberg reported that he had attempted to retain two very important members of his team; one was lost to another institution and the other was still in negotiations. Dr. Feinberg said that he had been an undergraduate at UC Berkeley and employed by UCLA his entire career. He was separating from the University next month to be near his children on the East Coast, to take advantage of an outstanding career opportunity, and because the current governance model had presented too many obstacles to efficient action.

Regent Kieffer said as Chair of the Committee on Compensation he has a weekly call to approve compensation requests, so it would be inaccurate to say that compensation requests are reviewed only every other month at Regents' meetings. There may be a reluctance to bring some compensation requests forward for public scrutiny. He agreed that compensation procedures should be considered as part of the governance structure. Committee Chair De La Peña added that he has a weekly call with Executive Vice President Stobo and that the Committee on Health Services could approve transactions of up to \$5 million within a week.

UC Irvine Medical Center CEO Terry Belmont commented that he was retiring at the end of June and noted the strength of the UC academic medical centers in research, education, and delivery of clinical care. However, the amount of effort required to accomplish various transactions was sometimes excessive. He appreciated the Regents' openness to considering governance changes.

Committee Chair De La Peña wished Dr. Feinberg and Mr. Belmont well in their future endeavors and thanked them for their contributions to the University.

5. **UPDATE ON STUDENT HEALTH AND COUNSELING CENTERS**

[Background material was provided to Regents in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Executive Vice President Stobo recalled that approximately three years prior there had been concern about the operations of UC's 11 student health centers, including one at UC Hastings. An outside group, Marsh, Inc., was asked to review the student health centers' practices. Marsh indicated some serious concerns, including the absence of bylaws and a governing group, absence of consistent practices for verification of credentials, privileging, and use of different information systems making sharing of data impossible. Over the past two-and-a-half years, work has been conducted with the student health centers to address these concerns.

Much progress has been accomplished. The student health centers currently use one medical record system, Point and Click, and a single credential verification process. Bylaws were developed and each student health center has a governing group. A second outside group, Keating and Associates, audited the student health centers; the few remaining issues have since been resolved to the satisfaction of UC's internal audit team. Significant progress has been made in operational issues that were raised in the Marsh report.

Dr. Stobo addressed Regent-designate Davis' earlier question about the relationship between the student health centers and UC's medical centers. UC San Diego's student health center reporting organization was changed to a direct reporting relationship to UC San Diego Medical Center CEO Paul Viviano and some level of accountability to the Vice Chancellor for Student Affairs, whereas in the past the direct reporting relationship was to the Vice Chancellor for Student Affairs and there was no relationship with the Medical Center. This new reporting structure at UC San Diego had been in place for about a year and was working very well. Dr. Stobo suggested that the other four campuses with medical centers try to move to a similar reporting relationship, with a closer relationship between the medical operations of the student health centers and the existing medical centers. If that is successful, then the student health centers at campuses without medical centers could be reviewed to see if they could be aligned with the medical center at a nearby campus. Dr. Stobo suggested exploring these possibilities

informally, through the Vice Chancellors of Student Affairs and the CEOs of the medical centers.

Dr. Stobo commented that the Regents should be proud of the work done at the student health centers caring for the health of the special population of UC students. He anticipated continued good work in the future.

Committee Chair De La Peña added that Chief Compliance and Audit Officer Vacca's team would audit the student health centers later that spring.

Regent-designate Davis asked about self-insurance plans for UC students. Dr. Stobo recalled the UC Student Health Insurance Plan (UCSHIP) was started several years earlier. The University was at full financial risk in this self-insurance program for 125,000 of its students. The program lost tens of millions of dollars over its first four to five years. The program was now fiscally solvent and in fact would build up a reserve in the current year. UC campuses were able to decide whether they wanted to remain in SHIP or move to a fully insured program. Half the campuses decided to move to a fully insured program; half stayed in UCSHIP. One of the larger campuses that had moved to a fully insured program was coming back into UCSHIP in the current year because of the organizational and financial changes that had been made. Dr. Stobo expressed hope that over the next year all UC campuses would have eligible students participate in UCSHIP.

Committee Chair De La Peña introduced student observer to the Committee on Health Services Alexander Hill. Mr. Hill commented that between July 1, 2104 and February 28, 2015, UC Counseling Services reported 6,011 urgent or crisis student visits, and 12,681 students, or 5.2 percent of all UC students, were seen for either crisis, urgent, or triage same-day appointments. Students in crisis are told to seek out counseling services immediately. UC counseling centers are in crisis and may not be able to handle several concurrent visits from students in crisis. Funding has failed to match the growth in use of UC counseling centers, even though it has been known for ten years that the centers were unable to meet the demand for services. In response to a request from the Office of the President, it was determined that \$38.25 million a year would be required to optimize UC counseling services. Not expecting to receive that amount, the Office of the President requested an estimate for funding critical services, which was determined to be \$17.5 million per year. Once funding is provided, it would take time to implement services for students. If funding is put off, services would not increase for another academic year. Students cannot wait for needed counseling services while budget negotiations are ongoing. The cost of funding critical services would be one-quarter of one percent of the UC budget. Mr. Hill urged immediate sustainable funding of student counseling services.

President Napolitano expressed appreciation for Mr. Hill's comments. Although the fiscal situation for the upcoming year was not yet known, the President said she was willing to meet with Dr. Stobo the upcoming week to determine whether to begin increasing staffing at the student counseling centers. She noted that the amount of the student fee increase, 50 percent of which would be allocated to student mental health services, had

not yet been determined. President Napolitano agreed that to have new staff in place by the fall, it would be necessary to begin the process soon.

6. **FUTURE CHALLENGES AND UPDATES TO THE COMMITTEE**

[Background material was provided to Regents in advance of the meeting, and a copy is on file in the Office of the Secretary and Chief of Staff.]

Committee Chair De La Peña commented that a future Committee on Health Services meeting would review areas under its oversight. He asked Committee members to consider what information would be important for the Regents to hear in regular Committee meetings.

The meeting adjourned at 4:50 p.m.

Attest:

Secretary and Chief of Staff