

The Regents of the University of California

**HEALTH SERVICES COMMITTEE**

August 11, 2016

The Health Services Committee met on the above date at the Ida and Cecil Green Faculty Club, San Diego campus.

Members present: Regents Blum, Lansing, Makarechian, Reiss, and Sherman; Ex officio members Lozano and Napolitano; Executive Vice President Stobo, Chancellors Hawgood and Khosla; Advisory members Dimsdale, Hernandez, and Ramsey

In attendance: Secretary and Chief of Staff Shaw, General Counsel Robinson, Vice President Duckett, and Recording Secretary Johns

The meeting convened at 1:05 p.m. with Committee Chair Lansing presiding.

1. **PUBLIC COMMENT**

There were no speakers wishing to address the committee.

2. **APPROVAL OF MINUTES OF PREVIOUS MEETING**

Upon motion duly made and seconded, the minutes of the meeting of June 14, 2016 were approved.

3. **REMARKS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH**

Executive Vice President Stobo reported that in the *U.S. News and World Report* rankings for the best hospitals in 2016-17, UCLA was ranked fifth in the U.S. and UCSF seventh. In the rankings for California, UCLA was in first and UCSF in second place; all UC hospitals were in the top ten. This was a tribute to the staff and leadership of the UC hospitals. He suggested that UC Health should present its strategic plan to the full Board of Regents at the November meeting.

Advisory member Hernandez commented on the current strategic plan document. Part of the plan addressed the workforce needs of UC Health. The UC system, along with the California State University, is the major provider of undergraduate education in the state. The strategic plan should incorporate broader consideration of the future workforce of the state, not just of UC Health. The question of how healthcare professionals are trained, now and in the future, is very much in the hands of UC. Dr. Stobo expressed agreement with this comment. The strategic plan was meant to focus primarily on UC Health's clinical enterprise; yet it is hard to divorce the success of the clinical enterprise from considerations of workforce and the educational enterprise. Dr. Hernandez's observations would be incorporated in the plan.

Advisory member Dimsdale stressed that it would be important to include the faculty's perspective in developing the strategic plan. Faculty should be made aware of this document and given the opportunity to review it. Dr. Stobo responded that the document would be made available to and discussed with faculty and UC Health chief executive officers.

President Napolitano asked Drs. Hernandez and Dimsdale which aspects of the strategic plan they found bold and strong. Dr. Hernandez drew attention the plan's call to action regarding the scenario of declining revenue versus increasing expenses, and its recognition of the need for a complex transformation in many areas such as training, delivery of care, use of data analytics, and consideration of patient populations for whom UC Health is under-reimbursed. The plan acknowledges that the present time was a disruptive time for healthcare delivery in the U.S. New models were needed, and some of the best new models already existed on a small scale throughout the UC system; these models should be identified and expanded.

Regent Makarechian recalled that according to data presented at an earlier meeting, Kaiser Permanente enjoys higher profitability per patient. He asked if UC could now find a way to duplicate Kaiser's success. Dr. Stobo responded that if one compares Kaiser's revenue to revenue for other health systems including UC, Kaiser's revenue is out of proportion in terms of number of patient beds. UC Health revenue was approximately \$9.7 billion, while Kaiser's was about \$54 billion. Kaiser has about 1.5 times more patient beds than UC. The reason for the great difference in revenue is that Kaiser is not just a provider of care but also an insurer, an integrated health system. A significant portion of Kaiser's total revenue is derived from its insurance program. The University has been moving toward more self-insurance for its employees, and Dr. Stobo anticipated that all UC health plans for employees might be self-insured within two to three years. One goal articulated in the strategic plan is to develop a health plan that UC could offer in the general market, subject to approval by the President. This goal could not be realized immediately; the University must first demonstrate that it can effectively manage the health care of its own employees. The University was planning to move its employee health plans to becoming self-insured and would keep annual increases below a certain percentage. This would save money for UC in an environment where the medical inflation rate was seven or eight percent.

#### 4. **UC HEALTH: SHOULD WE DO MORE AS A SYSTEM?**

[Background material was provided to the Committee 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 began the discussion by observing that the medical centers are functionally united, a circumstance that UC must better exploit in the marketplace, and that UC Health can use to improve its quality, through collaboration and the medical centers learning from one another. Dr. Stobo outlined the concept of the "second curve," by the futurist Ian Morrison. According to Morrison, businesses typically begin by enjoying success, the "first curve." Disruptions in their environment then

challenge the traditional business model. Some businesses adapt to changes and become more successful, in the “second curve,” while those who do not adapt then fail.

Dr. Stobo stated his view that this concept was relevant to UC Health, which had enjoyed success over the previous ten years in a volume-based environment where it was paid more for doing more, as a federation of five medical centers. The Patient Protection and Affordable Care Act (PPACA) was in effect a disruption, leading to a reexamination of the delivery of health care in the U.S. The second curve presents a value-based environment, where UC Health is compensated for the value it adds to the health of the population it treats, and where it functions not as a federation of five medical centers, but as an integrated system.

There are a number of imperatives for UC Health, including financial imperatives. All the five medical centers were in the black in terms of income and loss before other changes in net positions; one center showed a negative income, but this was due to a transitory factor. If one takes account of the academic support that the medical centers provide, chiefly to UC's schools of medicine, three medical centers are in the red. There was absolutely no desire to decrease support for the medical schools; if anything, UC Health would like to increase this support, but revenues were decreasing, and UC Health had not been able to control costs as well as it would like.

Regent Lozano called attention to information for two medical centers, both with about the same amount of income; however, one medical center provided a much higher amount of academic support and consequently experienced a greater loss or decrease in net position. She asked if this indicated a need to rationalize academic support. Dr. Stobo agreed that this information should provide an impetus for rationalization. UC medical centers should examine the programs that they are supporting and ensure that these are programs that add value. This would be done not with the idea of diminishing academic support, but to make sure it is correctly deployed. A systemwide approach would help increase the medical centers' income.

Dr. Stobo outlined some successes of the systemwide approach. UC Health is an obligate group for borrowing. UC Health's bond rating in the market and the cost of borrowing depends on all five medical centers. UC Health has been carrying out managed care contracting as a system for seven years. UC Health negotiates hospital fees and the Medical waiver as a system. The UC Health Center for Health Quality and Innovation promotes best practices as a system. Certain clinical programs work at the system level, such as cardiothoracic surgery and breast cancer treatment. For medical center chief executive officers, there are significant inducements to improve the performance of the entire UC Health system in the Clinical Enterprise Management Recognition Plan, incentives that are not paid unless all medical centers achieve certain goals. The Leveraging Scale for Value initiative had generated positive outcomes in revenue cycle activities and cost savings in information technology, but Dr. Stobo expressed disappointment with the results in procurement. Less than 20 percent of UC Health's purchasing was done as a system, and this represented significant missed opportunities for savings.

Regent Reiss requested clarification of data shown for one medical center, which showed a negative income of \$9 million. Dr. Stobo responded that this medical center was UCSF, and that the negative income was due to the move into the new Mission Bay Hospital. The move to a new hospital requires a certain number of staff to cover all patient beds, although the hospital will not be full when it first opens. Moving expenses and depreciation also contributed to the outcome. Income was projected to become positive again the following year.

In response to another question by Regent Reiss, Dr. Stobo explained that the figures displayed for academic support provided to the schools of medicine were totals “below the line,” including funding for faculty recruitment and support for programs, but not in fact the total. There was also a significant amount of support “above the line,” legitimately included in expenses, funding that would pay, for example, for a medical center director who is also an associate professor at a school of medicine. This other academic support comes from clinical income. Following accounting standards, it would legitimately be included above the line in expenses. Chancellor Hawgood added that the negative income number for UCSF was predicted and was included in the campus’ financial plans for five years before the new hospital opened. UCSF was well aware that this would occur and was in fact outperforming its budget plan. Chancellor Hawgood remarked that there is debate within UC Health about the term “academic support.” He expressed his own preference for the term “joint investment,” because the bulk of these funds are an investment in intellectual capital. The medical centers are investing in their own future.

Dr. Stobo returned to his discussion, commenting on areas of collaboration in which UC Health has not been as successful as desired, such as rationalization of clinical service delivery, ensuring that services are delivered where they are most cost-effective and lead to the best outcomes. Clinical strategies must be better coordinated. Funding is not moved around in the UC Health system, from one medical center to another, but could be. Dr. Stobo enumerated factors accounting for some of these missed opportunities. One was a campus culture of independence. UC Health did not wish to do away with the independence of the campuses, but to have them recognize the importance of a system approach. The system approach is not always recognized or rewarded. It is not accepted by all chancellors. The present governance structure supported a “federated state” rather than an integrated and coordinated system of medical centers.

Dr. Stobo described UC Health’s situation in terms of a diagram taken from a book by Jim Collins, “How the Mighty Fall and Why Some Companies Never Give In.” Mr. Collins identifies five stages of decline for corporations. Stage One, “hubris born of success,” leads to Stage Two, “undisciplined pursuit of more.” Stage Three is “denial of risk and peril,” at which point unsuccessful businesses move on to Stage Four, “grasping for salvation,” and Stage Five, “capitulation to irrelevance or death.” Dr. Stobo stated his view that UC Health was currently in Stage Three, and that its ability to avoid decline would depend on its ability to come together as a system, for the medical centers to learn from one other, and for the system to present itself as an integrated, coordinated institution to payers and providers.

Regent Makarechian asked about the formula or ratio for determining the amount of academic support each medical center provides, or if this funding is discretionary. Dr. Stobo responded that academic support is based on opportunities that arise on an ad hoc basis. A medical school may have an opportunity to develop a world-class program in a certain field by recruiting a certain individual, and might ask its medical center to invest in this program. Academic support is discretionary, not driven by a formula. UC Davis Medical Center Chief Executive Officer Ann Madden Rice added that the income/loss figure provided for UC Davis, \$73 million, was net of \$80 million worth of expenses, purchasing of services from the School of Medicine, such as coverage for the neonatal intensive care unit, or other specific purposes that are well documented. From year to year, other opportunities arise which fall in the category of “below the line” academic support, such as acquiring a new computer capability or new neurosurgery capability. These are joint investments to enhance the clinical enterprise and the academic mission. The medical centers do not all use the same approach for this, and needs can vary from year to year.

Regent Makarechian requested clarification of what had been described as insufficient endorsement by the chancellors for a systemwide approach. Dr. Stobo explained that it was a challenge for UC Health to work with chancellors and to convince them that the fate of their institution is tied to the fate of other institutions in their geographic region.

Regent Makarechian asked why systemwide purchasing was below 20 percent. Dr. Stobo responded that this was due to campus culture and a lack of commitment by the medical centers to purchase as a system, and the approach used by UC Health. He indicated that this missed opportunity could be addressed relatively easily. UC Health’s effort to disseminate and enhance best practices in revenue cycle activities has been more successful. Revenue cycle activities are the collection of payments for services, and occur in many stages.

Committee Chair Lansing discussed the factor of campus culture and campus pride. UC Health must work as a system to survive, and there should be a bold reassessment of which services are offered at which UC hospitals.

President Napolitano cited the changing and competitive environment in which UC hospitals were functioning and noted differences in business structure between Kaiser Permanente and UC Health, stressing that UC Health’s business structure should be different. Currently chancellors were responsible for their academic campus, medical school, and medical center. Historically, if UC hospitals have faced fiscal problems, this has been compensated at the expense of undergraduate and other campus programs. She suggested an organizational change: in addition to their reporting line to the chancellor, health sciences executives would have a dotted line reporting relationship directly to the Executive Vice President – UC Health. This would acknowledge that UC Health needs to be a better integrated system, better positioned in a competitive market. President Napolitano referred to Regent Makarechian’s question about procurement. She recalled that UC had been involved in large-scale procurement reform for its general campuses, achieving over \$200 million in savings. This has been successful because campuses have

been united as an integrated procurement system. The current structure of UC's health science campuses did not allow for the same kind of integration.

Regent Lozano stressed that UC Health was at a pivotal point and needed to take action. She asked what an integrated UC Health system would look like and if there were key action items to achieve that state. A change to the entire organization was being undertaken, far beyond implementing a new procurement system or new reporting lines. Dr. Stobo responded that the path to achieving this integrated UC Health system needs to take the existing culture and organizational structure into account and balance success with disruption, determining in what cases it would be effective to undergo disruption to reach certain goals. He stated his wish that UC Health should become a system like Johns Hopkins Medicine. He noted that the dotted line reporting mentioned by President Napolitano would codify already existing relationships between himself and the medical center chief executive officers. To outsiders, dotted line reporting would indicate that the UC medical centers are linked. Increasingly, payers would want to do business with the UC system rather than one campus. Suppliers would understand that they have to work with UC Health rather than one campus.

Chancellor Khosla recalled that in the past, university divisions such as science and engineering worked in an isolated way, independently. A great deal of research is currently focused on health care and life sciences. Funding agencies are creating pressure for greater integration. On many campuses there is a significant division between science departments and medical schools. Chancellor Khosla cautioned against such divisions, noting that the UC San Diego Medical Center and School of Medicine had provided most of the funding for the UCSD Center for Microbiome Innovation. UC's hospitals must work in an integrated manner, especially in the face of outside competition. He emphasized the complexity of UC Health. UC must find creative means and management structures that allow the organization to move forward.

In response to a question by Regent Reiss, Chancellor Khosla stated that in his view, the strategic plan for UC Health understood but did not recognize integration on campus. For example, if UCSD wishes to expand its cardiac research program, this necessarily involves engineering and focused faculty hires in engineering. In this process the campus becomes more integrated, but there might be problems if the amount of academic support is decided at the system level. Dr. Stobo emphasized that UC Health's intent is to help and facilitate such integration. Chancellor Khosla warned that systems can fall apart if one does not consider all their nuances and complexity.

Regent Makarechian emphasized that the UC Health executive at the systemwide level must have some authority; otherwise the integration of UC Health or efforts like systemwide procurement would not be successful.

President Napolitano observed that UC was now acquiring hospitals and physician practices, and that this was part of a national change in the healthcare market. UC must be certain that it takes into account the systemwide implications of an action by one

campus, such as acquiring a hospital. The outside world must see that UC Health is a system and issues must be fully vetted for their systemwide implications.

Chancellor Hawgood observed that one should not underestimate the progress already made by UC Health in working as a system. The dotted line reporting mentioned earlier would codify already existing relationships. He drew attention to the fact that UC Health must train across disciplines, a complexity not faced by systems like Kaiser Permanente. The prestige of UC's medical school derives in part from being comprehensive. In response to a remark by Committee Chair Lansing, Chancellor Hawgood noted that certain consolidations for treatment have occurred, such as a consolidation for liver transplants between UC Davis and UCSF. Chancellor Khosla added that certain capabilities must be present at every location; he compared this to the need to offer undergraduate English courses at all the general campuses.

Regent Reiss referred to statements of net income and loss for the medical centers that had been shown. She asked if academic support came out of these net income amounts. Chancellor Khosla and Dr. Stobo responded in the affirmative. Regent Reiss requested clarification of the decrease in net position, shown for some medical centers, after they have provided academic support. Chancellor Khosla responded that UC Health desires to have 90 to 120 days' cash on hand at its hospitals, although the minimum is 60. Decreases in net position are covered by days' cash on hand.

Regent Reiss asked about UC Health's actions to move its financial trajectory in a positive direction. Dr. Stobo responded that the medical centers were doing all they should be doing to develop larger delivery systems, increase their patient population, and ensure that revenues remain even or increase. He expressed concern about annual costs that have increased twice as much as revenues, and stressed that the current situation was critical. As a system, UC Health could address costs with measures such as securing contracts with national insurers. This approach would not intrude on individual medical centers and their local markets.

Advisory member Ramsey remarked that UC Health was at a critical point and needed to speed up the pace of movement toward functioning as a system. Hospitals across the country were engaged in this process, trying to function as systems in an integrated fashion. One important factor driving this change was contracting and the need for common standards. Contracts would increasingly create financial risk as they change from a fee-for-service basis to outcome-based reimbursement. He anticipated that there would be national contracts for advanced tertiary and quaternary care services. Discussion of a governance change at UC Health was necessary.

Regent Blum reflected on difficulties faced by UC Health, such as low funding from the State and the need to retain outstanding medical faculty. The healthcare industry was quickly consolidating. UC Health should work with the insurance industry. The question of integration of clinical services versus specialization at certain medical centers still needed to be worked out. UC Health should be cautious in pursuing clinical integration, taking time to figure out its approach, but moving quickly to operate medical centers

more efficiently. He stressed the complexity of the UC Health endeavor and the need for caution in making changes.

UC San Diego Health Chief Executive Officer Patricia Maysent referred to the amounts of academic support shown for the medical centers. These amounts are used to ensure that faculty are paid competitive salaries, especially in light of low Medi-Cal reimbursement levels, and for recruitment of clinical faculty. She noted a current concern, the possible coming to the San Diego area of the MD Anderson Cancer Center, but expressed confidence that UCSD Health's investment in cancer services, \$700 million to \$800 million, would outstrip the joint effort of MD Anderson and Scripps Health. UC Health must work together as a system, with a statewide infrastructure, to ensure the success of UC's Blue and Gold HMO.

In response to a question by Regent Sherman, Dr. Stobo explained that much of the total amount transferred from the medical centers to the medical schools is "above the line" support, not included the amounts shown for academic support. In the aggregate, support for the medical schools totals approximately \$500 million. Chancellor Hawgood added that the "above the line" transfer is before net income and reflects what a community hospital would pay its medical staff. This transfer is not money the medical schools can use as they wish; it is the purchase of services that every community hospital must make. If UC hospitals did not have affiliated medical schools they would have to purchase these services from somewhere else. Physicians must be paid for certain services in running a hospital that are unrelated to seeing patients, and these purchased services are paid for "above the line."

Regent Sherman recalled that a few years earlier, the amounts for increase or decrease in net position had been large positive numbers, greater than the current amounts. Dr. Stobo explained that this change was a result of decreasing reimbursement without any corresponding decrease in costs.

Regent Sherman asked about the difficulties encountered in trying to implement a procurement program at UC Health, compared to the P200 program at the general campuses. Dr. Stobo responded that the UC procurement program model was correct, but stressed that the worlds of academia and health care are different. The campuses and medical centers were using the same strategy, but dealing with different types of faculty and products. Currently, suppliers approach individual medical centers with offers; all five medical centers together would get better offers.

Regent Sherman stated his view that Dr. Stobo needed the authority to impose this on the medical centers. Dr. Stobo responded that his authority in this area was based on professional persuasion. He stated that the dotted line reporting relationship would help this effort. In a corporate setting, an individual in Dr. Stobo's position would have a direct line reporting relationship to chief purchasing officers, but Dr. Stobo stressed that this kind of structure is not consistent with UC's culture, and the disruption of implementing such a structure would outweigh any gains.



Advisory member Dimsdale observed that the current discussion was a view of UC Health from a high altitude, while faculty who teach students and see patients are at a different level and have a different viewpoint. Faculty have a direct knowledge of the complexity of UC Health and its interrelated missions. There must be direct consultation with faculty about changes that are being considered for UC Health, and as soon as possible. Dr. Dimsdale expressed concern about what he described as a surprising amount of unease and distrust among faculty. Dr. Stobo responded that he had visited every medical center on at least one occasion to speak to faculty about these matters. He stated his view that faculty in general understand the need to work as a system and can see the value in doing this, while the administration of the medical centers is a greater obstacle. Dr. Dimsdale warned of the possibility of making poor decisions inadvertently and losing faculty. Committee Chair Lansing concluded this part of the discussion by noting that these questions would be considered further at meetings in the coming months.

Ms. Maysent then briefly commented on MD Anderson's incursion into the San Diego area. MD Anderson was targeting markets in Northern and Southern California that already had National Cancer Institute-designated cancer centers. This was a difficult situation, but it had brought UC Health chief executive officers and cancer center directors together to work to address this challenge, both to keep out competitors and to remain centers of excellence in California.

Committee Chair Lansing underscored the aggressiveness of MD Anderson in moving into this market. This also made it clear that UC Health must work as a system.

Ms. Maysent recalled that it had taken more than two decades to build the Moores Cancer Center. Rivals could not in fact compete with the Moores Cancer Center, but they could create confusion in the market. UCSD Health had both short- and long-term strategies for this situation.

Regent Blum criticized MD Anderson's marketing tactics.

Chancellor Khosla stated that UC San Diego could take pride in its achievements but must be aware of its vulnerability in the region; UCSD Health must ensure that it has the support of the local community. UCSD is strong in many areas, with faculty and resources that are attractive to rivals.

Committee Chair Lansing concluded the discussion by remarking that many health systems aspire to be like the University of California and try to recruit away UC faculty.

5. **APPROVAL OF SALARY ADJUSTMENTS USING NON-STATE FUNDS FOR MARK LARET AS CHIEF EXECUTIVE OFFICER, UCSF HEALTH AND ANN MADDEN RICE AS CHIEF EXECUTIVE OFFICER, UC DAVIS HEALTH SYSTEM AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Committee on Health Services approve the following merit-based salary adjustments, effective on or about July 1, 2016, consistent with local processing schedules.

Last Name	First Name	Working Title	Current Annual Base Salary	Proposed Salary Increase %	Appointed On/After 1/1/2016 (Y/N)	Proposed Annual Base Salary	Funding Source
*Laret	Mark	Chief Executive Officer	\$991,946	5%	N	\$1,041,543	Non-State
*Rice	Ann Madden	Chief Executive Officer	\$848,720	3.5%	N	\$878,425	Non-State

\* These positions are eligible for incentive pay authorized by the Regents.

The base salary described above shall constitute the University's total commitment for base salary until modified by the Regents, the President, or the Chancellor, as applicable under Regents policy, and shall supersede all previous oral and written commitments. Compensation recommendations and final actions will be released to the public as required in accordance with the standard procedures of the Board of Regents.

Background to Recommendation

Consistent with the 2016 salary program for non-represented staff at all levels, the President of the University recommended approval of a base salary adjustment for Mark Laret, Chief Executive Officer, UCSF Health and for Ann Madden Rice, Chief Executive Officer, UC Davis Health System.

The Chief Executive Officer position is a Level One position in the Senior Management Group (SMG). Level One SMG members have had three general salary increases in the past nine years. Over this period, since 2007, wages within the Western region labor market increased by approximately 30 percent and the cost of living increased by more than 17 percent. The general lack of salary or merit programs during this period has had a detrimental impact on the University's competitive position, making it more difficult to recruit and retain employees for senior leadership and staff positions.

Participation by the SMG members in this organization-wide, non-represented staff salary program will allow the University to keep pace with general salary movement in the labor market. This program also aligns with President Napolitano's movement toward a more predictable salary program, consistent with the budget agreement reached with the Governor that provided for four years of stable funding.

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

Vice President Duckett introduced the item. The proposed salary increases were consistent with the current year's salary program for all non-represented staff at all levels. The proposed adjustments applied only to Level 1 Senior Management Group (SMG) members who had been serving in their current role since at least January 1, 2016. Mr. Duckett remarked that Level 1 SMG members had participated in three general salary programs in the preceding nine years. Increases in wages and cost of living during this period, and the general lack of UC salary programs have had a negative impact on the University's competitiveness in compensation.

Upon motion duly made and seconded, the Committee approved the President's recommendation.

6. **APPROVAL OF SALARY ADJUSTMENT USING NON-STATE FUNDS FOR BARRIE E. STRICKLAND AS SENIOR VICE PRESIDENT – FINANCE AND CHIEF FINANCIAL OFFICER, UCSF HEALTH, SAN FRANCISCO CAMPUS AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Committee on Health Services approve the following item in connection with the salary adjustment for Barrie E. Strickland as Senior Vice President – Finance and Chief Financial Officer, UCSF Health, San Francisco campus:

A. Per policy, an adjustment to Ms. Strickland's annual base salary to \$720,000.

All other aspects of Ms. Strickland's compensation are within policy and will continue unchanged. Ms. Strickland will continue to be eligible to participate in the Clinical Enterprise Management Recognition Plan's Short Term Incentive (STI) component, with a target award of 15 percent of base salary (\$108,000) and maximum potential award of 25 percent of base salary (\$180,000). Actual award will be determined based on performance against pre-established objectives.

Funding for this position will continue to come exclusively from medical center revenues. No State or UC general funds will be used. This action will be effective upon Regental approval.

The compensation described above shall constitute the University's total commitment for base salary until modified by the Regents, the President, or the Chancellor, as applicable under Regents policy, and shall supersede all previous oral and written commitments. Compensation recommendations and final actions will be released to the public as required in accordance with the standard procedures of the Board of Regents.

Background to Recommendation

The President of the University recommended approval of a salary adjustment of 15.2 percent, inclusive of this year's salary program increase, for Barrie E. Strickland as Senior Vice President – Finance and Chief Financial Officer, UCSF Health, San Francisco campus. UCSF Chancellor Hawgood and Chief Executive Officer Laret proposed increasing Ms. Strickland's base salary from \$625,000 to \$720,000 to retain Ms. Strickland in her current role as she continues building on her accomplishments to create a strong and efficient financial organization to support UCSF Health system's growth and strategic direction. Another premier academic health center has been aggressively pursuing Ms. Strickland. The proposed salary adjustment would place her base salary at 2.1 percent below the 90th percentile of the Market Reference Zone (MRZ) for this position, which is warranted for an incumbent with extensive senior management experience and reflects the increasing scope and complexity of the UCSF Health system. Funding for this position will come exclusively from non-State funds, specifically from UCSF Health revenue.

Ms. Strickland has overseen the transition from a single hospital to a health system and from a \$1.7 billion enterprise to what is now an approximately \$4 billion enterprise. When she was appointed as Senior Vice President – Finance and Chief Financial Officer, UCSF Health in July 2015, after having served as Chief Financial Officer for the UCSF Medical Center, Ms. Strickland's staff headcount increased from 387 to 691 and her budget increased from \$268,257,000 to \$341,082,717.

Ms. Strickland has overall fiduciary responsibility for all financial functions throughout the expanded UCSF Health system, plus new physician foundations (Bay Health and Benioff Children's Physicians) as well as the newly formed Accountable Care Organization, Canopy, which is critical to the UCSF Health system's strategy and market expansion. Canopy now has over 4,000 physicians and has added seven hospitals to its network throughout the Bay Area. Within the last 12 months, Ms. Strickland has reorganized the finance teams to support the combined Children's hospitals, UCSF's Cancer organization, and the Faculty Practice. In addition, she has created and launched a consolidated shared financial services system for UC Health systemwide, overseeing all accounting and revenue cycle responsibilities for the UC Health enterprise.

Ms. Strickland has been and continues to be central to the successful transition from a single hospital to a health system. She has built a health system financial infrastructure and senior finance team to meet the needs of the health system, supporting adult, pediatric, cancer, faculty practice and system affiliates, while maintaining strong relationships with the Chancellor, Office of the President, Deans, and campus as well as systemwide finance colleagues. UCSF Health's agenda for the next several years includes cutting costs and integrating affiliates, which Ms. Strickland and her team will oversee.

Ms. Strickland has 30 years of solid financial management experience. Prior to UCSF, Ms. Strickland served ten years as Chief Financial Officer for Memorial Hermann Healthcare System (Houston, Texas) as well as ten years in lead finance positions for

Columbia/HCA (Houston, Texas). Ms. Strickland has additional experience as an Adjunct Professor in the Masters of Healthcare Administration program for Texas Woman's University (Houston, Texas), Controller/Entercorp for Sisters of Charity Healthcare System (Houston, Texas), and Audit Manager at Ernst & Young (Houston, Texas).

The Regents' approval is required because the base salary exceeds the 75th percentile of the MRZ for this Level Two position in the Senior Management Group (SMG). Ms. Strickland's salary, after the proposed adjustment, will be 2.1 percent below the 90th percentile of the MRZ, which is consistent with the following guidance from Regents Policy 7701:

"A salary near the 90th percentile of the MRZ will be assigned to SMGs who have highly specialized credentials, professional accomplishments and expertise that set them apart from internal and external peers. In addition, a salary near the 90th percentile may be assigned where the SMG's position is highly complex and significantly broader in scope than that of peer positions or the benchmark position(s) used in surveys of the applicable market. A salary near the 90th percentile may also be assigned in situations where a very scarce candidate pool for the position exists and unique skill sets are critical."

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

Chancellor Hawgood introduced the item, stating that this request for a salary increase was justified by the complexity of the work carried out by Barrie Strickland as Senior Vice President – Finance and Chief Financial Officer, its excellent quality, and her prior experience.

Upon motion duly made and seconded, the Committee approved the President's recommendation.

The meeting adjourned at 2:55 p.m.

Attest:

Secretary and Chief of Staff