

The Regents of the University of California

HEALTH SERVICES COMMITTEE

October 18, 2017

The Health Services Committee met on the above date at the Luskin Conference Center, Los Angeles campus.

Members present: Regents Lansing, Makarechian, and Sherman; Ex officio member Kieffer; Executive Vice President Stobo; Chancellors Block and Hawgood; Advisory members Dimsdale, Lipstein, and Smith

In attendance: Secretary and Chief of Staff Shaw, Deputy General Counsel Nosowsky, 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.

Committee Chair Lansing introduced the new Student Observer to the Committee, Amir Kashfi. Mr. Kashfi, an undergraduate in the Human Biology and Society program at UCLA, described his academic interests and his wish to understand how forces such as government regulation and insurance policy can affect the delivery of health care, and noted his experience working as an emergency medical technician in clinical settings.

2. APPROVAL OF MINUTES OF PREVIOUS MEETING

Upon motion duly made and seconded, the minutes of the meeting of August 16, 2017 were approved.

3. REMARKS OF THE EXECUTIVE VICE PRESIDENT – UC HEALTH

[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 reported that the University was continuing to monitor the status of efforts to reform health care at the federal government level. Two executive orders had been issued that week. One pertained to insurance coverage and would allow healthy individuals to purchase health insurance with fewer benefits; it would have an effect on the marketplace and on risk pools. The impact of this order would be delayed and might be mitigated by the implementation process it must go through, including a public comment period. In a second executive order that Dr. Stobo described as more vexing, President Donald Trump had unilaterally reduced the cost sharing reduction that was essential to maintaining the affordability of health insurance on the exchanges. This order would go

into effect immediately. It was difficult to foresee the impact this order would have in the course of the coming year. Dr. Stobo anticipated that the order would cause insurers to think twice about remaining in the health insurance exchanges, and if they did remain, to consider increasing their insurance rates dramatically. The University had not changed its position or approach.

Committee Chair Lansing asked about a proposed bipartisan deal that would fund subsidies to insurers. Dr. Stobo responded that Republican opposition to the proposal had already begun, and that it had little chance of passing unless it were attached to a larger bill.

Advisory member Lipstein observed that voting on this bipartisan legislation proposed by Senators Patty Murray and Lamar Alexander could be prevented by leadership in either the U.S. Senate or House of Representatives; there was not a clear pathway to a vote. Under these circumstances, it was uncertain how the UC medical centers could budget their free care for 2018. While the medical centers can predict activity trends, they do not know how much they will be paid for that activity, and this would make the category of free care volatile in the coming year. Dr. Stobo responded that Anthem's exit from the California exchange had resulted in destabilization and a significant financial impact on UCLA. In this case UCLA had incorporated this factor into its budget. He acknowledged that UC Health did not know the number of uninsured patients for whom it would receive no reimbursement in the coming year.

Dr. Stobo briefly described the UC Cancer Consortium. The five National Institutes of Health-approved UC cancer centers have joined to work together as one unit on cancer research and treatment. Committee Chair Lansing expressed enthusiasm about the UC Cancer Consortium and the collaborative work that it would be able to accomplish for the benefit of patients. She asked that the Committee receive updates on the Consortium.

Dr. Stobo then discussed the Clinical Enterprise Management Recognition Plan (CEMRP), which had been in effect since 1992. There are two broad groups in CEMRP. CEMRP I has 102 participants, including the Executive Vice President, the chief executive officers (CEOs) and their direct reports, the chief operating officers, the chief financial officers, and the chief medical officers. There are three levels within CEMRP I, differentiated by the proportion of base salary at risk based on performance. For Level One, which would be the focus of the discussion, 30 percent of base compensation is at risk.

CEMRP II includes 35,863 participants such as chief nursing officers and clinical laboratory directors. This group represents roughly 70 to 75 percent of the UC Health workforce, both union and non-represented employees.

CEMRP is a performance-based compensation plan. In order to participate in CEMRP, medical centers must have a positive cash flow after paying out CEMRP awards. In CEMRP I, awards for CEOs are divided into two parts, with 50 percent of performance-based compensation for systemwide goals and 50 percent for entity-specific goals. The CEMRP award for the Executive Vice President is based 100 percent on systemwide goals.

Goals are developed in consultation with the CEOs, the chief financial officers, the chief medical officers, and chief nursing officers. The quality goals are developed in large part by the chief medical and chief nursing officers. Systemwide goals must be achieved by every location before any individual payout is received, and this fosters systemwide cooperation and sharing of best practices.

Oversight of CEMRP rests with the Administrative Oversight Committee (AOC). The members of the AOC are the Executive Vice President and Chief Operating Officer, the Vice President – Human Resources, the Executive Director – Compensation Programs and Strategy, and the five chancellors of the campuses with medical centers. The Executive Vice President – UC Health is a non-voting consultant to the AOC. The AOC is responsible for approving CEMRP awards for the CEOs and notifying the Health Services Committee of these actions; the Health Services Committee has responsibility for approving the CEMRP award for the Executive Vice President – UC Health.

Dr. Stobo provided fiscal year 2018 systemwide CEMRP goals. The first concerned cost reductions associated with procurement. The threshold for a payout was \$115 million in cost reductions, the target level was \$125 million, and the maximum payout would occur at \$150 million in cost reductions. For cost reductions related to information technology, these three levels were at \$22 million, \$24 million, and \$26 million respectively, and for savings in the area of labor management at \$2 million, \$5 million, and \$10 million. The second goal pertained to clinical improvement and specifically a three percent reduction in excess bed days. This goal would help ensure that individuals who no longer need to be in a hospital receive the care they need in other facilities after their hospitalization. The third goal, a tripartite goal, was for consolidation of UC Health activities in the area of population health, use of data from UC Health's clinical data warehouse of 16 million patient records to inform clinical improvement in population health, and development of a "private label" health insurance product, a UC-specific insurance product for large employers who are self-insured. Whether UC would pursue this insurance product on its own or in conjunction with an existing insurer remained to be determined. The achievement of all these systemwide goals is important not only for the Executive Vice President and the CEOs; it also accounts for a portion of the CEMRP awards to the chief medical officers, chief nursing officers, and others.

Dr. Stobo presented a chart showing the average CEMRP award as a percentage of base salary for the five medical centers and the Executive Vice President over a five-year period, from fiscal years 2012 to 2016. CEMRP goals are not developed with the foregone conclusion that they will be achieved. Only once in this five-year period was the maximum award level achieved. CEMRP is truly performance-based, its goals are challenging, and it promotes systemwide cooperation.

Regent Makarechian asked how the \$115 million threshold amount for the cost reduction goal had been calculated. Dr. Stobo responded that savings from pharmaceuticals would account for about \$40 million of this amount; the rest would come from purchasing of commodity items, such as bandages and latex gloves. UC Health had only recently begun to focus on physician preference items, such as the type of prosthesis used for joint

replacements. UC Health calculates the amount it would save by procuring these items as a system compared to the amounts paid by medical centers on their own in the past.

Regent Makarechian asked about figures for savings in the current versus the previous year. Dr. Stobo responded that these were net figures, minus the cost of administering the program. Regent Makarechian asked how specific targets were set, assuming that they were not fixed due to the environment of fluctuating revenues. Dr. Stobo responded that some medical centers derive more benefit than others from UC Health's cost reduction efforts. The amount of benefit to a location varies by commodity item, depending on the amounts paid in the past for these items, but he stressed that all the medical centers benefit.

Regent Makarechian asked how closely UC Health was monitoring these costs at each of the medical centers. While there might be savings in the aggregate at the end of a year, one medical center might still have paid three times as much for an item as another medical center. Dr. Stobo responded that UC Health was moving toward a management system that would allow each medical center and the central administration to monitor this.

Regent Makarechian asked if CEMRP has an effect on UC's retirement programs. Dr. Stobo responded in the negative.

Regent Makarechian referred to the requirement that in order to participate in CEMRP, medical centers must have a positive cash flow after paying out CEMRP awards. He asked if this meant positive cash flow before depreciation. Dr. Stobo responded that this cash flow was the amount of earnings before interest, depreciation, and amortization.

Regent Makarechian referred to the CEMRP policy document and actions in case of an inadvertent overpayment, when the University "may" require repayment of an award. He suggested that this language be changed to state that UC "will" require repayment.

Chair Kieffer asked if other health systems have programs like CEMRP. Dr. Stobo responded in the affirmative. Programs like CEMRP are an industry standard, although the portion of compensation at risk in CEMRP is lower than the industry average, which is closer to 50 percent; the CEMRP maximum portion at risk is 30 percent. CEMRP is audited frequently.

Chair Kieffer asked how achievement of the population health goal would be measured. Dr. Stobo responded that the three criteria were (1) the existence of a systemwide population health committee, (2) that the committee would be using the clinical data warehouse to inform campuses about clinical decision-making, and (3) development of a private label insurance product. Chair Kieffer estimated that the development of an insurance product would take a long time. Dr. Stobo responded that this product might be issued in 2019.

Chair Kieffer asked about any problems the campuses were encountering in implementing CEMRP goals. UCSF Health CEO Mark Laret responded that CEMRP is a helpful program for achieving alignment across campuses. The administrative processes for CEMRP are

lengthy, and he expressed his wish that the payment of the awards could be made sooner following achievement of CEMRP goals. Currently, the incentive awards for the fiscal year ending June 30, 2017 had not yet been paid out. Dr. Stobo added that goals for CEMRP II were not developed with the same rigor as for CEMRP I. He emphasized that CEMRP awards are not granted simply for doing one's job, but for achievements in addition to one's job. UC Irvine Vice Chancellor Howard Federoff anticipated that achieving alignment in the procurement of physician preference items would be among the most challenging of the goals discussed for UC Health, but that there might be progress to report in a year's time.

Regent Sherman asked how much longer UC Health would be able to achieve cost reductions, and suggested that CEMRP use efficiency ratios as a criterion. If revenues increased, UC Health would like its expenses to remain at the same percentage of revenues or to decrease. In his view, this would be more desirable as a goal than an absolute dollar amount. Dr. Stobo responded that UC Health was reaching a stage when the easy savings had been achieved. UC Health had achieved \$153 million in supply chain savings in the current year, but it would be quite challenging to achieve this same amount in the coming year. Further significant savings could be achieved in capital equipment and physician preference items, but this would be much more difficult. He acknowledged that CEMRP should consider setting percentages of revenue rather than absolute dollar amounts as targets.

Regent Sherman asked how information about the achievement of CEMRP goals is disseminated to participants. He asked if they receive progress reports regularly, such as quarterly. If participants know where they stand, this might enhance incentives. Dr. Stobo acknowledged that this could be improved in the CEMRP I program. UCLA Health Sciences Vice Chancellor John Mazziotta responded that progress at the Los Angeles campus is tracked monthly. Participants are made aware of their standing through dashboard charts. Dr. Mazziotta referred to Regent Sherman's earlier question about maintaining expenses as a percentage of revenues at level or reducing expenses. He observed that this has been impossible because 60 percent of UC Health's expenses are payroll expenses, over which the medical centers do not have control, other than through layoffs and hiring. Compensation is the largest factor driving expenses, and UC Health cannot control its biggest cost.

Regent Sherman observed that the medical centers still control their employee count. Dr. Mazziotta acknowledged that the medical centers can hire or lay off employees, but they cannot adjust compensation.

Advisory member Dimsdale asked about capturing savings for large capital items such as robots, disposables, and training. Recouping revenue from this kind of capital equipment procurement would seem to be straightforward. Dr. Stobo responded that enormous savings can be achieved in this area and had been achieved by some institutions, such as Johns Hopkins, especially in training employees to use equipment. UC Health had not yet embarked on this, but was considering recruiting an individual in the following year to head this effort.

Advisory member Smith referred to the uncertain environment for UC medical center budgets; there might be several years of volatility ahead given the uncertainty about the federal participation in insurance markets. Aside from the fiscal CEMRP goals, the institutional or entity-based goals might be difficult to plan. He suggested that it might be appropriate to adjust CEMRP incentives based on what factors can and cannot be controlled during a time of uncertainty for insurance markets. Mr. Laret responded that in this time of uncertainty, the medical centers have reflected on what areas they can control, such as the patient experience, efficiency, decisions about hiring and use of technology, and the variety of services that are offered. The medical centers have focused their efforts on these areas. UCSF was anticipating only small increases in Medicare, Medi-Cal, and commercial insurance reimbursements, and these would be overshadowed by increases in labor and other costs. The medical centers can control the basic elements of their operations, and have room for progress there. UCLA Health President Johnese Spisso referred to the issue of large capital equipment purchasing. At UCLA, such purchases are evaluated by a value analysis committee to ensure that there is a patient base for the technology and that equipment purchases will provide an appropriate return on investment in quality, safety, and value. UC Irvine Vice Chancellor Howard Federoff concurred with Dr. Smith that the current volatile environment was a challenge for CEMRP goals, which might be changed. Mr. Laret drew attention to UC Health's new efforts to foresee large capital equipment purchases systemwide over a five-year period; this might produce significant savings.

4. **APPROVAL OF INCENTIVE COMPENSATION USING HEALTH SYSTEM OPERATING REVENUES FOR FISCAL YEAR 2016-17 FOR JOHN STOBO AS EXECUTIVE VICE PRESIDENT – UC HEALTH, OFFICE OF THE PRESIDENT AS DISCUSSED IN CLOSED SESSION**

Recommendation

The President of the University recommended that the Health Services Committee approve the Clinical Enterprise Management Recognition Plan 2016-17 Plan Year Short Term Incentive award of \$190,135 for John Stobo as Executive Vice President – UC Health, Office of the President. The recommended incentive award represents 30 percent of his annual base salary.

Recommended Compensation

Effective Date: Upon approval

Base Salary: \$633,782

Recommended CEMRP STI Award: \$190,135 (30 percent of base salary)

Target Cash Compensation:* \$823,917, plus possible Long Term Incentive (LTI) awards starting after the end of the 2018-19 Plan Year

Funding Source: Non-State funded (100 percent from clinical enterprise revenues)

Prior Year Data (2015-16 plan year)

Base Salary: \$615,322

CEMRP Award: \$135,370 (22 percent of base salary)

Target Cash Compensation:* \$750,692

Funding Source: Non-State funded (100 percent from clinical enterprise revenues)

* Target Cash Compensation consists of base salary and, if applicable, incentive and/or stipend.

The incentive compensation described shall constitute the University's total commitment regarding incentive compensation until modified by the Regents or the President, 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 Clinical Enterprise Management Recognition Plan (CEMRP), previously approved by the Regents and fully funded from clinical revenues using no State funds, is a UC Health system clinical performance-based incentive plan that places a certain amount of pay at risk for each participant and pays out only if performance meets or exceeds benchmarks for pre-established objectives such as quality improvements and patient satisfaction, and other objectives such as financial performance. Performance-based, at-risk incentives are a typical component of total cash compensation at other teaching hospitals. CEMRP drives alignment of the five UC medical centers by establishing and rewarding the achievement of systemwide objectives, organization-specific objectives, and individual participant objectives based on the CEMRP tier in which the eligible employee participates. As the Executive Vice President – UC Health, John Stobo's achievement of CEMRP objectives is based on the approved systemwide objectives.

The Office of the President requested approval of a CEMRP Short Term Incentive (STI) award for Dr. Stobo as Executive Vice President – UC Health, which is tied to the attainment of a specific level of performance with regard to 2016-17 systemwide objectives. For the 2016-17 systemwide objectives, performance exceeded the maximum attainment level for all three objectives. The objective focusing on the Leveraging Scale for Value (LSFV) initiative resulted in a total combined savings across the UC Health system of \$541.9 million from improvements in supply chain and procurement, information technology expenditures, and the revenue cycle. The objective to improve access to care resulted in a reduction of Excess Bed Days by all six hospital locations (UCLA separates out the Ronald Reagan and Santa Monica locations in the calculation of performance targets) with an aggregate reduction of 286 percent. Lastly, the objective to mitigate financial risk in the current healthcare environment was focused on the development of best practices to monitor and report on metrics that contribute to financial risk for the UC Health system. This was accomplished through the development of a systemwide governance model, development and deployment of an electronic system to capture and monitor critical report parameters, and ultimately the implementation of the systemwide dashboard that reports on each UC Health enterprise and on the system as a whole.

Based on the achievement of the maximum level of performance of the equally weighted, pre-established and approved systemwide objectives, the amount of the award proposed for Dr. Stobo is \$190,135. This award represents 30 percent of Dr. Stobo's base salary as prescribed in the 2016-17 CEMRP Plan Document. No State funds are used to fund CEMRP incentive awards as the funding is solely from UC Health system revenues.

Under Dr. Stobo's leadership and coordination, the best practices at each of the five UC medical centers and their affiliated clinics continue to be leveraged to benefit the system as a whole with a demonstrated increase in the benefit of this systemwide effort year-over-year.

Consistent with Regents policy, this award has been reviewed and approved by the CEMRP Administrative Oversight Committee, comprised of the five chancellors of campuses with medical centers, the Executive Vice President – Chief Operating Officer, the Vice President – Human Resources, and the Executive Director – Compensation Programs and Strategy.

[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 Director Dennis Larsen briefly introduced the proposed Clinical Enterprise Management Recognition Plan (CEMRP) incentive award for Executive Vice President Stobo. Chair Kieffer noted that this item had been discussed extensively in the preceding closed session meeting.

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

Advisory member Lipstein reflected that the essential purpose of CEMRP is to encourage UC Health to work as a system. He suggested three criteria or indicators that would demonstrate successful collaborative work in the UC Cancer Consortium and that might prove useful to the Committee. The first he described as a "systemwide playbook" for cancer care prevention, detection, screening, and surveillance. The use of such a systemwide approach would be one indicator of successful collaboration. The second indicator pertained to patient accrual in clinical trials: the question of whether patients in these trials tended to come from medical centers other than the location of the principal investigator. The third indicator concerned implementation of systemwide programs and best practices in palliative care; many cancer patients are engaged in palliative care.

Committee Chair Lansing observed that there are many different views of effective cancer prevention among health professionals, and that patients can receive conflicting views. UC Health must maintain its innovative approach to research. Mr. Lipstein clarified that his idea of a "playbook" would include, as one example, all the types of cancer prevention being explored by UC Health, not one approach only. Committee Chair Lansing stressed that an important goal of the UC Cancer Consortium is to break down barriers so that patients have access to the benefits of the entire UC Health system.

Advisory member Smith commented on an existing barrier between the public health cancer surveillance and tracking functions, and the medical care cancer treatment functions. In the public health realm, the California cancer registry system collects a variety of data when individuals are diagnosed with cancer and vital statistics at the end of life, but has no data in between those two points. There is no relationship between the public health cancer registry data and clinical management data. The UC Cancer Consortium might be able to break down barriers between these two realms. He described these barriers as political rather than technical.

Referring to Mr. Lipstein's suggestion regarding patient accrual in clinical trials, UC Irvine Vice Chancellor Howard Federoff noted that it would be important to consider not only phase one trials, which are often limited to a single site, but to consider innovative trials as they move to phase two. Mr. Lipstein underscored that all UC medical centers have research pharmacies; clinical trials can be prepared at any medical center.

5. AFFILIATION FOR ADVISORY SERVICES IN CHINA, LOS ANGELES CAMPUS

[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.]

UCLA Health Sciences Vice Chancellor John Mazziotta began the discussion by recognizing that there are many opportunities for research, education, and patient interactions in international collaborations. For many years, faculty and students have requested that UCLA Health provide international opportunities, and the inception of UCLA's world health program was instigated by medical students. The affiliation discussed in this item would formalize one such opportunity in China. It had been crafted to provide maximal brand protection, to require no out-of-pocket costs, and to be financially beneficial to UCLA.

UCLA Health President Johnese Spisso explained that through this agreement, UCLA Health would enter a strategic affiliation to provide advisory services for the development of two hospitals in Guangzhou, People's Republic of China. UCLA Health would not be responsible for owning or operating these facilities. UCLA's role would be to share its consultative services to advance high performance and quality of care, patient safety, and effective hospital operations. UCLA Health would be responsible for providing those technical and advisory services with respect to operations and management, and through that would be entitled to receive fair market-value funding for those consultative services. UCLA Health had worked closely with legal counsel at the Office of the President to craft this agreement, which also is aligned with the mission and goals of the greater UCLA campus to improve health locally and worldwide. The affiliation would allow UCLA Health to establish an effective infrastructure for its international collaborations, to share best practices and expertise in quality and safety, and to improve health care in China. The affiliation is in alignment with the goals of a \$50 million gift to UCLA Health from Mattel, Inc. The affiliation would provide additional training opportunities and a new source of revenue for UCLA, remuneration for services that in the past were often provided free of

charge and without central coordination. UCLA Health had established safeguards that would allow it to terminate the agreement at any time, as well as strict controls on the use of the UCLA Health brand.

UCLA Center for World Health Director Thomas Coates explained that in conceptualizing its international health activities, UCLA had chosen as a focus the changes in longevity and health that are occurring worldwide. For the first time in history, human life expectancy is over 70 years of age, albeit with a lag due to the HIV epidemic in sub-Saharan Africa. The world's population would be aging and experiencing the diseases of aging. For this reason, it was important for UCLA to help build clinical capacity at the level of individuals and systems. UCLA Health has an integrated set of clinical, research, education, and management and consulting activities in pursuit of this goal. The proposed affiliation in China needed to be seen in the broader context of all UCLA Health's educational, academic, capacity-building, and collaborative research opportunities. UCLA Health has a large presence in China, and the proposed affiliation would enlarge this presence.

UCLA Health Executive Director of International Services Michael Burke named the two parties that would be involved in this agreement with UCLA: R&F Properties, a property development company in China that focuses mostly on construction and sales, but also has a large hotel management arm, and Medpoint Health Partners, a consulting and management firm based in Houston, Texas and in Singapore. Medpoint Health Partners has expertise in working with academic medical centers and assisting them with deploying their services in other countries. The proposed affiliation would help open two facilities in Guangzhou; it would be a ten-year master affiliation agreement. R&F Properties is solely the investor in this project, while UCLA Health would be the academic affiliate. Most of UCLA Health's activities in this affiliation would be identical to activities it has carried out in the past, such as hosting observers at UCLA so that they can gain an understanding of UCLA Health operations. Medpoint Health Partners would operate as UCLA's on-site, day-to-day manager in China. Before structuring this agreement, R&F Properties asked UCLA Health to complete a business plan, and UCLA Health wanted to ensure that these hospitals would be financially and operationally feasible. UCLA was now moving forward with the master affiliation agreement. Mr. Burke explained that both hospitals would have executive committees with representatives of UCLA Health, R&F Properties, and Medpoint Health Partners. The purpose of the executive committees is to provide recommendations to the investor, R&F Properties. UCLA Health would make recommendations and have access to information directly from the hospitals' executive offices, and make site or audit visits to ensure that quality standards are upheld. In the event that UCLA Health became uncomfortable in the agreement, termination could be triggered at any time the other parties did not follow a material recommendation made by UCLA Health in areas such as executive hiring; purchases of major medical equipment; short- or long-term strategic planning decisions; staffing, recruitment, and retention; financial, clinical, and operational performance; facility maintenance; and construction, including selection of materials. The agreement would apply only to Guangdong Province and would not block UCLA from any of its core activities of education and research.

Regent Makarechian asked how UCLA Health had come to choose Guangzhou. Mr. Burke responded that UCLA Health had received a range of requests for affiliations like this from Shanghai, Beijing, Chengdu, and other cities. The company, R&F Properties, distinguished itself as a good potential partner for UCLA Health. After completing the business plan, UCLA Health determined that it would be able to pursue a “first mover” strategy in this market. There were no affiliations of this type in Guangzhou at this time.

Regent Makarechian expressed concern about the University’s lack of control under this arrangement and the ability of the other partners to outvote UCLA. Mr. Burke responded that the termination provisions of the agreement addressed this. UCLA Health would have termination rights for the areas it considers most important. Principal Counsel Rowena Manlapaz acknowledged that four votes would be a majority vote on the hospitals’ executive committees, which would have seven members. Whether or not the executive committee passed a recommendation by UCLA Health, if the recommendation was not taken, UCLA would have the ability to terminate the agreement.

Regent Makarechian questioned the purpose of these committees, given this circumstance. Ms. Manlapaz responded that the committees had a governance function. UCLA Health hoped that all its recommendations would be taken up. Regent Makarechian stated that the University should have a majority vote on these committees. Ms. Manlapaz responded that UCLA could achieve this position as a practical matter. Regent Makarechian voiced concern that the other partners could easily force out UCLA Health, after having profited from the University’s work and expertise.

Committee Chair Lansing wondered about the rationale for this arrangement, which would be very risky for the UCLA Health brand, and asked what benefit the University would derive from it. Ms. Spisso responded that UCLA Health and other UC medical centers have carried out work in other countries for many years. The agreement would provide a structure for sharing UC expertise that had been shared in the past, as well as strict guidelines for the use of the UC brand. She anticipated that this agreement would provide an example of best practices for UC affiliations in other countries. In the past, UC faculty and staff have volunteered in other countries, sharing UC knowledge without much control over that sharing.

Regent Makarechian emphasized the many unknown quantities in this proposal and the possibility of financial and intellectual property loss for the University.

Committee Chair Lansing asked how the University might gain more control over the affiliation, and what the financial incentive would be. She asked what position UCLA would be in if the agreement ended after a year, in a worst-case scenario. Dr. Mazziotta responded that this would be a lucrative arrangement on a pay-as-you-go basis. He suggested that payments could be staggered so that UCLA would receive a better return in case of termination. Committee Chair Lansing underscored that she was not expressing opposition to the proposal, but real concern, and that the campus should examine a worst-case scenario. Ms. Spisso observed that the agreement was structured to balance two concerns of UCLA: the wish to avoid taking on operational risk and to avoid even the

appearance that UCLA was operating the facility – a reason for having a lesser degree of control and fewer votes – and the wish to be able to exit the agreement quickly if an issue of concern were to arise.

Chair Kieffer asked about the overall benefit UCLA would derive from this affiliation. Mr. Coates responded that China was currently undergoing significant changes, one of which was the increasing longevity of its population. In the next few years, life expectancy in China was expected to rise to 75 years. The major causes of death in China were cerebrovascular diseases and cancers. The Chinese healthcare system and healthcare providers needed the means to fight these diseases and to provide improved care for the country's large pediatric population. The gift to UCLA from Mattel would allow UCLA to work with children's hospitals in China to improve this care. The overall context of this affiliation was the effort to create centers of excellence that would provide training and improved clinical care in China. UCLA would benefit from research collaborations in a country with enormous patient populations and databases, and from exchanges between UCLA and Chinese faculty. The affiliation would provide pedagogical opportunities for UCLA students, who are keen to take part in international projects. In addition, UCLA would have the opportunity to help formulate health policy in an extremely important country.

Chair Kieffer remarked that UCLA would provide a great deal of information, technology, and knowledge in this affiliation. Beyond UCLA's motivation to do good in the world and improve understanding among nations, it was not clear to him what UCLA would gain. He asked that the campus delve more deeply into the question of the humanitarian and financial goals of the project. Dr. Mazziotta responded that the campus would provide an update at a future meeting.

Advisory member Dimsdale noted two kinds of reputational risk that might arise from this affiliation. An institution in China might have different values regarding conflicts of interest, conflicts of commitment, and the application of new drugs. Organ transplantation practices in China have drawn criticism internationally. These issues would reverberate and have an impact on UCLA. A second question concerned China's influence on UCLA and UC governance as an institution. An article recently published in *Inside Higher Education* reported that the Chinese government curtailed visits by Chinese students and scholars to UC San Diego and canceled scholarships after the Dalai Lama gave a commencement address there. The University would have to be prepared for unusual consequences resulting from this affiliation, and the termination provisions of the agreement might not address this concern.

Mr. Lipstein asked that UCLA provide the Committee with an estimate of possible monetary return from this affiliation and suggested that the agreement might not turn out to be as lucrative as anticipated. UCLA should address some other concerns as well. There was a question as to whether or not UCLA had adequate management time and resources for this undertaking. UCLA could achieve some of the positive results for clinical care in China that had been described without establishing this agreement structure. China has different human subject protection laws than the U.S., and if research were carried out

under these laws, this circumstance could affect the reputation of UCLA. He asked about the rationale for extending benefits to other communities outside Los Angeles and outside the U.S.

Regent Sherman asked if the University had engaged in similar activities in the past, without having complete control of a center or facility. Dr. Mazziotta responded that UCLA has provided medical advice in many countries without remuneration; the proposed affiliation would be the first formalized agreement of this magnitude and complexity. He stated that other campuses with medical centers must frequently receive requests to enter into agreements like the one being proposed.

Advisory member Smith suggested that UC Health work more as a system on the question of entering into agreements like this one. There should be a strategic systemwide approach to the use of the UC Health brand abroad and to generic questions about any such relationships.

6. **CLINICAL QUALITY DASHBOARD FOR UNIVERSITY OF CALIFORNIA MEDICAL CENTERS**

[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.]

UCSF Chief Medical Officer and Executive Vice President – Physician Services Joshua Adler presented updated information on the University’s clinical quality dashboard. Displaying a summary of statistics for measures of quality for inpatient care, he observed that UC Health was still facing a challenge in reducing its readmission rates. The systemwide score for central line-associated bloodstream infections was better than the national mean. Dr. Adler reviewed six-quarter trends through the second quarter of 2017. Inpatient mortality was decreasing, and UC’s mortality index, 0.78, was clearly below the national median of 1.0.

The rate of readmissions had been increasing, with absolute performance below the median, and this was a matter of concern. UC Health had now implemented what it believed to be best practices systemwide in areas such as discharge instructions for patients, safe transfers between units, transmission of information from the hospital to the next provider of care, and an automated telephone call program checking in on patients after their discharge.

UC Health’s next efforts would focus on partnering with post-acute care facilities: nursing homes, rehabilitation facilities, and home care agencies. A disproportionate number of UC hospital readmissions were patients from these types of facilities. In partnering with nursing homes, UC would help to set criteria about when nursing home personnel should call a UC medical center directly and discuss the case with the physician or team who cared for the patient most recently, and to see if the problem could be resolved locally, rather than by sending the patient back to the hospital. It would be difficult to bring about this

change in nursing home practices, since these are facilities the University does not own or operate. UC Health was beginning to see progress in this area.

Regent Makarechian asked if the median figures used for comparison were based on hospitals similar to the UC medical centers, or on all hospitals in the U.S. Dr. Adler responded that the benchmarks related to quality were established by Vizient Inc. and based on a large group of academic hospitals with teaching programs; some of these hospitals have research programs, others not. He remarked that UC medical centers might be more academic than the average academic hospital. The comparator group for patient experience benchmarks included all U.S. hospitals.

Chair Kieffer asked if the comparator group could be limited to a smaller group more like the UC medical centers, with a focus on the specialty care offered by UC Health. Whether one were to restrict the comparator group or not, UC Health should strive not merely to reach the median but to exceed the 75th percentile. Dr. Adler clarified that UC Health's target is the 90th percentile for all benchmarks. He noted that it is sometimes possible to delineate smaller comparator groups with institutions more like UC Health, working with Vizient, and UC would pursue this. Chair Kieffer suggested that a desirable policy position for UC Health might be to aim for the 90th percentile and always remain above the 75th percentile.

Advisory member Dimsdale asked about the reasons for the especially low inpatient mortality rate at the UCLA Santa Monica hospital. UCLA Health President Johnese Spisso responded that the reduction of inpatient mortality has been an important focus for UCLA, but put forward one caveat: compared to the Ronald Reagan UCLA Medical Center and other UC Health sites, the Santa Monica hospital might be better described as a community hospital, caring for patients with less severe conditions, with more tertiary care as opposed to quaternary care. Dr. Adler added that many factors are involved in reducing inpatient mortality, making it difficult to pinpoint one practice at one location that might account for lower rates. Overall, inpatient mortality across UC Health had been consistently decreasing over several quarters. He suggested that a large part of this reduction was due to infection prevention. UC medical centers have also been working on systems to reduce complications that may arise during or after surgery.

Dr. Adler commented on the fact that UC hospitals do not have affiliated or internal inpatient hospices. Some hospital systems have hospices inside their hospitals, and patients who are dying are transferred from the hospital to a hospice, and the case is not considered a hospital mortality. UC medical centers care for patients until the end of life if the patients do not have an option to leave the hospital and cannot receive good hospice care in the community.

Dr. Adler then briefly presented data on patient experience. UC Health was improving on most criteria, with some decrease in the quality of nurse communication in the last quarter. UC Health was examining the reasons for this decrease.

Regent Makarechian stressed that UC Health should be evaluated based on comparator hospitals that are truly similar to UC. Dr. Adler responded that UC Health seeks such a basis for comparison, but that deriving these benchmarks from the field is not easy.

Advisory member Lipstein observed that Vizient tries to adjust for case mix and risk. In his view, however, these risk adjustments were not adequate. He suggested that one could select a portion of the Vizient database to identify a specific type of teaching hospital, all those facilities with a case mix index above a certain threshold, in order to develop a more appropriate comparator group. He asked about the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) “Recommend” benchmark presented on one of the charts. He noted that this benchmark tends to reflect institutional reputation in addition to quality of service. There is another HCAHPS criterion, “Quality of Care,” and Mr. Lipstein asked why UC Health was using the “Recommend” rather than the “Quality of Care” benchmark. Dr. Adler responded that UC Health has focused on “Recommend” as the best summary indicator of how patients rate their experience, based on advice from Press Ganey Associates and other institutions. Mr. Lipstein suggested that UC Health examine the correlation of these two benchmarks in the HCAHPS survey – a patient’s likelihood to recommend a hospital and the quality of care.

Dr. Adler then outlined five ambulatory care quality benchmarks. Ambulatory care is an important part of the care provided by UC Health and by hospitals nationwide. The first benchmark concerned diabetes care, the degree to which UC Health can help patients control their blood sugar level, measured by the proportion of UC patients with high blood sugar. The second criterion pertained to colon cancer screening. Colon cancer is perhaps the most preventable form of cancer, and early detection often equals prevention. The third criterion was tobacco use screening, and the fourth was blood pressure control. The fifth benchmark was Caesarean section rate, and something of a controversial benchmark due to differences in patient preference in different regions of the nation and within California. Nevertheless, there is a belief in the medical community that lower Caesarean section rates are beneficial to mothers and children.

Dr. Adler presented a chart showing UC medical centers’ performance for these benchmarks. The diabetes benchmark reflects the proportion of patients whose blood sugar levels are too high. In the 90th percentile, 30 percent or less of patients fall into this category. Most UC medical centers were above the 90th percentile for this criterion and had only a small proportion of patients whose diabetes was poorly controlled. UC Health was performing well in this area, related to its work as part of the Medicaid waiver program. UC medical centers were also performing well in colon cancer screening, although they could screen even more patients, and they were performing well in tobacco use assessment and counseling. A criterion to be developed later would be the number of patients who then quit smoking. UC Health is very successful in controlling patients’ blood pressure. For the Caesarean section rate benchmark, the 90th percentile in the State of California represents a situation where only 20 percent of first-time, low-risk pregnancies have a Caesarean section. None of the UC medical centers was in the 90th percentile, but they were within reasonable range. Dr. Adler noted that UC Health was performing well in these five

outpatient measures, but that one could identify other measures for outpatient care in which UC was not performing quite so well.

Chancellor Block asked about the population of patients that was being screened for colon cancer. Dr. Adler responded that this population consisted of all ambulatory patients in UC's primary care clinics, well over 500,000 patients; it did not include patients referred to a UC medical center only for a specialized service.

Dr. Adler concluded his discussion by presenting a chart showing percentages of patients with hospital-acquired pressure ulcers. In these cases the skin and tissue beneath the skin are injured through excess pressure. UC Health has devoted time and effort to reducing these ulcers, but over the last several quarters the trend had been going in the wrong direction, and this caused UC to take a new look at this problem. In the past, patients who suffered pressure ulcers were predominantly frail or elderly and confined to bed without moving. The number of these cases had been reduced, but UC Health was now observing a new kind of pressure ulcers caused by equipment or devices, especially when plastic is held against a patient's skin for long periods. UC Health was reviewing the equipment it uses and identifying which kinds of equipment are preferable for the purpose of preventing pressure ulcers. Executive Vice President Stobo noted that this was an area where UC health's procurement program would work with this dashboard information to ensure purchasing of the best equipment.

Regent Makarechian asked why the pressure ulcer rate at UC Irvine was relatively high. Dr. Adler responded that UC Health was just beginning to investigate this issue. Regent Makarechian asked when UC Health might find an answer to this question. Dr. Adler estimated that this investigation would take a few months because the medical centers must inventory all pieces of equipment that have caused pressure ulcers. Committee Chair Lansing emphasized that this was a significant initiative that would alleviate suffering.

Regent Sherman asked if the figures presented on graphs for the medical centers were moving averages or specific points in time. Dr. Adler responded that the figures represented specific points in time. Regent Sherman suggested that it might be more effective and fair to evaluate the medical centers' progress using moving averages rather than specific numbers at specific points in time, given the significant variability among the medical centers. Committee Chair Lansing added that patient mix is also a crucial factor.

The meeting adjourned at 3:00 p.m.

Attest:

Secretary and Chief of Staff